J.B.N.Q.A. IMPLEMENTATION NEGOTIATIONS

POSITION PAPER

NO. 3

HEALTH
&
SOCIAL SERVICES

Submitted without prejudice to such other and further claims which Makivik and/or the Inuit of Nunavik may have.

Presented by

Makivik Corporation
on behalf of
The Inuit of Nunavik

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1. BACKGROUND

On November 11, 1975, the Inuit executed together with the Governments of Canada and Québec the James Bay and Northern Quebec Agreement ("J.B.N.Q.A.") which contains, in its Chapter 15[1], important provisions concerning health and social services for the population of the whole Nunavik territory. For purposes of health and social services delivery, the Nunavik region is presently identified as Administrative region 10A[2], which is described in Order-in-Council No 1020-79[3] as "all the territory of the Province of Québec located north of the 55th parallel, excluding Category IA and IB lands attributed to the Cree of Kuujjuaraapik".

The J.B.N.Q.A. contemplates the creation of a Regional Health and Social Services Council which was in fact created by the same Order-in-Council 1020-79 of April 11, 1979 under the name of "Kativik Regional Council for Health and Social Services\Conseil Régional Kativik de la Santé et des Services Sociaux" (C.R.S.S.S.). Two other establishments were also created within the Nunavik region, namely: the Ungava Bay Hospital (servicing the Ungava Bay sector) and the Inuulitisivik Hospital (servicing the Hudson Bay sector).

Health and Social services are currently provided in 14 communities scattered over a territory having a superficy of 563,515 square kilometers. Due to the particular geographical and demographical situation of Nunavik, the two establishments are providing, within their respective sectors, all the services normally delivered by what are known in southern Québec as the C.L.S.C., the Hospital Centre, Reception Centre and Social Services Centre. They are in fact playing the role of "Health Care Centres" even though they cannot yet carry on that denomination. They are

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1 See copy of Chapter 15, attached hereto as Annex 1

2 The region shall, in the future, be identified as region 17

3 See copy of Order-in-Council 1020-79 "Concerning the delimiting of the territory of region 10A and the institution of a board of health and social services for that region", attached hereto as Annex 2

operating according to a multi-disciplinary approach and philosophy, all the services being regrouped under the jurisdiction of their respective Board of Directors.

The two abovementioned establishments and the C.R.S.S.S. have been created and continued under an "Act Respecting Health and Social Services" (1971, ch. 48), subject, however, to some specific provisions negotiated and incorporated in the J.B.N.Q.A. to answer the needs and specificities of Nunavik and its population.

Since the execution of the J.B.N.Q.A., the abovementioned Act has been amended on numerous occasions and the Quebec Government is currently in the process of again substantially modifying the legislation concerning health and social services delivery for all the administrative regions of Québec. "An Act Respecting Health Services and Social Services", L.Q. 1991, Chapter 42 (Bill 120) was adopted on August 28, 1991 and assented to on September 4, 1991. It provides for a greater involvement of regional authorities in the overall administration of the health and social services system. It further provides that Health and Social Services Councils will be replaced by Regional Health and Social Services Boards which will have more latitude in the definition of regional health and social services priorities, in the organization and coordination of services, in the allocation of financial resources to institutions or community services as well as in the management of human, material and financial resources.

When first tabled in draft form, Bill 120 contained in its section 398 a provision which excluded Nunavik (region 10A) from its application. The old Health and Social Services Act was to continue to apply under a new title: "An Act Respecting Health Services and Social Services for Cree and Inuit Persons"

In a Brief tabled in January 1990 to the Parliamentary Commission on Health and Social services[4], the C.R.S.S.S. rejected the idea of being left out of the impending

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4 See the "Presentation to the Parliamentary Commission on Draft Bill on the Act respecting Health and Social Services made jointly, on March 15, 1990, by Mr Eli Weetaluktuk, Chairman of the Kativik CRSSS, Mr George Koneak, Chairman of the Ungava Hospital, Mr Paulosie Padlayat, Chairman of the Innulisivik Hospital and Mrs Lizzie Epoo-York, General Manager of the Kativik CRSSS, hereto attached as Annex 3

reform and clearly sought substantive modifications to the regime presently applicable to Nunavik:

> As Inuit, we wish to establish that we agree generally with the modifications to the powers and responsibilities of a regional authority as provided in the draft bill. We anxiously await ratification of these powers and responsibilities. We have been prepared to take these on for some time as evidenced by our previous statements to government."[5]

As we can see, the C.R.S.S.S generally supports the new direction and modifications to the powers and responsibilities proposed for regional authorities such as the Regional Health and Social Services Boards. Greater decentralization and regionalization of health and social services would provide for the possibility to develop more efficient and appropriate services to respond to the needs of the Inuit population.

> "The modifications to the powers and responsibilities of the regional authority will enhance our ability to develop the orientation and activities required to meet specific objectives in our region. The potential for flexibility within programs will stimulate involvement by health care personnel and the population at large. Therefore, the Inuit people are requesting the powers that the Ministry is ready to give to all regions but more significantly the budget necessary to make this power significant. It is time that the Regional Board of Health and Social Services be given the control over the budget spent to do studies on the state of Inuit's health and well being, on their needs and for service delivery. At this point in time, much money goes to southern establishments (in Québec, Montréal, Val d'Or) for services to the North without any control by our region."[6]

Even though the C.R.S.S.S. made such a presentation in January 1990 and reiterated its position subsequently in a supplementary Brief tabled to the same Parliamentary Commission in January 1991, [7] Nunavik (region 10A) was still being

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5 Idem, p.3

6 Idem, p. 2

7 See the Additional brief tabled to the Parliamentary Commission on Draft Bill 120" in January 1991, by the Kativik Regional Council of Health and Social Services, hereto attached as Annex 4.

"La réforme vise à corriger des problèmes d'accessibilité à certains services ainsi qu'à mieux adapter l'ensemble des services aux populations changeantes. Les jeunes et les personnes âgées à cet égard sont sources de préoccupation particulières et constituent une priorité du Ministère. À cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:

Nations autochtones

29- l'implantation de régies régionales en territoire cri et inuit.[10]

Additional legislative adjustments will be required in order to answer the needs and the specificity of the region and to meet some of the principles and undertakings contained in the J.B.N.Q.A. Conversely, some modifications will be necessary to adjust Chapter 15 of the J.B.N.Q.A. to address the evolution of the situation since 1975.

A meticulous review of Bill 120 as assented to as well as of Chapter 15 of the J.B.N.Q.A. and L.R.Q.. Chapter S-5, has been conducted in order to identify the provisions which will require adjustments and those which cannot find application as drafted in Nunavik. In the following pages, we will address each particular issue and provide the relevant explanations and documentation.

It is not possible nor advisable to limit the discussion to the technical aspects of legislative modifications required to include Nunavik into the new reform. We must also address the question of adequate financial and human resources which will have to be provided to the new Nunavik Board in order to fulfill its new mandate. We believe that the result of the discussions concerning the said resources with indicate the willingness of the Government to have the Inuit as full partners in the new system.

We will discuss at length the subject of training in the field of health and social services, an issue which has remained basically unimplemented for more than fifteen years. According to the J.B.N.Q.A., special programs were to be created with

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10 Idem P. 9

the objective of improving employment and advancement opportunities for Inuit personnel. However, no such programs were ever put in place despite the important needs of Nunavik.

Another outstanding issue remains the establishment of appropriate nursing facilities for the community of Kuujjuarapik to the satisfaction of the inuit residents of this community.. More specifically, a permanent solution has to be found to improve the delivery of health and social services and provide an adequate environment for patients and personnel.

The document will also address such issues as the non-insured services to be supplied without cost to the beneficiaries of the J.B.N.Q.A., the transfer of responsibility and budget from DCS\CHUL (Projet Nord) to the new Nunavik Regional Health and Social Services Board (hereafter the "Nunavik Board"), the urgent location of rehabilitation services within Nunavik, the reorganization of patients' services in the Montreal area and the access to Government-funded programs for community organizations.

2 APPLICABILITY TO NUNAVIK OF THE "ACT RESPECTING HEALTH SERVICES AND SOCIAL SERVICES AND AMENDING VARIOUS LEGISLATIONS" (1991, ch.42)

We will now discuss the specific provisions of the abovementioned law requiring adjustments in order to meet the specificity of Nunavik. We will follow the numerical order of the Act for easier reference to the new legislation and a better understanding of our positions.

2.1 USER'S COMPLAINT (Chapter III, Sections 29 to 78)

This Chapter of the new law formalizes the actual complaint process which has in fact been informally developed in most establishments and regional councils over the years. It creates an obligation for the two Nunavik Health Centres and the Nunavik Board to adopt a formal complaint procedure and to appoint a senior

management officer responsible for the application of this procedure. No such procedure presently exists in Nunavik.

In addition, the law contemplates the creation of the new position of "Complaints' Commissioner", like a Health and Social Services ombudsman, to whom patients can address their complaints when unsatisfied with the original answer of the Health Care Centre and/or the Regional Board. There are no major difficulties with the content of these provisions. In general, the Inuit agree with the idea but they would like to obtain greater assurances concerning the effective access to this new recourse. The Inuit do not want to see this "Complaint Commissioner" recourse remain theoretical because it would be perceived by the Inuit population as being open only to people from the south.

Proposed solution

Sections 55 to 65 shall apply to region 10A subject to the following provisions:

a) any complaint originating from a person who have received health or social services from an institution located within region 10A, or for services rendered to an Inuk beneficiary of the JBNQA outside said region, shall be examined by the complaints commissioner in joint collaboration with an assistant complaints commissioner specifically appointed by the Government to examine the above mentioned complaints;

b) the assistant complaints commissioner appointed for the application of this section shall be a beneficiary of the JBNQA duly registered according to sections 9 and 10 of the "ACT RESPECTING THE CREE, INUIT AND NASKAPIS PERSONS (Q.R.S. Ch A-33.1);

c) the assistant complaints commissioner shall be appointed upon the recommendation of the Nunavik Board, and act on an ad hoc basis, whenever a complaint is addressed to the Complaint Commissioner;

d) The Government shall fix the salary or fees and other terms of employment of the assistant commissioner;

2.2 PUBLIC INSTITUTIONS (Sections 79 to 99)

2.2.1 General Provisions

The new Act contemplates in Sections 79 and following, the creation and operation of different types of centres to provide a variety of services to the population of

Nunavik. According to these general provisions, those centres would normally be operated by institutions specialized in one particular field of activity. For example, an institution being administered by a Board of Directors could operate more than one rehabilitation Centre or Hospital Centre but would normally restrict its activities to one particular type of service centre.

However, in its Section 92, the Act provides the possibility for the Minister to designate as a "health care centre" an institution which offers more than one type of service taking into consideration the geographic and demographic factors of a region.

> Section 92
>
> "The minister may designate as a health care centre an institution which operates a Local Community Service Centre and which, owing to the low population density and the size of the territory, also operates a centre mentioned in paragraph 2 (hospital) or 4 (a residential and long term care centre) of section 79."

The Inuit agree with the principle set forth in Section 92 but this Section does not fully answer the needs of Nunavik. It would be desirable to see the legislation adapted so as to reflect the intent and spirit contained in Section 15.0.9 of the J.B.N.Q.A. which provides for the regrouping all the health and social services under the jurisdiction of the establishment operating in each of the two sectors in the territory. Such an approach would avoid the multiplicity of boards of directors and would permit the multi-disciplinary approach favored by the Inuit population.

A section similar to Section 92 could be added to address the specific context of Region 10A. The two "health care centre" institutions located within Nunavik should be authorized to operate (under the responsibility of their respective Board of Directors) all the services normally provided by the various centres listed in Section 79, namely:

- C.L.S.C.
- Hospital
- Child and Youth Protection Centre
- Residential and Long-Term Care Centre
- Rehabilitation Centre

Proposed solution

"Notwithstanding section 92, there shall be established by letter patents one Health Care Centre Institution for each sector of Region 10A which shall be entrusted to provide services as:

a) local community centre;
b) hospital;
c) child and youth protection centre;
d) residential and long-term care centre;
e) rehabilitation centre."

2.2.2 Composition of Boards of Directors of Public Institutions (sections 119 to 148)

Sections 119 to 148 establish the regulations for the composition of the boards of directors of public institutions, including "Health Care Centres". The rules for such centres are more particularly defined in Section 131. However, they cannot be applied, as drafted, to region (10A).

The Inuit wish to retain the procedure for the election of the Board of Directors for their Health Care Centres as defined in Section 15.0.12 of the J.B.N.Q.A. Minor modifications to the J.B.N.Q.A. would be needed to both the JBNQA and the Act in order to adjust the actual composition to the requirements of the new legislation.

The most significant difference between the composition of the Board of Directors proposed by Section 131 and the de facto situation is the exclusion of the person known, under the JBNQA, as the "director of the community health department of a Hospital Centre"[11] as a member of the Board.

In practice, said seats were often not filed because none of the two Nunavik establishments ever created Community Health Departments. Public health has always remained, until today, under the sole responsibility of DSC\CHUL which, despite working in close collaboration with the establishments and C.R.S.S.S., is not

11 As contemplated in section 15.0.12 (d) J.B.N.Q.A.

g) the executive director of the Health Care Centre institution concerned;

Such representatives shall be elected according to the election proceedings established by the Nunavik Regional Health and Social Services Board under section _____.

If an election is not held, the Nunavik Regional Health and Social Services Board shall make the appointment."

2.2.3 Reimbursement of expenses (Section 165)

This Section cannot be applied as drafted. The particular situation of the Region has to be taken into consideration. Board members often have to be absent from their communities from 2 to 5 days in order to attend a one-day Board of Directors' meeting.

Proposed solution

Notwithstanding the provisions of Section 165 and 400, the members of the Board of Directors and of the administrative committee of the Regional Health and Social Services Board and the members of the Board of Directors and of the administrative committee of a public institution situated in the region shall be indemnified in accordance with regulations to be adopted by such boards for the expenses and loss of income of the members as a result of attending meetings.

Such regulations shall take into account the prevailing conditions inNunavik, shall be subject to the approval of the Minister of Health and Social Services and shall also take into consideration the following:

a) Boards meetings shall be scheduled, whenever possible, to avoid conflict with the remunerated work of board members and to take advantage of convenient or inexpensive transport.

b) If in spite of the foregoing, individual members suffer loss of income, the board may indemnify such members for such loss, upon application therefore and where:

   i) the board member represents or normally resides in a community other than that in which the meeting is held, and

   ii) the board member is either self employed or employed under conditions which preclude continuation of remuneration during time absent to attend such meetings, and

   iii) loss of remuneration is clear and unequivocal rather than potential.

excluded from the application of the new legislation as is apparent from Sections 594 and 620:.

Section 594

"The title of the Act respecting health services and social services (R.S.Q.Ch. S-5) is replaced by the following title: "An Act respecting health services and social services for Cree and Inuit Native persons."

Section 620

"This Acts replaces the Act respecting health services and social services (R.S.Q. Ch S-5) except to the extent that it applies to the territory of the James Bay Cree health and social services council and the territory of the Kativik health and Social Services council."

Nevertheless, as it appears from a statement made by Mr. Marc-Yvan Coté, Minister of Health and Social Services at the second series of hearings held by the Parliamentary Commission on Bill 120 in March 1991, the Government is well aware of the fact that Inuit wish to have their own Regional Health and Social Services Board and, consequently, the Minister agreed to initiate discussions to secure full participation of the Inuit in the reform of health and social services.[8]

Following this commitment, a letter from the Coordinator to Native Affairs for the Ministry of Health and Social Services, Mr Roger Richard, together with assurances received at a meeting with Government officials in December 1991, confirmed the fact that the Government would accept to review its position and would modify the new Health and Social Services legislation to amend Section 620 so as to ensure the full participation of Nunavik.

That commitment was reaffirmed in the "plan d'implantation" of the new legislation rendered public by Mr Marc-Yvan Côté, on March 23, 1992. [9]

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8 See "Notes pour la présentation du Ministre de la Santé et des Services Sociaux lors de l'ouverture de la Commission Parlementaire sur le Projet de loi 120, 19 mars 1991, P. 13" hereto attached as Annex 5

9 Une réforme axée sur le citoyen, Plan d'Implantation, M.S.S.S., 23 mars 1992, Page 9, hereto attached as Annex 6

2.2.4 Number of Board of Directors' meetings per year (Section 176)

Taking into consideration the geography of the Region and the high cost involved to gather all the directors in any one location, it appears impossible for the two institutions to hold ten (10) meetings per year. At the present time, the general by-laws adopted by the institutions provide for the holding of a minimum of four (4) meetings per year. It is desirable and more economical to maintain the same rule under the new law.

Proposed solution

> "Notwithstanding section 176, the Boards of Directors of the public institutions of the region shall meet at least four (4) times a year. They must also meet at the request of the chairman or at the written request of one third of the membership.

2.2.5 Appointment of an Executive Director to a public institution (section 193)

Section 193 contains a reference to the "Centre de référence des directeurs généraux et des cadres", a new body created to assess whether or not candidate qualify to hold the position of Executive Director of a regional board and/or public institution. This section reads as follows:

> "No person may be appointed as Executive Director of an institution unless the "Centre de référence des directeurs généraux et des cadres" attests that heor she qualifies for such an appointment
>
> The appointment of an Executive Director may not be renewed unless the body referred to the above attests that he qualifies for reappointment or that he meets the requirements for holding the position as established at the time the classification of the position is determined."

However such a rule raises an important question concerning the hiring of Inuit or even their reappointment if they do not meet some of the criteria set for southern institutions. Presently, the two Executive Directors of the Health Ccare Centres and the Executive-Director of the C.R.S.S.S. are Inuit. Future criteria may not allow Inuit to qualify for the positions.

Clearly the present appointments must be maintained and protected against subsequent reconsideration.

The Board of Directors of each institution and the Board of Directors of C.R.S.S.S. wish to retain the possibility to hire Inuit candidates to any position which they feel that such candidates answer their needs. It is difficult to imagine how such flexibility could be retained if there were to be a compulsory prior approbation from the "Centre de référence". Yet, it could be useful to have access to the bank of candidates from the "Centre de référence" in cases of vacancies.

Proposed solution

> "Notwithstanding section 193, 414 and 521 to 530, the criteria of qualification applicable to the selection of Executive Directors or senior management directors of regional boards and public institutions, as defined in by-laws adopted by the "Centre de référence des directeurs généraux et des cadres" shall not be applicable to candidates applying to any of the above mentioned positions within Region 10A."

2.2.6 Council of nurses (sections 219 to 225)

There is no desagreement with the creation of such Council if due consideration is given to the specific circumstances of the region. The nurses' aid should be full members of such Council instead of belonging to a sub-committee of the Council. Perhaps more than anywhere else in Québec, nurses and nurses' aids are working in close collaboration within Nunavik. This situation should be recognized.

Proposed solution

> "Notwithstanding sections 219 to 225, the Councils of nurses for the institutions located within each of the sector of region 10A are composed of all the nurses and nurses' aids in a centre operated by these institutions."

2.3 NUNAVIK REGIONAL HEALTH AND SOCIAL SERVICES BOARD

2.3.1 Regional Medical Commission (Section 367)

This Section provides for the creation of a "Regional Medical Commission" mandated to advise the Nunavik Board on the organization and distribution of medical services, as well as on the remuneration methods and on the organization of the practice of physicians.

There are no difficulties with the intent or spirit of said Section but important adjustments would be required taking into account the unique situation of Nunavik.

The membership of this Committee would, according to the law, be composed of three general practitioners, three specialists, the director of public health, the Executive-Director of the Regional Board, four doctors appointed by the Regional Board and four observers (doctors) appointed, upon recommendation of the Medical Commission, by the Regional Board, as resource persons.

It is impossible, to set up such a large Committee within Nunavik. Therefore, it is recommended that this Committee be composed as follows:

- two (2) physicians, being members of the Council of Physicians, Dentists and Pharmacists of each health care centre;
- the Director of Public Health;
- the Executive-Director of the Nunavik Board, or his nominee;
- a number of observers who could act as resource persons.

Proposed solution

Notwithstanding section 367, the Nunavik Medical Commission constituted in Nunavik is composed of:

(1) two members of the Council of physicians, dentists and pharmacists established in the institution of each sector;

(2) the Director of Public Health;

(3) the Executive-Director of the Nunavik Board or his nominee;

> On the recommendation of the Nunavik Medical Commission, the Nunavik Board may also appoint a maximum of four resource persons as observers. Such persons shall participate in the discussions of the commission but shall be without voting rights.

2.3.2 Functions related to Public Health (Sections 371 to 375)

The above-referred to sections can apply as presently worded.

However, the question which remains to be addressed is that of the allocation of adequate financial resources. Until now, the DSC-CHUL has been responsible providing public health services in Nunavik. In fact, Nunavik is still the only region in Québec not to have a Community Health Department in one of its own establishments. The DSC\CHUL (Projet Nord) is operating out of Québec City, a situation which is no longer acceptable.

While the DSC/CHUL was originally appointed, its mandate and the extent of its involvement in Nunavik were never clearly spelled out. "Projet-Nord" was set up as a separate administrative sub-unit within the DSC\CHUL and over the years, its role and functions did vary according to changing needs.

With the creation of the Nunavik Board in the near future, it would only be logical to reallocate the funding (evaluated at approximately $400,000. presently) allocated to DSC-CHUL through "Projet-Nord" in order to allow the Nunavik Board itself to fulfill the mandate given by Sections 371 to 375 of the new legislation.

As stated by representatives from Nunavik in the Parliamentary Commission on Bill 120 in March 1990:

> It is time that the Regional Board of Health and Social Services be given the control over the budget spent to do studies on the state of Inuit's health and well being, on their needs and for service delivery. At this point in time, much money goes to southern establishments (in Québec, Montréal, Val d'Or) for services to the North without any control by our region."[13]

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13 Op. cit. note 4, P. 2

It is important to underline the fact that the above mentioned $400,000. budget has not been revised or indexed for many years. It should consequently be adjusted.

In addition to the positions already existing at DSC\CHUL (Projet Nord) the Nunavik Public Health Department will require additional human resouces to fulfill the new mandates given to it under the new legislation, namely:

- one Public Health Director;
- one Administrative secretary;
- one information agent attached to Public Health issues;
- one interpreter.

The "plan d'implantation" released on March 23, 1992 by the M.S.S.S. identifies Public Health as one of the important sectors to be reorganized before April 1993.

> "D'autres mesures sont retenues pour améliorer l'accessibilité aux services médicaux et hospitaliers, réorganiser la mission de la santé publique, consolider la recherche et l'enseignement et accroître l'efficience du système.
>
> À cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:
>
> Santé publique
>
> 50- la rérganisation des responsabilités du Ministère en santé publique et la nomination du directeur provincial de la santé publique;
>
> 51- la nomination d'un directeur régional de la santé publique dans chaque région;
>
> 52- la conception d'un plan de réorganisation de la santé publique dans chaque région et l'amorce de sa mise en oeuvre.14

According to information from the CRSSS Conference, budgets for the reorganization of Public Health Services are supposed to be made available for as early as the fall of 1992. Nunavik must not be left out of such budget allocation.

It is consequently requested:

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14 Op. cit. note 9, P. 12 - 13

- that the $400,000. budget actually allocated to DSC\CHUL (Projet-Nord) be reallocated to the Nunavik Board for the fulfilment of its responsibilities under the new law;

- that this $400,000. budget shall be retroactively revised and indexed according to the cost of living index;

- that in order to allow the Nunavik Board to maintain the actual level of Public Health Services the $400,000. budget be revised and increased, to include the cost of living differential applicable following the relocation of the DSC\CHUL positions to Nunavik;

- that additional funding be allocated for the hiring of the new personel required for the fulfilment of new mandates and functions given to the Nunavik Board under the new law.

Note: Actual positions at DSC/CHUL

- One physician — costs covered by RAMQ
- one dentist — costs covered by RAMQ
- one coordonator
- one nurse
- one secretary
- one research agent
- 1/2 epidemiologist

2.3.3 BOARD OF DIRECTORS OF THE REGIONAL HEALTH AND SOCIAL SERVICES BOARD (Sections 397 to 413)

Some important adjustments will be required for the sections of this division. It is virtually impossible to contemplate operating a Regional Assembly in Nunavik. The costs and difficulties related to the organization and operation of such a body would be prohibitive.

Given that most of the members of the Board of Directors are to be elected by the Regional Assembly, the greatest participation of the population of the region has to be promoted through an alternative scenario.

a) Administration by a Board of Directors other than the Kativik Regional Government Councillors

Before elaborating on our proposed approach for the composition of the Board of Directors of the future Nunavik Board, it is important to examine some of the administrative difficulties presently met by the Kativik Council in its daily operations.

This issue was also discussed in 1975 when the JBNQA was being negotiated. It was then decided that the Kativik Regional Government Council was to exercise all the rights, powers, privileges and obligations of the Kativik Health and Social Services Council.

Section 15.0.4 of the J.B.N.Q.A. reads as follows:

> "All the rights, powers, privileges and obligations of the Kativik Health and social services Council shall be exercised by the council of the Regional Government.
>
> The functions, powers and duties of the administrative committee, general manager and staff of the Kativik Health and Social Services Council shall be exercised by the executive committee, the head of the Health and Social Services Department of the Regional Government and the officers of the Regional Government respectively."

Experience has now shown that this option is the source of constant and pervasive administrative difficulties in the daily operation of the Kativik CRSSS.

The last fifteen (15) years have illustrated the limitations of too close an administrative link between the two organizations. A drafted Section 15.0.4 violates the principle of an independent legal and operational structure for a regional health and social services council. The wording used has often created confusion concerning the dividing line of responsibilities or powers between the Kativik C.R.S.S.S. General Manager and the K.R.G.'s General Manager, rating frustration and dissatisfaction on the part of the two persons occupying those positions. A similar situation also occured occasionally between the Kativik C.R.S.S.S. General Manager and the K.R.G.'s Secretary when it was necessary to determine who was responsible to sign official documents or contracts in the name of the Kativik C.R.S.S.S. While in another C.R.S.S.S., the Director General can sign most of the contracts, it has proven to be impossible to do so in Nunavik.

The Kativik C.R.S.S.S. recently hired a Director of Finance but again, division of the same unsettled problem arose between him and KRG's Treasurer. Technically speaking, the Kativik CRSSS cannot have its own Treasurer.

It has become obvious to all involved, within both organizations that a clarification of their respective roles is required. If not modified, such duplication of roles between K.R.G. and the Kativik C.R.S.S.S. officers could create even greater administrative difficulties when the new orientations and the new legislation of the Ministère de la Santé et des Services Sociaux (MSSS)will have to be fully implemented. By virtue of its largely increased mandate, the Nunavik Board has to be in a position to itself exercise all the powers and responsibilities which will be devolved to it. Therefore and in the best interest of both organizations, it will be absolutely necessary for the Nunavik Board to have its own administration without having to share its senior management directors or officers with another organization.

This position of the Kativik CRSSS does not imply that it could not continue to collaborate with KRG on files of common interest such as public health issues. The legal separation between the two organizations is the natural result of the the Kativik CRSSS's recent development as well as of the enlargement of its mandate under the health and social services reform.

b) **Composition of the Board of Directors**

*I*n fact, in order to preserve a good working relation and good communication between the KRG and the Nunavik Board, one Regional Councillor would continue to sit as representative of KRG on the Board of directors of the Nunavik Board. Community representatives would be appointed among the elected members of each Municipal Council instead of, as elsewhere in Québec, of being elected by a Regional Assembly. Each municipality would then have the flexibility to appoint the person already designated as Regional Councillor or to appoint another representative.

Mr Eli Weetaluktuk, Chairman of both the Kativik CRSSS and KRG, told the Parliamentary Commission:

> "The Kativik Regional Board of Health and Social Services already meets the objectives of the Government's new orientations in that the Board is comprised of elected representatives from each municipality in the region. This unique composition result from the provisions of Chapter 15 in the James Bay and Northern Québec Agreement. As such, it answers the numerous questions raised by this Commission in regards to accountability. As elected people, each one of us as representative of a specific community or village, has to be responsible in front the population of our community."[15]

It is important to recall that other people would join the Councillors as members of the Nunavik Board, namely one representative from each Health Care Centre and the Executive-Director of the Regional Board.

It is also important to correct the unique and awkword situation of the Kativik CRSSS's General-Manager who is not a member of the present Kativik CRSSS Board of Directors. This situation should be reviewed to allow the full participation and involvement of the Executive-Director, as it is the case elsewhere and as contemplated in section 397 of the new legislation.

Proposed solution

398, 399, 400, 401

Notwithstanding sections 397 and 419, the Board of Directors of the Nunavik Board shall consist of the following members:

a) one representative from each municipality, said representative being appointed by the respective Northern Village Corporation among the elected members of the Council;

b) one representative from each Health Care Centre Institution , appointed by the respective institution among the inuit members sitting on said Boards of Directors;

c) the Executive-Director of the Nunavik Regional Health and Social Services Board;

d) one Regional Councillor appointed by the Board of Kativik Regional Government;

? Durée du terme. En ce moment les représentants des Munic. à K.R.G. = 2 ans.

15 Op. cit. note 4, Presentation to the Parliamentary Commission on draft Bill 120, March 15, 1991 (P. 1)

With the exception of the Executive-Director, the term of office of members of the Board of Directors is the same as the one determined for their position as *Municipal Councillors* or Regional Councillors of theKativik Regional Government or members of the Health Care Centre Board of Directors.

Any vacancy among the members elected or appointed in accordance with the present section shall be filled by following the mode of election prescribed for the election of the member to be replaced, but only for the unexpired portion of the term of such member.

2.3.4 Reimbursement of Expenses (Section 400)

This section cannot apply as drafted. The particular situation of the region has to be taken into consideration. Due to travel time and weather conditions, Board members often have to be absent from their communities from 2 to 5 days in order to attend Board of Directors meetings.

Proposed solution

Notwithstanding the provisions of Section 165 and 400, the members of the Board of Directors and of the administrative committee of the Nunavik Health Care Centre Board and the members of the Board of Directors and of the administrative committee of a public institution located in Nunavik shall be indemnified in accordance with regulations to be adopted by such boards for the loss of income suffered by the members as a result of attending meetings. The members may also be indemnified in accordance with the said regulations for their expenses incurred in attending such meetings.

Such regulations shall take into account the prevailing conditions in Nunavik, shall be subject to the approval of the Minister of Health and Social Services and shall also take into consideration the following:

a) Boards meetings shall be scheduled, whenever possible, to avoid conflict with the remunerated work of board members and to take advantage of convenient or inexpensive transport.

b) If in spite of the foregoing, individual members suffer loss of income, the board may indemnify such members for such loss, upon application therefore and where:

   i) the board member represents or normally resides in a community other than that in which the meeting is held, and

   ii) the board member is either self employed or employed under conditions which preclude continued remuneration during time absent to attend such meetings, and

   iii) loss of remuneration is clear and unequivocal rather than potential.

2.3.5 Selection of Executive-director (Section 414)

Section 414 of the new Act indicates that the "Centre de référence des directeurs généraux et des cadres" is the new body created to determine whether or not candidates qualify to hold the position of Executive Directors of regional boards and public institutions.

As in section 193, section 414 provides that "no person may be appointed as executive director of the Regional Health and Social Services Board unless the "Centre de référence" attests that he qualifies for such an appointment"

The comments on section 193 (see page12) apply here also. As mentioned previously, the Board of Directors of each institution and the Board of Kativik Health and Social Services Council wish to retain the entire freedom and responsibility to hire inuit candidates to any position when they feel that such candidates meet the requirements of the position without having to refer to the "Centre de référence".

2.3.6 REGIONAL ASSEMBLY (Section 418)

As mentioned before, it is impossible to organize within Nunavik a Regional Assembly as foreseen for the other regions in Québec. One of the important tasks of the Regional Assembly will be to elect, every three years, the members of the Board of Directors of the various Regional Boards. The Inuit favor universal elections to select their representatives, which goal would be reached by appointing a Municipal Councillor from each community to the Board of Directors of the Nunavik Board. A proposal to that effect has already been exposed and explained in detail at page 20.

The other functions of the Regional Assembly are to approve the list of regional priorities in matters of health and social services and to approve the annual activity report of the regional board.

The Kativik Health and Social Services Council is already holding, every year, an "Annual General meeting" to which attend, at the expense of the Kativik CRSSS, representatives from each community, namely:

- At least one representative from each community health committee;
- the Regional Councillor from each Municipality;
- the members of the Board of Directors of each establishment.

Are also welcome any other individuals or organizations who wish to attend at their own expenses.

It is the intent of the Nunavik Board to continue the same practice and to discuss regional priorities at these Annual meetings.

Proposed solution

"Notwithstanding sections 418 to 430, the Nunavik Regional Assembly shall be composed as follows:

a) ~~a representative~~ The president from each community health council; local health committee

~~b) the Regional Councillor from each municipality;~~ K.R.C.

c) the members of the Board of Directors of each establishment; BOARD Régie.
community elected to

The functions of the Nunavik Regional assembly are :

1) to approve the list of regional priorities in matters of health and social services submitted by the regional board; and

2) to approve the annual report of activities of the regional board .

2.4 CENTRE DE REFERENCE DES DIRECTEURS GENERAUX ET DES CADRES (Sections 521 to 530)

The Centre contemplated in section 521 might prove useful as long as the concerns raised in relation to sections 193 and 414 are addressed.

However, reading section 522, it is difficult to imagine how any inuit candidate, at this point in time, could be registered in the bank of candidates qualified to hold the position of Executive Directors. This bank is meant to regroup all the candidates admissible to positions in all of Québec. In addition, this section mandates the Centre with ascertaining that Executive Directors, holding office as of September 4, 1991 meet the requirements established by the Centre. This could trigger the reevaluation of the three positions of Executive-Directors presently held by Inuit.

Proposed solution

> "Notwithstanding section 193, 414 and 521 to 530, the criteria of qualification applicable to the selection of Executive Directors or senior management directors of regional boards and public institutions, as defined in by-laws adopted by the "Centre de référence des directeurs généraux et des cadres" shall not be applicable to candidates applying to any of the above mentioned positions within Region 10A."

2.5 CONTINUATION OF LEGAL PERSONALITY

2.5.1 Public Institutions (sections 540 and following)

It would be important to ensure that these sections cover the continuation of the two Nunavik Health Care Centres who are authorized to deliver all the services enumerated in section 79.

2.5.2 Health and Social Services Councils (section 554)

Continuance of Kativik Health and Social Services Council as a Regional Board shall take place taking into consideration the comments made above about the necessity to clarify the confusion which presently exist between KRG and Kativik CRSSS effective role in the administration of the latest. Order-in Council 1020-79 will have to be repealed.

All the "Regional Health and Social Services Boards" save and except for the Kativik and the Cree Regional Health and Social Services Boards, have been created since December 18, 1991.[16] The Nunavik Regional Health and Social Services Board will also have to be created in the near future.

2.6 AMENDING, TRANSITIONAL AND FINAL PROVISIONS

Obviously sections 564 and 565 create problems because they provide for the maintained application of the old law which would be renamed "An Act respecting health services and social services for Cree and Inuit Native persons".

3. HUMAN, FINANCIAL AND MATERIAL RESOURCES

For many years the Kativik Health and Social Services Council has been understaffed and is just currently starting to catch up in the number of resources normally attached to a CRSSS. Funding for four (4) new positions[17] was finally recognized and authorized to fill in some important holes in its organizational

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16 Orders-in-Council 1813-91 to 1822-91 concerning the creation of Regional Health and Social Services Boards, Gazette Officielle du Québec, Part 2, January 15, 1992, p. 263, hereto attached as Annex 7

17 A Planning and Programming Advisor, one Regional Community Worker, one translator, an additional secretary.

structure. Still, there is no funding for the hiring of a research agent, while such position exists in all other CRSSSs.

While the Kativik Health and Social Services Council had to wait a long time to obtain adequate financial resources to hire staff to fulfill the regular mandates of a CRSSS under the former legislation, it would not accept to see the same situation repeated under the new legislation.

Considering the current negotiations between other CRSSSs and the MSSS for the reallocation of resources and budgets under the new legislation, the Kativik Council is concerned about what resources it will ultimately be allocated for the fulfillment of its new mandates and functions. These discussions and negotiations presently exclude the Kativik Health and Social Services Council and are conducted as if the future Kativik Regional Health and Social Services Board was not to exist.

This situation could be blamed on the fact that the region is still, technically, excluded from the new legislation. But, the Government has already indicated that it wants to see Nunavik included as a Regional Health and Social Services Board. The MSSS will consequently have to take into consideration the specific needs of the region as it does for the other administrative regions of Québec. When created the Nunavik Regional Health and Social services Board will have to fulfill exactly the same mandates and assume the same responsibilities and functions as other such Boards, and it should consequently be allocated similar types of resources. Kativik CRSSS cannot be an hybride structure half CRSSS and half Regional Board. As indicated in documents prepared by the MSSS, the ministry will no longer be directly involved in the organization of services at the local and regional levels.

> "Le M.S.S.S. n'est plus directement impliqué dans l'organisation des services au niveau local et régional. Il alloue les ressources aux régies en fonction des besoins de la population de leur territoire respectif et sur la base de l'équité interrégionale. Les régies, quant à elles, deviennent responsables de l'allocation budgétaire et des contrôles financiers à exercer auprès des établissements.

> Ultimement, le M.S.S.S. s'assure que la situation est sous contrôle et que le tout s'est fait dans le respect des règles établies."[18]

The Nunavik Board being then responsible to allocate resources to institutions and community organizations, it will be essential to give it the necessary personnel to ensure adequate follow-up as required under the new legislation.

The new responsibilities and functions of the Regional Boards shall become effective on April 1st 1993.

> "Au 1er Avril 1993, les nouvelles responsabilités et les fonctions seront prises en charge par les régies régionales et les établissements. Les régies régionales assumeront entre autres, l'élaboration des plans d'organisation de services, l'allocation des ressources aux établissements et aux organismes ainsi que les fonctions reliées au droits des usagers.[19]
>
> "À compter du 1er Avril 1993:
>
> Mise en oeuvre des fonctions confiées par la Loi 120 à tous les nouveaux acteurs, dont:
>
> - au niveau des régies régionales:
>
> - gestion budgétaire régionalisée;
> - planification de l'organisation des services;
> - traitement des plaintes selon nouveau régime;
> - fonctions de la commission médicale régionale.[20]

A study prepared by Samson, Bélair, Deloitte & Touche for the CRSSS Conference provides a fairly good evaluation of the additional resources which would be required in each region for the fulfillment of the new mandates and functions enumerated in the new legislation. This document is presently being used by the CRSSSs which have been officially created on December 18, 1991, in their

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18 Impact de la réforme sur le plan d'organisation du M.S.S.S. et Orientation, Document du M.S.S.S., mars 1992, p. 3, hereto attached as Annex 8

19 Le Passage de l'ancien au nouveau régime juridique: faits saillants, M.S.S.S., 26 février 1992, p. 1, hereto attached as Annex 9

20 Idem, p. 5

discussions with the MSSS. As mentioned above, the Kativik CRSSS is unfortunately not yet involved in these discussions. Three committees between CRSSSs and MSSS have been created:

1- One for the programming and interregional allocation of resources (Programmation et allocation interrégionale des ressources;

2- One for the funding of future Regional Board (Budgétisation des futures régies);

3- One for the redistribution of personnel (Redéploiement des effectifs);

The absence of direct and timely participation by the Kativik CRSSS could severely prejudice the populationof Nunavik in that it could easily end up without sufficient financial resources.[21]

Kativik Regional Health and Social Services Board needs for material resources

The Kativik Council is actually occupying a relatively small space within the Kativik Regional Government building in Kuujjuaq. This space will soon no longer be available due to KRG's own needs for additional space.

Temporary and intermediary solutions are presently being studied to identify locations which could house the Kativik CRSSS for a 12 to 18 months period, awaiting the construction of their own facilities. There are presently no available buildings in Kuujjuaq which could offer the space required to lodge all the new personnel necessary to implement the mandate given to the new Board. The Kativik CRSSS has presently its full time employees and that number will easily double within a near future with the additional mandates given to the Nunavik Board under the new law.

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21 List of new functions for the Regional Health and Social Services Boards, hereto attached as Annex 10

MSSS requirements demand an average space of 220 square feet per employee in all new constructions. This would consequently mean that a building offering an office space of at least 6,600 square feet would have to be built to accomodate the Nunavik Board.

In addition, every time a new position is allocated to the Kativik CRSSS or the Nunavik Board to be created, it does not include sufficient financial resources to cover employee northern benefits and housing subsidy. As a consequence, the Kativik CRSSS has to use funds allocated for other purposes so as to cover the difference.

Liaison Services with Northern Regions

While various positions in the liaison services with the regions will be abolished within MSSS[22] in order to reallocate these positions to various Regional Health and Social Services Board. At the present time, there are no indications that the mandate of the "service de liaison avec les régions nordiques" would be modified. This appears to contradict the intent and spirit of the new law which promotes the transfer of responsibilities to the regions. The Nunavik Board is asking to repatriate the responsibilities and budgets of this "Service".

It is difficult to understand why such " Service de liaison avec les régions nordiques" would be maintained, in Québec city, while the current needs are for additional resources at the regional level.

The existence of a Service de liaison nordique was understandable under the former legislation, but the continuation of its existence under the new legislation could prove unproductive as it would become an unnecessary intermediary between Nunavik and the various other departments of the MSSS.

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22 Impact de la réforme sur la gestion du personnel au M.S.S.S., hereto attached as Annex 11

This is not intended to unduly critizise the personnel of the "Service de liaison avec les régions nordiques" but the Nunavik Board could be allowed to progress at the same speed as the other CRSSSs in Québec.

It is true that Nunavik has different and particular needs which must be addressed but this should not become an excuse to justify delays in the allocation of funds and resources.

While the "Service de liaison avec les régions nordiques" could have a role to play for regions or native groups which are not as organized as region 10A, it is difficult to understand why an autonomous region such as Kativik constantly has to communicate with the various departments within the MSSS through an additionnal intermediary while it could do so directly and more effectively.

4. OTHER IMPLEMENTATION ISSUES

4.1 TRAINING

4.1.1 General Comments

Training is a key element to reaching involvement and more effective participation of the Inuit in the delivery of health and social services in Nunavik. Mr Weetaluktuk, in his presentation to the Parliamentary Commission, clearly expressed the Inuit position:

> "The Kativik Regional Board must be assigned specific funding for human resources development to provide basic and specialized training to Inuit aside from Human Resources Development programs established by Government. This training is a prerequisite to effective participation by Inuit at all levels of delivery and development of health and social services. You have had a good example of what can be accomplished through the Mid-Wife Program at the Hudson Bay establishment.[23]

It is important to refer to the exact wording of section 15.0.21 of the JBNQA:

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23 Op. Cit. note 4, p. 3

In implementing the Agreement, Québec should recognize and allow to the maximum extent possible for the unique difficulties of operating facilities and services in the North:

a) in recruiting and retaining staff, generally, working conditions and benefits should be sufficiently attractive to encourage competent personnel from outside Region 10A to accept posts for periods of time ranging from three (3) to five (5) years;

b) in providing employment and advancement opportunities for Native people in the fields of health and social services, *and in providing special educational programs to overcome barriers to such employment and advancement*;

c) in budgeting for the development and operating of health and social services and facilities so as to compensate for the disproportionate impact of northern costs, including transportation, construction and fuel costs.

It must be told at the outset that most of the work remains to be done in the area of training. There have never been any serious concerted efforts to find a permanent solution to training needs for Health and Social Services. We only have to consider the insufficient training support offered to the community workers, who are often left by themselves in their respective community, to measure the importance of this issue.

These community workers are among the persons who are involved with the most serious and difficult cases in the community. They have been demanding for a long time that a permanent training and upgrading program be established. This request was again reiterated by some experienced community workers during the preliminary consultations held by the "Inuit Justice Task Force".[24]

If we consider the total funding available for training purposes either within the budget of the institutions or of the Kativik Health and Social Services Council, we must conclude that only minimal sums are dedicated to training. Such a situation prevents the pursuit of any sustained training program for any group of workers.

The creation of adequate training programs will become one of the main issues not only for community workers but also for the new Mental Health Councillors who are

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24 Verbal interviews with community workers at a meeting held in Kangirsuk in April 1991

Additional funding, through "formation réseau" will consequently be required to organize these sessions for the Nunavik Board as well as of the two Health Care Centres from the Nunavik territory.

It is consequently requested that:

- a minimum annual budget of $150,000 for "formation réseau", be allocated for the Nunavik territory, taking into consideration the impact of all new mandates and new government policies and programs which will have to be administered by the Nunavik Board and the two Nunavik Health Care Centres.

4.1.3 Community Workers Education Program

It is interesting to examine more closely the sequence of events of the last few years concerning this program because they illustrate well the type of difficulties encountered to develop adapted programs for the region.

A lot of energy has already been spent by Kativik CRSSS personnel, the CSS coordinator and McGill University consultants to prepare a Training Program leading to the obtention of Certificate in Social Work.[26] This program has been in place since 1984 and some courses were even given in Nunavik over a period of two to three years. Those courses were given on the same model as the Inuit Teachers' Training Program, . However, they had to be interrupted for lack of funding. The few sessions which took place were funded by Kativik CRSSS with whatever small amounts they could put together from other budgets, even if it was not the legal responsibility of Kativik CRSSS to finance such activity. However, Kativik CRSSS can not continue to assume responsibilities which do not fall under its jurisdiction and for which it has not budget.

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26 Program for the Obtention of a certificate in Social and Community Work, McGill University, hereto attached as Annex 12

For the past three years, an important exchange of correspondence[27] has taken place between various organizations and departments involved or concerned with the question, but without result yet. The "Ministère de l'Enseignement Supérieur et de la Science" (M.E.S.S.) has been identified as a key player in this file but there are no clear commitments yet concerning its participation for the funding of so vital a program.

In the case of the Community Workers Training Program, a postsecondary program developped by the McGill University School of Social Work, the M.E.S.S. will have to be directly involved in any discussions leading to the permanent implementation of this program. The M.E.S.S. Minister clearly has jurisdiction in that field of activity.

According to section 7 of the "Act respecting the Ministère de l'Enseignement Supérieur et de la Science (L.R.Q. Ch M-15.1) the responsible Minister is responsible for education at the university and college or postsecondary levels.

In addition the Minister has the following duties and powers:

Section 8

"The Minister shall devise policies relating to the fields within his competence and propose them to the Government, with a view to, in particular,

1) ...

2) giving access to the higher forms of learning and culture to any person who wishes to have access thereto and has the necessary ability;

Section 9

In the fields within his competence the duties of the Minister shall be, more particularly, to

1) foster consultation and cooperation between the departments, agencies and interested persons;

2) adopt measures designed to further the training and development of individuals

27 Various correspondence concerning Community Workers Education Prog attached hereto as Annex 13

Section 10

For the purposes of the carrying out of his duties, the Minister may, in particular

1) f urnish any person, group or agency with the services considered necessary;

2) grant any financial assistance out of the sums put at his disposal, on the conditions he may fix;

A recent correspondence,[28] addressed to Mr. Putulik Papigatuk seems to indicate that the M.E.S.S. intend to become more active in search of a solution for that important issue.

Discussions with the Ministère de l'Enseignement Supérieur et de la Science (M.E.S.S.) shall be intensified in order to find a permanent solution to secure adequate funding to allow the continuation of training under the "Program for the obtention of a certificate in Social and Community Work" as prepared by the McGill University School of Social Work.

4.1.4 Auxiliary Nurses Program

Three auxilliary nurses are presently completing their high school up grading, through the K.S.B. Adult Education Department,would be appointed among the elected members of each Municipal Council with a view to beginning their registered nurses course as soon as funding for the program will have been secured. This course is cheduled to be given in Kuujjuaq.

Disccussions with various actors such as the Kativik School Board, the John Abbott College, the Ministère de l'Enseignement Supérieur et de la Science, the Kativik CRSSS and KRG (Manpower section) have already been initiated by the Ungava Bay Hospital which is the main proponent of this project. All parties have demonstrated a great interest but the vital question of funding is not yet resolved.

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28 Letter to Putulik Papigatuk, President of Kativik School Board from Mr. Leonce Beaupré, Assistant-Deputy-Minister, Ministry of Higher Education and Science, hereto attached as Annex 14

The John Abbott College has developped a program known as the "Registered Nurses' Aids to Registered Nurses (RNA to RN), nursing program 180.21" and has also developped an important expertise with Cree students who are presently following this course in Ste-Anne-de-Bellevue.

A document prepared by Mrs Colette Couture, consultant for the Ungava Bay Hospital offers a good presentation of the project.[29]

> "The project for a recycling course for the Inuit auxiliary nurses developed from the desire of three (3) individuals who are presently working as auxiliary nurses to upgrade their qualifications in order to be more autonomous in the practice of their profession. The goal they are seeking is to become qualified professional, authorized to fill all the roles normally assigned to nurses in remote regions. They are all women over 30 years of age with families and deep roots within the community."[30]

One of the main objectives of the Auxiliary Nurses Training Project is to develop local competence which would diminish the high turnover among nursing personnel as presently encountered by the Nunavik Health Care Centres. There are a variety of reasons affecting the lenght of stay of nursing personnel, one of the main reasons being, as stated in Mrs Couture document, the lack of understanding of the Inuit culture:

> "The lack of understanding of Inuit culture acts negatively on the lenght of stay of nursing personnel. In the beginning, the nurse may perceive the differenvce between her own culture and that of the Inuit in a very positive, if not flokloric manner. Eventually sher understands that in order to have a lasting influence on health, her intervention has to cross the cultural barrier. To be able to conceive of projects that are adpted to the needs of the clientele, it must be understood that culture gives a meaning to events and behaviour (Dufour, 1990). Unfortunately, it is often at the very moment when the nurse realizes the necessity of having an open attitude towards the culture that she also understands the amount of work that remains to be done to achieve specific objectives: at this point some choose to get involved, most to withdraw."

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29 Dossier concerning the recycling of Inuit Auxiliary Nurses, hereto attached as Annex 15

30 Idem P. 2

> "We could recite several other factors that have direct or indirect influence on the retention of nurses in Ungava. What is fundamental to remember is that at the present, turnover of nursing personnel in Ungava greatly exceeds that of the province as a whole, that the situation has not improved in the last ten years and that the Ungava Hospital has to continually recruit its nursing personnel in the south.[31]"

It is consequently requested that

- The Government, through the Ministère de l'Enseignement Supérieur et de la Science (M.E.S.S) provide the funding required to implement, as soon as September 1992, the "Registered Nurses' Aid to Registered Nurses, nursing program 180.21" to be given in Kuujjuaq, in accordance with the program developped by John Abbott College.

4.1.5 Access to "Professionnal Training Commission" funding for Health and Social Services network employees

There are many numerous training needs within establishments such as the Health Care Centres or an organization like the Nunavik Board. These needs apply to positions occupied by clerical personnel as well as kitchen, maintenance or support staff.

At the present time, it is impossible for institutions or organizations within the Health and Social Services network to obtain funding from the Professional Training Commission (C.F.P.) due to a restriction into eligibility criteria governing the allocation of training subsidies.

The C.F.P. rules provide that the establishments or organizations entirely funded through Government subsidies are not elegible to their programs. Taking into consideration the particular situation of employment and training in the Nunavik region, those restrictions should be removed to facilitate the access to C.F.P. programs for Health and Social Services personnel.

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31 Idem P. 12

4.2 KUUJJUARAAPIK NURSING FACILITIES

It is a well know fact that the community of Kuujjuarapik has been expecting the construction of new nursing facilities for a long time. The actual installations servicing the Inuit community were built in 1962 by the National Health and Welfare Department and do not meet the needs of the population anymore.

Discussions have been taking place between the Kativik Council, the Innuulisivik Hospital and Québec government officials since at least 1985 in order to find a solution to the deficiency of health and social services infrastructure in Kuujjuarapik.

Various documents charting the historical background of this file are provided in annex to the present document.[32] Both the municipal authorities and the administration of the Innuulisivik Hospital have clearly expressed their position concerning the construction of a new nursing station in Kuujjuarapik. The hospital as well as the Kativik Council wish to retain their entire jurisdiction over the health and social services to be provided to the Inuit population of Kuujjuarapik.

It is completely out of the question to authorize or delegate or contract out to another Regional Health and Social Services Council, namely the Cree Council, the planning, programming and delevery of services to the Inuit population. The needs of the Cree and Inuit population are often quite different. Some examples are: the Hearing and Otitis Program developped specifically for the Inuit, some particularities of the Perinatal Program, and some specific needs in social services.

In a letter addressed to Mr Marc-Yvan Côté on November 23, 1990, Mr. Paulussie Padlayat, Chairman of the Innuulisivik Hospital, clearly stated the position of the Hudson Bay institution to maintain its full jurisdiction over health and social services to be delivered to the inuit community of Kuujjuarapik. On the other hand, he left the door open for discussion on issues such as the sharing of equipment, emergency room and specialized human resources.

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32 See Annex 16 hereto attached

In March 1992, a delegation from M.S.S.S. visited the community of Kuujjuaraapik where they met with representatives from the Northern Village Corporation and Innuulitisivik Hospital. Mr Maurice Boisvert, Deputy-Minister, reiterated the position of the M.S.S.S. concerning the construction of a joint Cree/Inuit nursing station being scheduled to begin in summer 1992.

It was then agreed that a coordination meeting would be organized between representatives from Innulitisivik Hospital and the Cree Council of Health and Social Services to discuss the joint operation of new facilities. It is useful to remember that the Cree and Inuit populations in Kuujjuarapik are equal in number.

The Inuit wish to ensure that the new common nursing installations will enable them to:

- conduct their own specialized clinics with their own nursing personnel and interpreters;
- have their own exclusive space for the delivery of the above mentioned special clinics and the operation of their social services programs.
- obtain a guarantee that the space allocated for delivery of health and social services to the Inuit population within the common installation will always be of a size proportional to the Inuit population ratio and will not be reduced by unilateral decision from the Cree Council of Health;
- have a separate access to the nursing station whereever it will be located within Kuujjuaraapik or Whapmagoostui at any time;
- location of new nursing station shall be decided in collaboration with the Inuit representatives from Kuujjuaraapik.

4.3 UNINSURED / INSURED SERVICES

The Inuit are covered by the medicare system, like other residents of Québec. However, according to section 15.0.19, they also benefit from additional coverage

which were never included in provincial legislation or in the programs for the general population.

Section 15.0.19

> "The budget from the Province of Québec to each establishment shall include funding for the support of health services which are not included in provincial programs for the general population but which are provided to the Natives people by the Department of National Health and Welfare or other agencies."

In a document released in December 1990[33], the MSSS gives the following definition of "uninsured services":

> "A limited number of goods and services that are not already provided to the beneficiairies of the J.B.N.Q.A. and the Northeastern Québec Agreement by other organizations or programs:
>
> a) medication and other supplies;
> b) transportation for health reasons, escorts, interpreters, lodging;
> c) prescription eyesglasses;
> d) dental care
> e) hearing aids.

Even though section 15.0.19 is included in the JBNQA since 1975, serious discussions and exchanges of documentation have only taken place since 1990 between the MSSS, the two Institutions in Nunavik and the Kativik C.R.S.S.S. concerning this issue.

The purpose of these discussions was to initiate, at long last, the implementation of section 15.0.19 of the JBNQA. A preliminary document [34]has been transmitted to the Kativik Council for review and comments. The list of uninsured/insured services established in the said document represents a good basis for discussion on the identification ofthe services to be covered.

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33 Program for uninsured health services. General Information, M.S.S.S., December 1990, hereto attached as Annex 17

34 Idem note 32

Since the financial year 1990-91 the two hospitals have received an annual budget to cover their expenses in the delivery of the abovementioned uninsured\insured services. If maintained at its present level plus an annual indexation to the cost of living, this budget could probably be sufficient if the two hospitals did not have to encounter important costs related to transportation and accomodation expenses for children whom have been prescribed orthodontic and other treatments.

In addition, the hospitals always have to cover the expenses of escorts, a child under 18 years old being obliged, according to M.S.S.S. policies, to travel with an escort designated by the immediate family. If we take into consideration the fact that orthodontic treatments are only reimbursed for children under 18 years of age, the global travelling and accomodation expenses are extremely high.

At the present time, 7 young patients from the Ungava Bay Hospital are undergoing prescribed orthodontic treatments. Due to the lack of adequate specialized equipment within Nunavik all these orthodontic treatments have to be performed in the south, which requires a monthly follow-up visit to the orthodontist. The costs for those treatments are estimated at $18,000. per patient per year.

That amount could be greatly reduced if more specialized equipment would be made available in the two establishments of the territory. It would required more sophisticated radiology equipment, which is evaluated at approximatly $20,000. to $30,000. With such equipment, most of the follow-up could be made within the region with the assistance of a specialist who could visit the two hospitals at a much lower cost than sending patients to Montreal for orthodontic treatments.

No patients from Innulitisivik Hospital are presently sent for orthodontic treatments in part because of the costs involved but also because it is too time-consuming for children to go for follow-up treatments in Montreal. Access to proper equipment would help to solve that difficulty.

Proof of Eligibilty to uninsured / insured services

According to M.S.S.S. policy, in order to have access to uninsured / insured health services, the patient must:

a) have in his/her possession a health insurrance card; and
b) have his/her status as a beneficiary under the J.B.N.Q.A. clearly established.

Discussions concerning the issuance of special "medicare cards" containing informations about individual registration as beneficiary of the JBNQA have also been initiated with the MSSS in order to facilitate follow-up in the application of the new system.

4.4 MONTREAL PATIENTS' SERVICES

Services are offered to the Inuit transient patients through "Module du Nord québécois", a program affiliated with the Community Health Department of the Montreal General Hospital.

The services offered include mainly: the coordination of transportation for the patient and his escort from and to the north, transportation in Montreal, interpreter services, visit to the patients as well as coordination of appointments with various medical institutions. The Montreal General Hospital/Community Health Department receives direct funding from the MSSS to provide the above mentioned services to the Inuit patients.

The Kativik Council wishes to repatriate this funding in order to have greater control on its administration. The Kativik Council is presently negotiating specialized services contracts with various institutions in the Montreal area, such as with the Montreal Jewish Hospital, the Montreal Children Hospital, the Montréal General Hospital and the Douglas Hospital.

The services to transient patients will most probably need to be adjusted to take into consideration these new service contracts which shall be signed in a near future. Consequently, the Kativik CRSSS should soon recuperate the control and the administration of the funds allocated for Inuit patient services in Montreal. It would

then be in a better position to negotiate and enter into any service contract considered beneficial for the inuit patients.

As under the issue of uninsured/insured services, the biggest pressure on the patient services budget is the cost of transportation and accomodation for the patients themselves and their escorts. In 1991-92, 1,883 persons will have been assisted by Patients services in Montreal, i.e. 1,432 patients and 441 escorts. That average cost per stay is evaluated at $782. for a minimal budget of $1,472,000.

Again these costs could be greatly reduced if some specialized equipment could be made available within Nunavik. Here are some examples which will illustrate how health services could be provided in a more cost-efficient manner.

Between twenty (20) to thirty (30) women from the Ungava region are going south each year for consultation for "colposcopy". These exams could easily be conducted within the territory if the specialized equipment, which is worth approximately $20,000., would be available at the Ungava Bay Hospital. Instead, at the present time, the costs encountered for said exams are approximatly $2,500. per patient per visit in Montreal.

At least 30 patients from Ungava Hospital are sent each year for "Gastroscopy-colonnoscopy", while again these exams could be conducted in the region if the specialized equipment, which is worth $40,000., would be available at the hospital. The same equipment could also have a preventive utility in case of cancers which can be detected at an early stage. Some emergency medical evacuations could also be prevented if acccess to these specialized exams would be made available.

It is consequently requested that

-The funding actually allocated directly from the M.S.S.S. to Montreal General Hospital\ Community Health Department be redirected to the Nunavik Board.

-Specialized medical equipment purchasing be authorized for the two establishments in order to reduce the pressure on patient services budget.

4.5 YOUTH REHABILITATION (GROUP HOME)

At the present time, most rehabilitation services for the youth population from Nunavik are offered at l'Etape, a reception center located in Val d'Or. An estimated number of twelve (12) youth are usually staying at the center at any one time for periods varying from six (6) to twelve (12) months.

A special unit for young Inuit has been created in the early 1980s and l'Etape receives an annual operation budget of approximately $400,000.00 for the maintenance of this Inuit unit. In addition, a budget of $150,000.00 to $200,000.00 per year is set aside for coordination and communication with the region and the training of Inuit personnel.

While l'Etape, and the services its offers, have over the years been an important resource ultimately its budgets for the young Inuit unit should be used to develop services within Nunavik. It would then be easier to associate families, friends and community volunteers in the readaptation of the youth in need of assistance.

As mentioned above, in addition to its operations budget, L'Etape receives an annual budget for the training of Inuit personnel. These persons had originally been hired to work as full time educators within the institution, but it has proven difficult to hire Inuit willing to move to Val d'Or for a long stay. All the trainees who graduated at l'Etape are now back in their communities.

The immediate transfer of the training budget would allow the Nunavik Board to set up training-on-the-job directly with the population, in establishments such as the Kuujjuaq Group Home or the Group Home soon to open on the Hudson Bay coast.

In 1991, the Coordination, Communication and Training budget normally allocated to l'Etape has been used mostly to finance an Assessment Study on the youth in need of protection. While no one will contest the importance of such a study, this confirms the difficulty encountered in trying to get those amounts used for the training of Inuit personnel for subsequent employment in Val d'Or.

This Assessment Study has been conducted in close collaboration between l'Etape and the Kativik Council. M. Pierre Portelance, from l'Etape, and Mrs. Jeannie Sala Gordon, a Kativik CRSSS consultant, have visited all the Nunavik communities to meet the population at large as well as various community representatives. Their final report should be tabled in April 1992. The preliminary conclusions appear to confirm the need to develop services located within Nunavik, preferably through group homes (one on each coast) and through the creation of a single readaptation centre which would service all of Nunavik.

It is interesting to note that the Inuulisivik Hospital has developed a proposal for the creation of a group home, to be located on the Hudson Bay coast, similar to the group home operating in Kuujjuaq. Documents outlining the objectives of such group homes and of the support for this project are annexed to this paper.[35] All this shows the interest of the region to develop its own tools, better adapted to its needs.

In conclusion, the Nunavik Board to be created should receive, as early as possible and as part of its general budget, the "inuit" share of the "Budget for Natives beneficiaries" presently allocated directly to l'Etape.

Aware that additional planning remains to be done before the services of l'Etape can be fully transferred, the Nunavik Board could grant service contracts to l'Etape for the continuation of service delivery until these same services can be taken over by its regional and/or local staff.

Kuujjuaq Group home

The Group Home presently operating in Kuujjuaq is placed under the responsibility of the Ungava Hospital. It is presently the only facility for the youth in difficulty located within Nunavik.

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35 Resolution 88-45 of the Innulitisivik Hospital, Resolution 90-59 from Pituvik Landholding Corporation, hereto attached as Annex 18

It is operating with a minimal budget of approximately $200,000. per year, which indeed prevents the group home from offering all the specialized services which should normally be offered to its clientele. This budget does not permit the hiring of human resources such as a psychologist or a special educator. Neither does it allow complete training and support for persons such as the Houseparents, who are responsible for the daily, basic child-care and development of the residents.

An additional funding at least equal to the actual budget would be required to allow the group home to operate with increased chances of success in the rehabilitation of young Inuit in difficulty and without overloading the personnel in charge of the group home.

A recent study[36] by Mr Robert Vyncke from Consultation Réseau as well as request for additional funding from the Ungava Bay Hospital [37]give a complete picture of the difficulties encountered by the Kuujjuaq Group Home since its first opening in June 1988.

4.6 ALCOHOL, DRUG & SUBSTANCE ABUSE

4.6.1 Rehabilitation & Detoxification

At the present time, an estimated 15 to 20 persons per year from the Ungava coast and a similar number from the Hudson Bay coast are entering detoxification and rehabilitation programs in various institutions outside the territory. In most cases, these centers are located in the greater Montreal area. But the number of attendants would most probably be higher if such services were available in Nunavik.

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36 Robert Vyncke, Consultation Report, Kuujjuaq Group Home, C.S.S. Ungava, May 13-17, 1991, Consultation Réseau Montréal, hereto attached as Annex 19

37 Letter to Mr. Roger Richard, March 18, 1992 concerning funding for Kuujjuaq Group Home, hereto attached as Annex 20

The programs offered in these centers are generally not well adapted to the needs of the Inuit. In addition, it goes without saying that the persons entering these programs cannot fully benefit from the support of their families and friends because of the distance between them. In addition, Inuit are not always admitted on a priority basis in these centers and when they are admitted, the environment is not the most adapted.

It is becoming urgent to offer this type of facility within Nunavik as soon as possible. Indeed, all available informations tend to indicate that most incidents of crime and violent behaviours take place under the influence of drugs, alcohol or other subtance. In addition, a great number of crimes are related to drug trafficking.

Nunalituqait, a program funded by the Federal Government addresses prevention measures largely targeting the student population. This important work is already hindered by insufficient financial resources which further prevent the development of rehabilitation and detoxification facilities.

That issue can be linked with the under development of social services for adult population within Nunavik. The main reason for said under development is the lack of sufficient financial resources. "Social Services Centres" actually have the mandate to provide social action services to both youth and adult population.

The largest share of the budget received by the Nunavik "Social Services Centres" is dedicated to youth in need of protection and only a small portion of the resources can be dedicated to adults' needs, even though the Social Services Centres should normally provide services for prevention consultation as well as psycho-social or rehabilitation treatment. The human and financial resources are simply not there to offer said essential services.

We will address that issue in greater details hereabove under subject 4.9 (Social Services to the adult population of Nunavik".

4.6.2 Funding to Kativik CRSSS

Like all other CRSSSs in Québec, the Kativik Council has recently received a budget to hire a coordinator for alcohol and drug abuse. This person must work in close collaboration with all the Nunavik organization in order to identify the needs and develop new services for the population.

For the year 1991-92, Nunavik received a budget of $27,147.00 for prevention and information programs related to drug and alcohol abuse. All other regions, to the exception of region 10B (Cree), have received much more substantial funding for the same type of activity. As appears from a document prepared by the MSSS[38] each administrative region in Québec was to receive a minimal annual amount of $90,000.00 for detoxification and rehabilitation services. For obscure reasons, Nunavik has been excluded from this program.

It is certainly not because the needs are not well identified. Without any doubt, Nunavik should receive its fair share of budget allocation for prevention programs.
At the present time, the "Direction générale des services de réadaptation et de soins de longue durée" of MSSS refuses to increase prevention budget for on the ground that the "organizational plan of services for alcohol and drug abuse" would have not yet been submitted to the MSSS. Yet at a meeting with MSSS representatives to which also attended representatives from all CRSSSs, it was clear that the Kativik Council was far from being the only region which had not yet submitted its plan. However, these other regions were duly allocated their annual prevention budget of at least $90,000.00.

The representatives from Nunavik attending the Parliamentary Commission on Bill 120 expressed their feelings of frustration with budgets being allocated to all regions except "10A" and "10B":

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38 See Annex 21

> "We often feel forgotten in the budget allocation process. Sometimes, we find out that money is about to be distributed or as been distributed through all regions and the Kativik region is not included.
>
> Taking into account the characteristics of our region should not mean putting us aside from the allocation process or doing long studies that bring nothing to the region.[39]

Nunavik should be entitled to a fair treatment. The available funding should be adjusted so that, at least, the Inuit be entitled to receive the same amount as the other CRSSSs.

It is certainly not because the needs are not well identified. Discussions at local and regional level have been initiated a long time ago. For example, the community of Inukjuak, in collaboration with Innuulisivik Hospital, already indicated its willingness to get a rehabilitation and detoxification center. Such center could service all the Nunavik communities with programs well-adapted to Inuit needs. It is important to mention and underline that if no new initiative is undertaken within a short period of time in the field of drug and alcohol abuse prevention and rehabilitation, the social cost to bear will become extremely overous..

4.7 Enquête Santé-Québec (Québec Health Survey)

Santé-Québec is an organization funded by the MSSS and composed of researchers specialized in various fields of activity related to health and social services. These researchers are mandated to conduct extensive studies on various aspects of the health and well-being of the entire population of Québec.

The informations gathered through those studies are used by the MSSS to guide the allocation budgets for various programs, Santé-Québec has initiated this research few years ago. For the rest of Québec, the first phase of the study was completed in 1989-90 and the second phase is just about to be initiated. For various reasons having to do with planning and organization, the Santé-Québec study was initiated

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39 Op. cit. no.4, P. 2

in Nunavik more than two years after the other regions. The researchers are scheduled to start the travelling in the communities in the spring of 1992. The results of the study should not be available before the fall of 1993 or the winter of 1994.

It is important to discuss this issue because the distribution of funds to be allocated under the various MSSS programs is based on the data gathered through the Santé-Québec studies. The fact that Nunavik was not included in Santé-Québec study at the same time as the other regions appears to carry negative consequences.

There is another issue that warrants a review concerning Santé-Québec. As mentioned above, the second phase of the Santé-Québec study is just about to begin in the rest of Québec. In Nunavik, this second phase will take place only in 1994 or 1995 for region 10A. The Inuit would have no major difficulty with this if it were not that the MSSS adopted a new method to fund the second phase of Santé-Québec.

In the first phase, the MSSS was funding directly the Santé-Québec researchers to conduct their study. In the second phase, the Government indicated that the funding shall come from each CRSSS through their annual budget on "Projets d'intervention et d'études". Each region shall contribute 30% of the budget for the years 1991-92/ 1992-93/ 1993-94. Because the budgets are exhausted for the year 1991-92, the contribution has now been established at 60% of the budget for the year 1992-93.

For a region such as Nunavik, which should normally receive a contribution of $101,400. as its budget for "Projets d'intervention et d'études". the Kativik CRSSS has been informed that it should, as the other regions, contributed 60% of that amount for the second phase of Santé-Québec, which would leave the region with a remaining budget of $41,677, all the while they will be excluded from this second phase. This is unfair and unacceptable.

The region is ready to contribute to studies which can be of benefit to its population but not for studies which will not benefit the population.

To compound the injustice, the funding allocated for the first phase of the Santé-Québec for the Nunavik region, yet not finalized, has proved to be insufficient. The Kativik CRSSS already, despite investing important amounts still encountered a deficit of $80,000. in 1991-92. Said deficit is mostly due to the necessity to translate all the documentation in Inuktitut and the costs involved to travel in the region. We request that an adjustment be made to CRSSS's budget in order to acknowledge the special needs of the region when it comes to communication and travelling expenses.

4.8 Development of Community Services

In the recent years, some community groups have started to develop and are now beginning to offer their services to various segments of the population. Thus, the "Arnautiit Women Association" which began operating a women shelter in 1991, and the "Ikayurasuttut Piqayatsiangittuniq Helping Group"[40] which offers help and organizes activities for the elders and the handicapped. These two community groups are based in Kuujjuaq and have generated a lot of attention from other communities.

These two non-profit organizations are mostly operating with the assistance of volunteers. Despite this dedication, these two organizations also need some minimal funding in order to survive.

This leads to the issue of funding for community groups in Nunavik. Until recently, no funding was ever made available for Nunavik due to an archaic Order-in-Council having the effect to exclude the Nunavik-based community groups from any funding. This order-in-council has finally been repealed in December 1991.

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40 See "Formulaires de demande de subvention pour l'année 1992-93", hereto attached as Annex 22

For that very reason, the Arnautiit Women Group application for funding has been refused in 1991-92. A new application has been presented for 1992-93 but it is far from being sure that funding will be allocated. We are hereby requesting an overall funding policy and matching budgets starting this year.

As contemplated in the new legislation, community organizations shall play for the future a much greater role.

> "The Bill also includes provisions dealing with community organizations. They will hereforth be eligible for subsidies according to the services they provide. Subsidies will be granted by the regional boards, or in certain special cases, by the Minister"[41]

According to the "plan d'implantation" previously referred to in the present document, one of the measure contemplated to improve health and social services network efficiency will increase, the total amount of subsidies allocated to community organizations.

"D'autres mesures seront retenues pour améliorer l'accessibilité aux services médicaux et hospitaliers, réorganiser la mission de la santé publique, consolider la recherche et l'enseignement, et accroitre l'efficience du système.

A cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:

> 57. Organismes communautaires, l'augmentation du montant total des subventions versées aux organismes communautaires."[42]

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41 Explanatory notes, Bill 120 (1991, Chapter 42)

42 Op. Cit. Note 9, P. 14

4.9 Level of funding for Social Services provided to the adult population of Nunavik

This issue has been a constant difficulty encountered by Social Services (Centre des services sociaux - CSS) over the years. Most of the budgets allocated to the CSS are granted for the fulfilment of its mandate under the "Youth Protection Act" and must consequently be used for youth protection cases, preventing the CSS to provide basic services to its adult clientele. [43]

This lack of funding is most apparent when the CSS are asked to help out on rehabilitation and detoxification. It also means that the CSS can not hire any social workers or other specialized personnel to deal with adults needs. This situation will have to be corrected under the new legislation.

That chronic lack of financial resources will become even more obvious when the new legislation will become into force. CSS will be transformed in two "Child and Youth Protection Centres" (C.P.E.J.) and will no longer have responsibility to provide social services to the adult population.

Local Community Service Centre (CLSC) will, from now on, be responsible to provide services to the adult population as we can see from the definitions under the actual law and the new mandates defined under the new legislation.

Section 80 (bill 120)

> "The mission of a Local Community Service Centre is to offer, at the primary level of care, basic health and social services of a preventive or curative nature and rehabilitation or reintegration services to the population of the territory served by it.

43 That information was confirmed with the Finance department of Ungava Bay Hospital. The only amount received for services to the adult population is $30,926. for social elder peoples and foster home for adults.

To that end, an institution which operates such a centre shall see to it that the persons who requires such services for themselves or for their families are contacted, assess their needs, dispense the required services in its facilities, or in the persons' own environment, in school, at work or at home or, where necessary, refer the persons to the centres, organizations or persons best suited to assist them.

Section 1 (g) (L.R.Q. Ch. S-5)

"local community service centre": facilities other than a professionnal's private consulting office in which sanitary and social preventive and action services are ensured to the community, in particular by receiving or visiting persons who require current health services or social services for themselves or their families, by rendering such services to them, counselling them or, if necessary, by referring them to the establishments most capable of assisting them."

Section 82 (bill 120)

"The mission of a child and youth protection centre is to offer in the region such psychosocial services, including social emergency services, as are required by the situation of a young person pursuant to the Youth Protection Act and the Act respecting young offenders (R.S.C. 1985, Chapter Y-1), and services for child placement, family mediation, expertise at the Superior Court on child custody, adoption and biological history.

To that end, every institution which operates such a centre shall ensure that the needs of the persons who require such services are assessed and that the services which these persons or their families require are offered to them either directly or through the centres, organizations or persons best suited to assist them."

Section 1 (j) (L.R.Q. Ch S-5)

"social services centre": facilities in which social action services are provided by receiving or visiting persons who require specialized social services for themselves or their families and by offering to persons facing social difficulties the aid necessary to assist them, especially by making available to them services for prevention, consultation, psycho-social or rehabilitation treatment, adoption and placement of children or aged persons, excluding however a professionnal's private consulting office."

The two Health Care Centres are already authorized under their establishment permit, to operate as CLSC but these CLSCs are also suffering from an important lack of adequate funding to develop services to the adult clientele. In practice, CSS will be transferring a mandate which they were not able to adequately fulfill in reason of unsufficient human and financial resources to another organization (CLSC) which also suffers from a lack of adequate resources.

That situation will have to be addressed in priority by the Ministère de la Santé et des Services Sociaux, which in its "plan d'implantation" identified the "reorientation of social services" as one of the important measure to be implementated prior to April 1993.

> "A cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:
>
> Services sociaux, 53 - : La réorientation des services sociaux de première ligne par:
>
> a) ...
> b) le transfert des responsabilités et des ressources des centres de services sociaux aux CLSC;
> c) la transformation des centres de services sociaux en centres de protection de l'enfance et de la jeunesse (CPEJ)."[44]

This question of social services to the adult population of Nunavik will have to be seriously taken into consideration when we know that many of the 18 to 25 years old population are facing important personal or family problems which can no longer be addressed through the Youth Protection system and are left without adequate resources to answer their needs.

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44 Op. Cit. Note 9, P. 13

ANNEX 1

15.0.1 The Kativik Health and Social Services Council and the establishments shall be governed, mutatis mutandis, by the provisions of the Act respecting Health Services and Social Services (1971, c.48) and all other laws of general application in the province, save where these laws are inconsistent with this Section, in which event the provisions of this Section shall prevail.

15.0.2 The Regional Government shall be charged with promoting, by all means and measures which it may deem adequate, the advancement and development of public health in Region 10A which shall encompass the territory under the jurisdiction of the Regional Government established pursuant to Section 13 of the Agreement.

15.0.3 There shall be a health and social services council for the said Region 10A under the name of "Kativik Health and Social Services Council".

15.0.4 All rights, powers, privileges and obligations of the Kativik Health and Social Services Council shall be exercised by the council of the Regional Government.

The functions, powers and duties of the administrative committee, general manager and staff of the Kativik Health and Social Services Council shall be exercised by the executive committee, the head of the Health and Social Services Department of the Regional Government and the officers of the Regional Government respectively.

15.0.5 The Council shall regulate and supervise the election of the members of the boards of directors of the establishments contemplated by paragraph 15.0.9 of this Section.

Every regulation made by the Council under this paragraph must deal with the procedure to be followed in such election and provide for a voting period of at least four (4) hours for the members of each of the electoral colleges contemplated by paragraph 15.0.12.

Such regulation must be submitted for the approval of the Lieutenant-Governor in Council; if it receives such approval, it shall come into force on the date of its publication in the Québec Official Gazette. Québec agrees to repeal Order-in-Council 1888-75 of May 7, 1975.

15.0.6 If the Council fails to exercise the functions assigned to it by paragraph 15.0.5 of this Section, such functions shall be exercised by the Minister.

15.0.7 Notwithstanding the provisions of paragraph 2.9 of Schedule 2 of Section 12 and paragraph 2.9 of Schedule 2 of Section 13 of the Agreement, any ordinance passed by the Regional Government under this Section shall apply within the whole territory of the Regional Government and its application shall not be limited to municipalities.

15.0.8 For the purposes of health services and social services, Region 10A initially shall be divided into two sectors: the Hudson Bay Sector and the Ungava Bay Sector.

Every city or town, village, county, mining town and other municipalities customarily receiving health and social services in the Hudson Bay Sector shall be included in the Hudson Bay Sector; the Ungava Bay Sector shall include all city or town, village, county, mining town and other municipalities customarily receiving health and social services in the Ungava Bay Sector.

15.0.9 There initially shall be established by letters patent one establishment for each sector including all of the four (4) following classes:

a) local community service centers;

b) hospital centres;

c) social service centres;

d) reception centres.

A hospital centre for general care shall be encompassed within each of the initially designated establishments in accordance with the implementation schedule set forth in Schedule 1 of this Section.

15.0.10 All persons normally resident or temporarily present in Region 10A shall be entitled to the services included within the jurisdiction and powers of the establishment.

15.0.11 All the powers of the establishment shall be exercised by a board of directors composed in accordance with paragraph 15.0.12.

15.0.12 Each establishment shall be administered by a board consisting of the following members, who shall be members of it upon their election or appointment:

a) one representative from, and elected for three (3) years by, each municipality of the sector;

b) three (3) representatives elected for three (3) years, from among and by those persons who are considered to be members of the clinical staff of an establishment in the said Region within the meaning of the said Act providing that no more than one member of any one professional corporation may serve on the board at any time;

c) one representative elected for three (3) years, from among and by those persons who are members of the non-clinical staff of any establishment in the said Region;

d) the director of the community health department of a hospital centre, or agency forming part of the Kativik Health and Social Services Council or

of a hospital centre with which the Kativik Health and Social Service Council has a service contract or his nominee or the professional directc or his nominee. The Kativik Health and Social Services Council sha appoint such person if there is more than one such centre;

e) the head of the Health and Social Services Department of the Regiona Government or his nominee;

f) the general manager of the base facility in the sector.

Such representatives shall be elected according to the election pro ceedings established by the Kativik Health and Social Services Counc under paragraph 15.0.5.

If the election of a member is not held, the Kativik Health and Socia Services Council shall make the appointment.

15.0.13 The provisions of paragraphs 13 to 15 and 45 to 47 of Schedule 2 o Section 12 of the Agreement shall apply, mutatis mutandis, to the qualifi cation of candidates and electors for the election of the members of the board of directors elected under sub-paragraph a) of paragraph 15.0.12 Persons otherwise eligible to hold office under sub-paragraphs b), c), d) e) and f) of paragraph 15.0.12 shall be exempted from any residency o domicile requirements.

15.0.14 Any vacancy among the members elected in accordance with paragraph 15.0.12 shall be filled by following the mode prescribed for the election of the member to be replaced, only for the unexpired portion of the term of such member.

15.0.15 Notwithstanding the provisions of Section 24 of the Act respecting Health Services and Social Services, the members of the board of directors shall be indemnified in accordance with regulations to be adopted by such board for loss of income suffered by the members as a result of attending meetings. The members may also be indemnified in accordance with the said regulations for their expenses incurred in attending such meetings.

Such regulations shall take into account the prevailing conditions in the said Region, shall be subject to the approval of the Minister of Social Affairs, and shall take into consideration the following:

a) Board meetings shall be scheduled, whenever possible, to avoid conflict with the remunerated work of board members and to take advantage of convenient or inexpensive transport.

b) If in spite of the foregoing, individual members suffer loss of income, the board may indemnify such members for such loss, upon application therefor and where:

i) the board member represents or normally resides in a community other than that in which the meeting is held, and

ii) the board member is either self employed or employed under conditions which preclude continuation of remuneration during time absent to attend such meetings, and

iii) loss of remuneration is clear and unequivocal rather than potential.

15.0.16 The board of directors of every establishment must establish, by by-law, an administrative committee and determine its functions, powers and duties.

15.0.17 The administrative committee shall consist of the chairman of the board of directors, the general manager and three other members of the board of directors of the establishment appointed each year by such board.

15.0.18 Paragraph 15.0.15 shall apply, mutatis mutandis, to members of the administrative committee when attending meetings of such committee.

15.0.19 The budget from the Province of Québec to each establishment shall include funding for the support of health services which are not included in provincial programs for the general population but which are provided to the Native people by the Department of National Health and Welfare or other agencies.

15.0.20 The basis for determining the amounts of the budget support in paragraph 15.0.19 shall be the actual expenditures for health and social services for the fiscal year 1974-75 provided by Canada and Québec to the extent of the responsibilities assumed by Québec under this Section and Schedule I hereof. Funding will be modified on the basis of changes in the population, the cost of the specific services included, and the evolution of provincial programs for the general population.

15.0.21 In implementing the Agreement, Québec should recognize and allow to the maximum extent possible for the unique difficulties of operating facilities and services in the North:

a) in recruiting and retaining staff, generally; working conditions and benefits should be sufficiently attractive to encourage competent personnel from outside Region 10A to accept posts for periods of time ranging from three (3) to five (5) years;

b) in providing employment and advancement opportunities for Native people in the fields of health and social services, and in providing special educational programs to overcome barriers to such employment and advancement;

c) in budgeting for the development and operating of health and social services and facilities so as to compensate for the disproportionate impact of northern costs, including transportation, construction and fuel costs.

15.0.22 Every establishment may make contracts of professional services with any other establishment or body whereby one party binds itself to make services of a professional nature available to the other or by which the parties exchange such services; such a contract shall be valid only from the date on which it is filed with the Kativik Health and Social Services Council.

15.0.23 Every establishment must, at least once a year, hold a public information meeting, in which the population of the sector served by the establishment shall be invited to participate.

The members of the board of directors must there answer the questions put to them respecting the establishment's financial statements, the services it provides and the relations it has with the other establishments and with the Kativik Health and Social Services Council.

The mode of calling such meeting and the procedure to be followed at it shall be determined by the Kativik Health and Social Services Council.

15.0.24 Québec shall take all measures necessary in order to implement this Section. The legislation to be enacted to give effect to the foregoing shall apply notwithstanding the provisions of section 2 of the Act respecting Health Services and Social Services.

15.0.25 Health centers, nursing stations and health stations at various locations, in accordance with the attached Schedule 2, belonging to the Department of National Health and Welfare and all material and other assets located in such buildings as part of the regular equipment shall be turned over to the province of Québec by reciprocal Order-in-Council. The time schedule for turning over the federal health facilities shall coincide with the assumption of full responsibility for administration of health services by the Kativik Health and Social Services Council at which time the said assets shall be transferred by Québec to the said Council at no cost to it.

15.0.26 This Section shall be implemented gradually over a maximum Transition Period of five (5) years, in accordance with the provisions of Schedule 1, beginning upon the execution of the Agreement.

15.0.27 The provisions of this Section can only be amended with the consent of Québec and the interested Native party.

Legislation enacted to give effect to the provisions of this Section may be amended from time to time by the National Assembly of Québec.

(1) This Section shall preserve and improve the scope, extent, conditions and availability of existing health and social services and related services, but in a way that does not inhibit mutually desirable changes in programs or in their administration; foster progressively the training and education of health and social services personnel from among the Native people; and recognize the unique needs and the problems associated with meeting such needs in northern areas.

(2) Except as indicated below, the existing federal and provincial services shall remain intact during the period of time preceding the creation of the Kativik Health and Social Services Council and shall be modified thereafter only by definitive action by or through the Council, but in any event the existing federal services shall be terminated not later than the last day of the five (5) year Transitional Period mentioned in paragraph 15.0.26.

(3) Forthwith upon the execution of the Agreement, a working group shall be assembled under the auspices of the Ministry of Social Affairs of Québec to review the means by which, and with the intention of expeditiously organizing, a broad range of support services, including but not limited to assistance with transportation and housing, translation, and counselling, might be made available to Inuit travelling to centers in the south or returning to their homes in the north. The working group should include representatives of those agencies currently providing or coordinating such services and two (2) representatives appointed by the Northern Québec Inuit Association.

The working group shall table its recommendations with the Minister of Social Affairs by May 1, 1976. In the interim, Canada and Québec shall maintain existing supportive services to the Inuit.

(4) Agencies of Québec and Canada will immediately undertake to improve health and social services for persons residing in the communities of Aupaluk, Port Burwell, and more urgently, Akulivik. As the need arises health and social services shall expeditiously be considered for the residents of new communities that may be established in the future within Region 10A.

(5) Québec undertakes to expeditiously review health and social services staff, facilities and equipment at Kuudjuak (Fort Chimo) with the intention of upgrading the capabilities of the existing establishment to fulfill the sectoral responsibilities envisaged by this Section, and similarly for the community of Povungnituk, including plans for the earliest feasible construction of a hospital centre for general care.

Section 15 (Inuit) Schedule 2

Land Information Sheet
Real Property Holdings

Plot No.	Owner of Land	Department Operating the Facility	Legal Description (or Other Identification)	Nature of Interest	Nature of Installations and Purpose for Which Land is Held or Used	Comments (Including Location)
152	Province of Québec	National Health and Welfare	60°N – 78°W – Lot 400' × 300' – 575 mi. north of Rupert House – East shore of Hudson Bay	Two bldgs., one trailer on Prov. Crown Land	*Povungnituk* Nursing Station for provision of medical services to Native people	Occupied since 1955 No legal transfer of site
176	Province of Québec	National Health and Welfare	62°12'N – 75°38'W – 365 mi. N.W. of Fort Chimo – South shore of Hudson Strait	Two bldgs., three trailers on Prov. Crown Land	*Sugluk* Nursing Station for provision of medical services for Native people	Occupancy 1962
133	Province of Québec	Ministère des Richesses naturelles	770 mi. north of Québec City 30 mi. south of Ungava Bay	Two bldgs. on loan to Province. Constructed 1961	*Fort Chimo* Nursing Station for provision of medical services to Native people	Installation on temporary transfer to Province P.C. 1969-12/1497, July 29/69
136	Province of Québec	Ministère des Richesses naturelles	58°40'N – 66°W (Port Nouveau-Québec) S.E. shore of Ungava Bay	One bldg. on Prov. Crown Land	*George River* Health Station for provision of medical services to Native people	Installation on temporary transfer to Province P.C. 1969-12/1497, July 29/69

Section 15 (Inuit) Schedule 2

Land Information Sheet

Plot No.	Owner of Land	Department Operating the Facility	Legal Description (or Other Identification)	Nature of Interest	Nature of Installations and Purpose for Which Land is Held or Used	Comments (Including Location)
163	Province of Québec	Ministère des Richesses naturelles	200 mi. N.W. of Fort Chimo; North west shore of Ungava Bay 60°12'N – 65°50'W	One bldg. on Prov. Crown Land Acquired 1962	*Koartak* Health Station for provision of medical services to Native people	Installation on temporary transfer to Province P.C. 1969-12/1497, July 29/69
160	Province of Québec	Ministère des Richesses naturelles	100 mi. N.W. of Fort Chimo, South west shore of Ungava Bay 60°N – 70°06'W	One bldg. on Prov. Crown Land	*Payne Bay* Health Station for provision of medical services to Native people	Installation on temporary transfer to Province P.C. 1969-12/1497, July 29/69
166	Province of Québec	Ministère des Richesses naturelles	60°25'N – 70°25'W – 260 mi. N.W. of Fort Chimo; south shore of Hudson Strait	One bldg. on Prov. Crown Land	*Wakeham Bay* Health Station for provision of medical services to Native people	Installation on temporary transfer to Province P.C. 1969-12/1497, July 29/69
92	Province of Québec	National Health and Welfare	55°20'N – 77°W – Lot 4, 200' × 300' – 1.4 acres; east shore of Hudson Bay at Great Whale River	Three bldgs. one trailer on Prov. Crown Land	*Great Whate River* Nursing Station for provision of medical services of Native people	Constructed in 1962
174	Province of Québec	National Health and Welfare	62°25'N – 77°50'W – north east shore of Hudson Bay	One bldg., two trailers on leased site	*Ivujivik* Health Station for provision of medical services to Native people	Legal agreement being finalized to lease two trailers to Province
123	Province of Québec	National Health and Welfare	58°N – 78°W; Inukjuak (Port Harrison) east shore of Hudson Bay	Two bldgs., one trailer on Prov. Crown Land	*Inukjuak (Port Harrison)* Nursing Station for provision of medical services to Native people	New nursing station constructed in 1971

15.0.1 Le Conseil Kativik des services de santé et des services sociaux ainsi que les établissements sont régis, mutatis mutandis, par les dispositions de la Loi sur les services de santé et les services sociaux (1971, c. 48) et toutes les autres lois d'application générale du Québec, sauf lorsque ces lois sont incompatibles avec le présent chapitre, auquel cas les dispositions dudit chapitre prévalent.

15.0.2 L'Administration régionale est chargée de promouvoir, par tous les moyens et mesures qu'elle juge appropriés, l'amélioration de la santé publique dans la région 10A, laquelle englobe le territoire relevant de la compétence de l'Administration régionale établie conformément au chapitre 13 de la Convention.

15.0.3 Un conseil des services de santé et des services sociaux est institué pour ladite région 10A sous le nom de « Conseil Kativik des services de santé et des services sociaux. »

15.0.4 Tous les droits, pouvoirs, privilèges et obligations du Conseil Kativik des services de santé et des services sociaux sont exercés par le Conseil de l'Administration régionale.

Les fonctions, pouvoirs et devoirs du Comité administratif, du directeur général et du personnel du Conseil Kativik des services de santé et des services sociaux sont exercés respectivement par le Comité exécutif, le chef de la Direction des services de santé et des services sociaux de l'Administration régionale et les fonctionnaires de l'Administration régionale.

15.0.5 Le Conseil réglemente et surveille l'élection des membres des conseils d'administration des établissements visés par l'alinéa 15.0.9 du présent chapitre.

Toute réglementation formulée par le Conseil en vertu du présent alinéa doit traiter de la procédure à suivre lors d'une telle élection et prévoir un scrutin d'une durée d'au moins quatre (4) heures pour les membres de chaque collège électoral visé à l'alinéa 15.0.12.

Cette réglementation est soumise au lieutenant-gouverneur en conseil pour approbation; si elle reçoit cette approbation, elle entre en vigueur à la date de sa publication dans la Gazette officielle du Québec. Le Québec convient d'abroger l'arrêté en conseil 1888-75 du 7 mai 1975.

15.0.6 Si le Conseil néglige d'exercer les fonctions qui lui sont assignées en vertu de l'alinéa 15.0.5, celles-ci sont exercées par le ministre.

15.0.7 Nonobstant les dispositions de l'alinéa 2.9 de l'Annexe 2 du chapitre 12 et celles de l'alinéa 2.9 de l'Annexe 2 du chapitre 13 de la Convention, toute ordonnance de l'Administration régionale adoptée aux termes du présent chapitre s'applique dans tout le territoire

de l'Administration régionale et son application n'est pas restreinte aux municipalités.

15.0.8 Dans le cas des services de santé et des services sociaux, la région 10A est, à l'origine, divisée en deux secteurs, à savoir celui de la baie d'Hudson et celui de la baie d'Ungava.

Le secteur de la baie d'Hudson comprend chacune des villes, villes minières, chacun des villages, comtés et chacune des autres municipalités habituellement desservis par ce secteur quant aux services de santé et aux services sociaux; le secteur de la baie d'Ungava comprend chacune des villes, villes minières, chacun des villages, comtés et chacune des autres municipalités habituellement desservis par ce secteur quant aux services de santé et aux services sociaux.

15.0.9 Un établissement doit être à l'origine constitué par lettres patentes pour chaque secteur comprenant les quatre (4) catégories suivantes:

a) centres locaux de services communautaires;
b) centres hospitaliers;
c) centres de services sociaux;
d) centres d'accueil.

Un centre hospitalier dispensant des soins généraux fait partie de chacun des établissements désignés à l'origine conformément au programme d'implantation qui figure à l'Annexe 1 du présent chapitre.

15.0.10 Toute personne résidant habituellement dans la région 10A ou s'y trouvant temporairement a droit aux services relevant de la compétence et des pouvoirs de l'établissement.

15.0.11 Tous les pouvoirs d'un établissement sont exercés par un Conseil d'administration composé selon les dispositions de l'alinéa 15.0.12.

15.0.12 Chaque établissement est administré par un Conseil composé de membres dont le titre leur est attribué lors de leur élection ou nomination. Ces membres sont les suivants:

a) un représentant de chaque municipalité du secteur, élu pour trois (3) ans par celle-ci;
b) trois (3) représentants choisis parmi les membres du personnel clinique d'un établissement de ladite région, au sens de la loi, et élu pour trois (3) ans par lesdits membres, étant entendu qu'il ne peut y avoir simultanément au Conseil plus d'un membre d'une corporation professionnelle donnée;
c) un représentant choisi parmi les membres, autres que ceux du personnel clinique de tout établissement de ladite région et élu pour trois (3) ans par lesdits membres;

d) le directeur du département de santé communautaire d'un centre hospitalier, d'une agence relevant du Conseil Kativik des services de santé et des services sociaux ou d'un centre hospitalier avec lequel le Conseil Kativik des services de santé et des services sociaux a passé un contrat de services ou le délégué de ce directeur, ou encore le directeur des services professionnels ou de son délégué. Le Conseil Kativik des services de santé et des services sociaux nomme ces personnes s'il y a plus d'un centre hospitalier;

e) le directeur des services de santé et des services sociaux de l'Administration régionale ou son délégué; et

f) le directeur général des installations principales du secteur.

Ces représentants sont élus conformément aux procédures d'élection fixées par le Conseil Kativik des services de santé et des services sociaux en vertu de l'alinéa 15.0.5.

Si l'élection d'un membre n'a pas lieu, le Conseil Kativik des services de santé et des services sociaux pourvoit le siège par voie de nomination.

15.0.13 Les dispositions des alinéas 13 à 15 et 45 à 47 de l'Annexe 2 du chapitre 12 de la Convention s'appliquent, mutadis mutandis, aux conditions d'admissibilité des candidats et des électeurs pour l'élection des membres du Conseil d'administration élus en vertu du sous-alinéa (a) de l'alinéa 15.0.12. Les personnes autrement admissibles au Conseil en vertu des sous-alinéas (b), (c), (d), (e) et (f) de l'alinéa 15.0.12 sont exemptées de toute condition de résidence ou de domicile.

15.0.14 Toute vacance parmi les membres élus conformément à l'alinéa 15.0.12 est comblée selon le mode prescrit pour l'élection du membre à remplacer, mais seulement pour la partie non écoulée du mandat du membre en question.

15.0.15 Nonobstant les dispositions de l'article 24 de la Loi sur les services de santé et les services sociaux, les membres du Conseil d'administration sont indemnisés, conformément aux règlements devant être adoptés par ce Conseil, de la perte de revenu qu'entraîne leur présence aux séances du Conseil. Ils peuvent également être indemnisés, conformément auxdits règlements, des frais courus pour assister à ces séances.

Ces règlements sont soumis à l'approbation du ministre des Affaires sociales et doivent tenir compte des conditions qui prévalent dans le territoire, et de celles qui suivent:

a) Les séances du Conseil se tiennent, dans la mesure du possible, à des dates fixées de façon à éviter les conflits avec les heures de travail rémunérées des membres et de façon à leur faire profiter des moyens de transport commodes ou économiques.

b) Si, en dépit de ce qui précède, certains membres subissent une perte de revenu, le Conseil peut les en indemniser sur demande, pourvu que les trois conditions suivantes soient remplies:
i) que la communauté que le membre représente ou dans laquelle il réside normalement ne soit pas celle dans laquelle se tient la séance, et
ii) que le membre travaille pour son propre compte ou dans des conditions qui l'empêchent de toucher une rémunération lorsqu'il est absent pour assister à ces séances, et
iii) que la perte de revenu soit certaine et non seulement probable.

15.0.16 Le Conseil d'administration de chaque établissement met sur pied, par voie de règlement, un Comité administratif et en détermine les fonctions, les pouvoirs et les devoirs.

15.0.17 Le Comité administratif se compose du président du Conseil d'administration, du directeur général et de trois autres membres du Conseil d'administration de l'établissement que ce Conseil nomme chaque année.

15.0.18 L'alinéa 15.0.15 s'applique, mutatis mutandis, aux membres du Comité administratif qui assistent à des séances de ce Comité.

15.0.19 Le budget du Québec pour chaque établissement prévoit des fonds pour financer les services de santé qui ne sont pas inclus dans les programmes provinciaux offerts à la population en général, mais qui sont fournis aux autochtones par le ministère de la Santé nationale et du Bien-être social ou par d'autres agences.

15.0.20 Les dépenses réelles pour l'exercice financier 1974-75 pour les services de santé et les services sociaux fournis par le Canada et par le Québec, dans la mesure des responsabilités que le Québec a assumées en vertu du présent chapitre et de l'Annexe 1, servent de base pour les affectations budgétaires visées à l'alinéa 15.0.19. Le financement sera modifié en fonction des changements démographiques, du coût des services spécifiques fournis et de l'évolution des programmes provinciaux offerts à la population en général.

15.0.21 Pour la mise en application de la Convention, le Québec doit tenir compte, dans toute la mesure du possible, des difficultés exceptionnelles de l'exploitation des installations et des services dans le Nord:

a) en recrutant et en essayant de garder le personnel en général; les conditions de travail et les avantages doivent être suffisamment attrayants pour encourager des personnes compétentes de l'extérieur de la Région 10A à accepter des postes pour une durée de trois (3) à cinq (5) ans;

b) en fournissant de l'emploi et des possibilités d'avancement aux autochtones dans les services de santé et les services sociaux et en leur offrant des programmes de formation spéciaux pour les aider à surmonter les obstacles qui pourraient nuire à leurs possibilités d'emploi ou d'avancement.

c) en prévoyant, pour le développement et l'exploitation des services de santé et des services sociaux et de leurs installations, des budgets suffisants pour compenser la disproportion des coûts dans le Nord, notamment ceux des transports, de la construction, des carburants et combustibles.

15.0.22 Chaque établissement peut conclure, avec tout autre établissement ou organisme, des contrats où l'une des parties s'engage à fournir à l'autre des services d'ordre professionnel, ou par lesquels les parties échangent de tels services; un tel contrat n'est valide qu'à compter de la date à laquelle il est déposé auprès du Conseil Kativik des services de santé et des services sociaux.

15.0.23 Chaque établissement doit, au moins une fois l'an, tenir une séance publique d'information à laquelle la population du secteur desservi par l'établissement est invitée à participer.

Les membres du Conseil d'administration doivent lors de cette séance répondre aux questions qui leur sont adressées au sujet des états financiers de l'établissement, des services qu'il fournit et des relations qu'il entretient avec les autres établissements et avec le Conseil Kativik des services de santé et des services sociaux.

Le mode de convocation de cette séance et la procédure qui doit être suivie sont déterminés par le Conseil Kativik des services de santé et des services sociaux.

15.0.24 Le Québec prend toutes les mesures qui s'imposent pour l'application du présent chapitre. La législation à adopter pour donner effet à ce qui précède doit prévaloir sur les dispositions de l'article 2 de la Loi sur les services de santé et les services sociaux.

15.0.25 Les cliniques, les postes infirmiers et les postes de soins médicaux en divers endroits, conformément à l'Annexe II ci-jointe, et qui appartiennent au ministère de la Santé nationale et du Bien-être social, ainsi que tout le matériel et les autres biens se trouvant dans ces édifices et faisant partie de l'équipement régulier doivent être cédés au Québec par arrêtés en conseil du Canada et du Québec. La ou les dates où les installations de santé fédérales sont cédées au Conseil Kativik des services de santé et des services sociaux coïncident avec la ou les dates où le Conseil assume l'entière responsabilité de l'administration des services de santé, et c'est alors que lesdits biens sont cédés au Conseil, de par l'initiative du Québec, sans aucuns frais pour ledit Conseil.

15.0.26 Les dispositions du présent chapitre entrent progressivement en vigueur au cours d'une période transitoire maximale de cinq (5)

ans, conformément aux dispositions de l'Annexe 1, dès la signature de ladite Convention.

15.0.27 Les dispositions du présent chapitre ne peuvent être amendées qu'avec le consentement du Québec et de la partie autochtone intéressée.

Les lois adoptées pour mettre en vigueur les dispositions du présent chapitre peuvent être modifiées en tout temps par l'Assemblée nationale du Québec.

(1) Le présent chapitre préserve et améliore la portée, l'ampleur, les conditions et la disponibilité des services de santé, des services sociaux et des autres services connexes actuels, sans toutefois entraver les changements que les parties souhaiteraient réciproquement apporter aux programmes ou à leur administration; il encourage progressivement la formation et l'éducation d'un personnel autochtone pour les services de santé et les services sociaux; et il reconnaît également les besoins particuliers des régions septentrionales et les problèmes qu'ils suscitent.
(2) À l'exception des cas ci-après, les services fédéraux et provinciaux demeurent inchangés durant la période précédant la création du Conseil Kativik des services de santé et des services sociaux et ils ne peuvent, par la suite, être modifiés que par action définitive du Conseil ou par l'entremise de ce dernier. Toutefois, les services fédéraux actuels doivent dans tous les cas se terminer au plus tard le dernier jour de la période de transition de cinq (5) ans mentionnée à l'alinéa 15.0.26.
(3) Dès la signature de la Convention, un groupe de travail est formé sous les auspices du ministère des Affaires sociales du Québec pour étudier les moyens favorisant une organisation rapide et la disponibilité d'une vaste gamme de services d'aide, y compris, sans s'y restreindre, l'aide concernant le transport et le logement, la traduction et la consultation pour les Inuit qui se rendent à des centres du sud ou qui retournent à leur foyer dans le nord. Le groupe de travail doit comprendre des représentants des agences qui fournissent ou coordonnent actuellement de tels services ainsi que deux (2) représentants nommés par la Northern Quebec Inuit Association.

Le groupe de travail dispose d'un délai se terminant le premier mai 1976 pour déposer ses recommandations auprès du ministre des Affaires sociales. Dans l'intervalle, le Canada et le Québec doivent maintenir les services d'aide qu'ils fournissent actuellement aux Inuit.
4. Les agences du Québec et du Canada s'engagent immédiatement à améliorer les services de santé et les services sociaux offerts aux personnes qui résident dans les communautés d'Aupaluk, de Port Burwell, et plus instamment, d'Akulivik. À mesure que le besoin s'en fait sentir, il faut déterminer sans délai la nécessité d'organiser des services de santé et des services sociaux pour les résidents des nouvelles communautés pouvant être éventuellement établies dans la région 10A.
5. Le Québec s'engage à faire sans délai des études sur le personnel, les installations et l'équipement des services de santé et des services sociaux à Kuudjuaq (Fort-Chimo) avec l'intention d'améliorer les capacités de l'établissement actuel pour s'acquitter des responsabilités des secteurs visés par le présent chapitre; il doit faire de même pour la communauté de Povungnituk et établir, entre autres, des plans pour la construction, dans le plus bref délai possible, d'un centre hospitalier dispensant des soins généraux.

Chapitre 15 (Inuit) Annexe 2
Renseignements sur les terres

No de lot	Propriétaire des terres	Ministère exploitant les installations	Description juridique (ou autre identification)	Genre d'installations	Nature des installations et fins d'utilisation des terres	Remarques (y compris l'emplacement)
160	Québec	Ministère des Richesses naturelles	60°N – 100 milles au nord-ouest de *Fort-Chimo*, rive sud-ouest de la baie d'Ungava	Un édifice sur des terres de la Couronne provinciale	Poste de soins médicaux de *Bellin* – Dispensant des soins médicaux aux autochtones	Installation sur transfert temporaire à la province P.C. 1969 – 12/1497, 29 juillet 1969
166	Québec	Ministère des Richesses naturelles	60°25'N – 70 25'0 – 260 milles au nord-ouest de *Fort-Chimo;* rive sud du détroit d'Hudson	Un édifice sur des terres de la Couronne provinciale	Poste de soins médicaux de *Maricourt* – Dispensant des soins médicaux aux autochtones	Installation sur transfert temporaire à la province P.C. 1969 – 12/1497, 29 juillet 1969
92	Québec	Santé nationale et Bien-être social	55°20'N – 77 0 – Lot de 200' x 300' – 1.4 acre; rive est de la baie d'Hudson à Poste-de-la-Baleine	Trois édifices et une remorque sur des terres de la Couronne provinciale	Poste infirmier de *Poste-de-la-Baleine* – Dispensant des soins médicaux aux autochtones	Construit en 1962
174	Québec	Santé nationale et Bien-être social	62°25'N – 77 50'0 – rive nord-est de la baie d'Hudson	Un édifice et deux remorques sur un terrain loué	Poste de soins médicaux *d'Ivujivik* – Dispensant des soins médicaux aux autochtones	Convention juridique en voie de conclusion pour la location de deux remorques à la province
123	Québec	Santé nationale et Bien-être social	58°N – 78°0; Inoucdjouac (Port Harrisson), rive est de la baie d'Hudson	Deux édifices et une remorque sur des terres de la Couronne provinciale	Poste infirmier d'Inoucdjouac (Port Harrisson) – Dispensant des soins médicaux aux autochtones	Nouveau poste infirmier construit en 1971

Chapitre 15 (Inuit) Annexe 2
Renseignements sur les terres
Détention d'immeubles

No de lot	Propriétaire des terres	Ministère dont relève l'installation	Description juridique (ou autre identification)	Genre d'installations	Nature des installations et fins d'utilisation des terres	Remarques (y compris l'emplacement)
152	Québec	Santé nationale et Bien-être social	60 °N – 78 °0 – Lot 400′ x 300′ – 575 milles au nord de *Fort Rupert*, rive est de la baie d'Hudson	Deux édifices et une remorque sur des terres de la Couronne provinciale	Poste infirmier de *Povungnituk* – Dispensant des soins médicaux aux autochtones	Occupation depuis 1955 – Aucun transfert légal d'emplacement
176	Québec	Santé nationale et Bien-être social	62 °12′N – 75 °38′0 – 365 milles au nord-ouest de *Fort-Chimo*-rive sud du détroit d'Hudson	Deux édifices et trois remorques sur des terres de la Couronne provinciale	Poste infirmier de *Saglouc* – Dispensant des soins médicaux aux autochtones	Occupation depuis 1962
133	Québec	Ministère des Richesses naturelles	770 milles au nord de la ville de Québec et 30 milles au sud de la baie d'Ungava	Deux édifices érigés en 1961 et prêtés à la province	Poste infirmier de *Fort-Chimo*-Dispensant des soins médicaux aux autochtones	Installation sur transfert temporaire à la province P.C. 1969 – 12/1497, 29 juillet 1969
136	Québec	Ministère des Richesses naturelles	58 °40′N – 66 °0 (Port-Nouveau-Québec), rive sud-est de la baie d'Ungava	Un édifice sur des terres de la Couronne provinciale	Poste de soins médicaux de *Port-Nouveau-Québec* – Dispensant des soins médicaux aux autochtones	Installation sur transfert temporaire à la province P.C. 1969 – 12/1497, 29 juillet 1969
163	Québec	Ministère des Richesses naturelles	60 °12′N – 65 °50′0 – 200 milles au nord-ouest de *Fort-Chimo*, rive nord-ouest de la baie d'Ungava	Un édifice sur des terres de la Couronne provinciale acquis en 1962	Poste de soins médicaux de *Koartac* – Dispensant des soins médicaux aux autochtones	Installation sur transfert temporaire à la province P.C. 1969 – 12/1497, 29 juillet 1969

Exception. Except in the regions contemplated in Divisions III and IV of this Act, a physician, a dentist or a pharmacist is not a member of the clinical staff of an establishment where a council of physicians, dentists and pharmacists is constituted in the establishment.

Exception. However, physicians and dentists, other than those holding administrative posts at the establishment, shall not be considered to be members of the staff.

1971, c. 48, s. 1; 1974, c. 42, s. 1; 1977, c. 5, s. 14; 1977, c. 48, s. 1; 1979, c. 85, s. 82; 1981, c. 22, s. 40; 1984, c. 47, s. 208; 1985, c. 23, s. 24; 1986, c. 57, s. 6.

§2.— *Application*

Application. **2.** This Act and the regulations shall apply to every establishment by whatever law governed, notwithstanding any general law or special Act.

Proviso. This Act and the regulations shall not apply, however, to benevolent activities principally supported by public subscription, to activities for social betterment, public information or mutual social aid or to the other activities provided for by the regulations when such activities are not carried on under the authority of an establishment.

Proviso. This Act and the regulations also do not apply to the psychiatric establishments for detained persons contemplated by the Mental Patients Protection Act (chapter P-41).

1971, c. 48, s. 2; 1972, c. 44, s. 66.

Powers of Minister. **3.** The Minister shall exercise the powers that this Act confers upon him in order to:

(*a*) improve the state of the health of the population, the state of the social environment in which they live and the social conditions of individuals, families and groups;

(*b*) make accessible to every person, continuously and throughout his lifetime, the complete range of health services and social services, including prevention and rehabilitation, to meet the needs of individuals, families and groups from a physical, mental and social standpoint;

(*c*) encourage the population and the groups which compose it to participate in the founding, administration and development of establishments so as to ensure their vital growth and renewal;

(*d*) better adapt the health services and social services to the needs of the population, taking into account regional characteristics, including the geographical, linguistic, sociocultural and socioeconomic characteristics of the region, and apportion among

Annual report.

41. Every regional council shall, not later than 30 June each year, make a report of its activities to the Minister for the year ending on the preceding 31 March. Such report must also contain all information the Minister may prescribe. It shall be laid before the National Assembly within thirty days if it is in session or, if it is not, within ten days of the opening of the next session.

Information.

A regional council shall also at any time give the Minister any information he requires on its activities.

1971, c. 48, s. 38; 1977, c. 48, s. 8.

DIVISION III

PROVISIONS APPLICABLE TO REGION 10A CONTEMPLATED IN THE AGREEMENT CONCERNING JAMES BAY AND NORTHERN QUÉBEC

Definitions: *"Regional Government"*;

42. In this division,

(*a*) "Regional Government" means the Regional Government created under section 13 of the Agreement;

"Agreement".

(*b*) "Agreement" means the Agreement tabled in the National Assembly, 9 June 1976, as Sessional Documents, Nos. 101 and 102.

1977, c. 48, s. 9.

Establishment of council.

43. The Government may delineate the territory of Region 10A, divide it into sectors and establish a health and social services council for the said region.

Exercise of prerogatives.

The rights, powers, privileges and obligations of such council shall be exercised by the council of the Regional Government.

Scope of ordinances.

Notwithstanding article 2(9) of Schedule 2 to Section 12 and article 2(9) of Schedule 2 to Section 13 of the Agreement, every ordinance of the Regional Government made under this division applies to the whole territory of the Regional Government and its application shall not be restricted to the municipalities under its jurisdiction.

Functions, powers and duties. Exercise.

The functions, powers and duties of the administrative committee, director general and staff of the health and social services council contemplated in this section shall be exercised by the executive committee, the head of the Health and Social Services Department of the Regional Government and the officers of the Regional Government, respectively.

1977, c. 48, s. 9; 1986, c. 57, s. 6.

Administration of public establishments.

44. Notwithstanding sections 78 to 82, the powers of a public establishment belonging to the classes enumerated in subparagraphs *a*, *b*, *d* and *e* of the first paragraph of section 64 and situated in a sector of Region 10A, shall be exercised by a board of directors consisting of the following members:

(*a*) one representative from, and elected for three years by, each municipality of the sector;

(*b*) three persons elected for three years by the members of the clinical staff advisory council constituted in the establishment and chosen among the members of that council, with not more than one representative for each professional corporation;

(*c*) one person elected for three years by all the members of the non-clinical staff of the establishment and chosen among such members;

(*d*) the director of the community health department of a hospital centre, of an agency governed by the Region 10A Health and Social Services Council or of a hospital centre with which the said council has a service contract, or his nominee, or the director of professional services or his nominee, such persons shall be appointed by the Region 10A Health and Social Services Council if there is more than one such hospital centre;

(*e*) the head of the Health and Social Services Department of the Regional Government or his nominee;

(*f*) the director general of the establishment.

Qualifications.

Only a person qualified to hold municipal office and entitled to vote in accordance with articles 13 to 15 and 45 to 47 of Schedule 2 to Section 12 of the Agreement is qualified to be elected and to vote for the application of subparagraph *a* of the first paragraph.

Exemption.

A person qualified to hold municipal office and entitled to vote under subparagraphs *b*, *c*, *d*, *e* and *f* of the first paragraph is not subject to residence or domicile requirements.

1977, c. 48, s. 9; 1978, c. 72, s. 6; 1986, c. 57, s. 6.

Vacancy.

45. Any vacancy among the members elected in accordance with section 44 shall be filled by following the mode of election prescribed for the election of the member to be replaced, but only for the unexpired portion of the term of such member.

1977, c. 48, s. 9.

Administrative committee.

46. Notwithstanding section 97, the administrative committee of an establishment of the region shall consist of the chairman of the board of directors, the director general and three other members of

the board of directors of the establishment appointed each year by such board.

1977, c. 48, s. 9; 1986, c. 57, s. 6.

Indemnities.

47. Notwithstanding sections 27, 33, 94 and 102, the members of the board of directors and of the administrative committee of the regional council and the members of the board of directors and of the administrative committee of a public establishment situated in the region shall be indemnified for attending meetings in accordance with the regulations made for such purpose by their respective councils. Such regulations shall come into force upon approval by the Minister.

1977, c. 48, s. 9.

Application for contestation or annulment.

48. Any person concerned may make an application to the Commission for contestation or annulment of any election held under subparagraphs *b* and *c* of the first paragraph of section 44.

Decision.

The Commission may confirm or annul the election or declare another person validly elected.

New election.

Where the Commission annuls the election of a member without declaring another person validly elected, a new election must be held without delay.

Term of office.

The member thus elected shall remain in office for the unexpired portion of the term of office of the member whose election was annulled.

1977, c. 48, s. 9.

Act and regulations apply.

49. Except in the case of inconsistency with the provisions of this division and the regulations made thereunder, the provisions of the other divisions of this Act and the regulations apply *mutatis mutandis* to the regional council and to a public establishment contemplated in this division, notwithstanding section 2.

1977, c. 48, s. 9.

DIVISION IV

PROVISIONS APPLICABLE TO REGION 10B CONTEMPLATED IN THE AGREEMENT CONCERNING JAMES BAY AND NORTHERN QUÉBEC

Definitions:

50. In this division,

ANNEX 2

ANNEX 2

ORDER IN COUNCIL

CHAMBER OF THE EXECUTIVE COUNCIL

NUMBER 1020-79

APRIL 11, 1979

PRESENT

The Lieutenant-Governor in Council—>

CONCERNING THE delimiting of the territory of region 10A and the institution of a board of health and social services for that region;

WHEREAS under section 38b of the Act respecting health services and social services (1971, chapter 48), the Lieutenant-Governor in Council may delimit the territory of region 10A, divide it into sectors and institute a board of health and social services for that region.

WHEREAS, under the same section, the rights, powers, privileges and obligations of that board are exercised by the council of the Cree Regional Government under Section 13 of the James Bay and Northern Québec Agreement;

WHEREAS by the terms of section 239 of the Act concerning Northern Villages and the Kativik Regional Government (1978, chapter 87), the Regional Government contemplated in the preceding paragraph was created under the title of "Kativik Regional Government" and its powers are exercised by its council known and cited under title of "the council of the Kativik Regional Government";

WHEREAS there are grounds for delimating the territory of region 10A and instituting a board of health and social services;

IT IS ORDAINED, THEREFORE, upon the recommendation of the Minister of Social Affairs:

THAT the territory of region 10A be delimited as follows:

> "All the territory of the Province of Québec located North of the fifty-fifth paralled, excluding category IA and IB lands intended for the Cree community of Poste-de-la-Baleine and designated as such under the Act respecting the land regime in the James Bay and New Québec territories (1978, chapter 93) or, in the interim, under the Act respecting Cree and Inuit Native persons (1978, chapter 97) and the Order in Council number 2084-78 of June 28, 1978, adopted on the authority of section 4 of that Act."

...

THAT be instituted in region 10A a board of health and social services which will be designated as :

"Kativik Regional Board of Health and Social Services"

and this in accordance with section 38b of the act respecting health services and social services (1971, chapter 48);

THAT the above-mentioned board have its registered office in Fort Chimo, in the judicial district of Mingan;

THAT the rights, powers, privileges and the obligations of the above-mentioned board be exercised by "the council of the Kativik Regional Government" in accordance with the Act.

Louis Bernard
Greffier du Conseil exécutif

Annexe 3

ARRÊTÉ EN CONSEIL
CHAMBRE DU CONSEIL EXÉCUTIF

NUMÉRO 1020-79

11 AVR. 1979

PRÉSENT
Le lieutenant-gouverneur en conseil

CONCERNANT la délimitation du territoire de la région 10A et l'institution d'un conseil de la santé et des services sociaux pour ladite région

ATTENDU QU'en vertu de l'article 38b de la Loi sur les services de santé et les services sociaux (1971, chapitre 48), le lieutenant-gouverneur en conseil peut délimiter le territoire de la région 10A, le subdiviser en secteurs et instituer un conseil de la santé et des services sociaux pour ladite région;

ATTENDU QUE, suivant le même article, les droits, pouvoirs, privilèges et obligations de ce conseil sont exercés par le conseil de l'administration régionale créée en vertu du chapitre 13 de la Convention de la Baie James et du Nord québécois;

ATTENDU QU'aux termes de l'article 239 de la Loi concernant les villages nordiques et l'Administration régionale Kativik (1978, chapitre 87), l'administration régionale visée à l'alinéa précédent a été créée sous le nom de "Administration régionale Kativik" et ses pouvoirs sont exercés par son conseil connu et cité sous le nom de "le conseil de l'Administration régionale Kativik";

ATTENDU QU'il est donc opportun de délimiter le territoire de la région 10A et d'y instituer un conseil de la santé et des services sociaux;

IL EST ORDONNÉ, EN CONSÉQUENCE, sur la recommandation du ministre des Affaires sociales:

QUE le territoire de la région 10A soit délimité comme suit:

> "Tout le territoire de la province de Québec situé au nord du cinquante-cinquième parallèle, à l'exclusion des terres de la catégorie IA et IB destinées à la communauté crie de Poste-de-la-Baleine et désignées comme telles en vertu de la Loi concernant le régime des terres dans les territoires de la Baie James et du Nouveau-Québec (1978, chapitre 93) ou, entre-temps, en vertu de la Loi concernant les autochtones cris et inuit (1978, chapitre 97) et de l'arrêté en conseil numéro 2084-78 du 28 juin 1978 adopté sous l'autorité de l'article 4 de cette loi."

1020-79

ARRÊTÉ EN CONSEIL
CHAMBRE DU CONSEIL EXÉCUTIF

NUMÉRO

PRÉSENT
Le lieutenant-gouverneur en conseil

2/...

QUE soit institué dans la région 10A un conseil de la santé et des services sociaux qui sera désigné sous le nom de:

"Conseil régional Kativik de la santé et des services sociaux"

et ce, conformément à l'article 38b de la Loi sur les services de santé et les services sociaux (1971, chapitre 48);

QUE ledit Conseil ait son siège social à Fort Chimo, dans le district judiciaire de Mingan;

QUE les droits, pouvoirs, privilèges et obligations dudit Conseil soient exercés par "le conseil de l'Administration régionale Kativik" conformément à la loi.

le Greffier du Conseil exécutif

Louis Bernard

DÉCRET

GOUVERNEMENT DU QUEBEC

NUMÉRO 2000-87

2 DEC. 1987

Concernant la révision des limites des régions administratives du Québec

ATTENDU QUE le gouvernement a établi des régions administratives par le décret 524 du 29 mars 1966 et qu'il a modifié par la suite le territoire de certaines d'entre elles pour tenir compte notamment de la constitution de nouvelles régions et de la création des municipalités régionales de comté;

ATTENDU QU'il convient de s'assurer que ces régions puissent correspondre aux réalités sociales, économiques et culturelles du Québec et que chacune d'entre elles respecte les limites des territoires des municipalités régionales de comté;

ATTENDU QUE les régions administratives doivent servir de base territoriale à la production des statistiques des ministères et organismes du gouvernement, à l'implantation de bureaux régionaux et locaux ainsi qu'à la concertation entre le gouvernement et les régions;

ATTENDU QUE, suite au moratoire décrété en janvier 1986, une consultation exhaustive a été menée auprès des milieux régionaux et auprès d'une vingtaine de ministères ou organismes gouvernementaux sur une proposition de nouvelle carte des régions administratives tenant compte de celles existantes et à créer;

ATTENDU QU'une consultation sera menée incessamment auprès du Comité consultatif de la municipalité de la Baie James afin de préciser la limite sud du territoire du Nord-du-Québec;

ATTENDU QU'une évaluation des implications administratives et financières de l'implantation des bureaux régionaux et locaux sur une nouvelle base régionale, a été réalisée en collaboration avec les ministères concernés;

ATTENDU QU'il y a lieu d'augmenter le nombre des régions administratives et d'adopter une nouvelle carte établissant leurs limites officielles;

IL EST ORDONNÉ, en conséquence, sur la proposition du ministre des Transports, responsable du Développement régional:

QUE le territoire du Québec soit désormais divisé en seize (16) régions administratives, suivant la description et la carte de délimitation apparaissant à l'annexe I, et que chacune d'elle respecte intégralement les limites actuelles des municipalités régionales de comté;

QUE dans un premier temps, la région Nord-du-Québec comprenne tout le territoire non constitué en MRC situé au nord des MRC Abitibi-ouest (à l'exception des communautés locales de Beaucanton, Villebois et Val-Paradis), Abitibi, Vallée-de-l'Or, Haut-St-Maurice, Domaine-du-Roy, Maria-Chapdelaine, Fjord-du-Saguenay et Caniapiscau, et que ses limites définitives soient arrêtées après consultation du Comité consultatif de la municipalité de la Baie James;

CLASSE

11. Région 06D Lanaudière

Comprend six (6) MRC, soit:

Matawinie	(décret 2381-82 du 20 octobre 1982)
D'Autray	(décret 3229-81 du 25 novembre 1981)
Joliette	(décret 3296-81 du 2 décembre 1981)
Montcalm	(décret 2607-81 du 23 septembre 1981)
L'Assomption	(décret 2378-82 du 20 octobre 1982)
Les Moulins	(décret 3377-81 du 9 décembre 1981)

12. Région 06E Laval

Comprend une (MRC), soit:

Laval	(chap.89, lois du Québec, 1965)

13. Région 07 Outaouais

Comprend trois (3) MRC, soit:

Papineau	(décret 2618-84 du 28 novembre 1984)
La Vallée-de-la-Gatineau	(décret 2617-84 du 28 novembre 1984)
Pontiac	(décret 2619-84 du 28 novembre 1984)
et Communauté régionale de l'Outaouais	(Loi sur la CRO, chap. c. 37.1 lois refondues du Québec)

14. Région 08 Abitibi-Témiscamingue

Comprend cinq (5) MRC, soit:

Abitibi-Ouest	(décret 3370-81 du 9 décembre 1981)
Abitibi	(décret 2371-82 du 20 octobre 1982, modifié par le décret 3008-82 du 21 décembre 1982)
Vallée-de-l'Or	(décret 2620-84 du 28 novembre 1984)
Témiscamingue	(décret 542-81 du 25 février 1981, modifié par le décret 762-81 du 11 mars 1981)
Rouyn-Noranda	(décret 541-81 du 25 février 1981, modifié par le décret 761-81 du 11 mars 1981)

15. Région 09 Côte-Nord

Comprend cinq (5) MRC, soit:

Caniapiscau	(décret 3293-81 du 2 décembre 1981)
La Haute-Côte-Nord	(décret 2603-81 du 23 septembre 1981)
Manicouagan	(décret 3236-81 du 25 novembre 1981)
Sept-Rivières	(décret 3245-81 du 25 novembre 1981)
Minganie	(décret 3376-81 du 9 décembre 1981)

et la Municipalité Côte-Nord du Golfe-Saint-Laurent.

16. Région 10 Nord-du-Québec

Comprend dans un premier temps, tout le territoire non constitué en MRC situé au nord des MRC Abitibi-ouest (à l'exception des communautés locales de Beaucanton, Villebois et Val-Paradis), Abitibi, Vallée-de-l'Or, Haut-Saint-Maurice, Domaine-du-Roy, Maria-Chapdelaine, Fjord-du-Saguenay et Caniapiscau, soit en particulier:

- la municipalité de la Baie James;
- les villes enclaves de Matagami, Lebel-sur-Quévillon, Chibougamau et Chapais;
- les communautés Cries;
- les municipalités de villages [illegible]

ANNEX 3

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ᐃᓄᓂᕐᓂᖅᓯᒪᓕᒃᑐᑦ ᑲᑎᒪᔨᖏᑦ
Kativik Regional Board of Health and Social Services
Conseil régional Kativik de la Santé et des Services Sociaux
P.O. Box 9 KUUJJUAQ (QUÉBEC) CANADA J0M 1C0

ANNEX 3

PRESENTATION TO THE PARLIAMENTARY COMMISSION

ON THE DRAFT BILL ON THE ACT RESPECTING

HEALTH AND SOCIAL SERVICES

REGION KATIVIK

Mr. Eli Weelaluktuk
Chairman of the Kativik CRSSS

Mr. George Konsak
Chairman of the hospital CSS-CLSC
establishment, Ungava Bay

Mr. Paulosie Padlayat
Chairman of the hospital CSS-CLSC
establishment, Hudson Bay

Mrs Lizzie Epoo-York
General manager, Kativik CRSSS

March 15, 1990

Mr. Chairman:

The Kativik Regional Board of Health and Social Services and the two Health and Social Services establishments welcome the opportunity to address the Parliamentary Commission on the Draft Bill on the Act respecting health services and social services.

As you must have already observed, the presentation of our vision of the organization of health and social services is the vision of the Inuit population and not of one specific establishment as opposed to another. The Kativik Regional Board of which I am an elected representative and both establishments responsible for the delivery of health and social services in our 14 villages spread on a distance of 1 400 miles along the coast of Ungava Bay and the Hudson Bay, these three instances and their elected boards have a concerted message to address to this Commission. It is as such a demonstration of our will to assume fully the responsibility for the planning, delivery and evaluation of services to our population.

The Kativik Regional Board of Health and Social Services already meets the objectives of the Government's new orientations in that the Board is comprised of elected representatives from each municipality in the region. This unique composition established by decree no. 1020-79 resulted from the provisions of Chapter 18 in the James Bay and Northern Quebec Agreement. As such it answers the numerous questions raised by this Commission in regards to accountability. As elected people, each one of us as representative of a specific community or village, has to be responsible in front of the population of our community.

Generally, Inuit feel that the proposed modifications to the powers and responsibilities of the regional authority will be a positive step towards improvements in the development and delivery of health and social services in the Kativik region.

It must be reminded that the Kativik region covers an area of 563 515 square kilometers in Quebec north of the 55th parallel. The population of which a majority are Inuit, is divided among 14 communities linked only by air. The geographic and demographic particularities of the region have a great impact on development and delivery of services. We are a relatively young population with specific problems and concerns.

Speaking of some of the characteristics of our region, it is surprising to note that the new decree on administrative regions has not yet recognized region 10A as a distinct region from 10B . As far as we are concerned there is no place for discussion on this issue and we request that the government give a specific number to our region different from the one of the Cri Region.

The modifications to the powers and responsabilities of the regional authority will enhance our ability to develop the orientations and activities required to meet specific objectives in our region. The potential for flexibility within programs will stimulate involvement by health care personnel and the population at large. Therefore, the Inuit people are requesting the power that the Ministry is ready to give to all regions but more specifically the budget necessary to make this power significant. It is time that the Regional Board of Health and Social Services be given the control over the budget spent to do studies on the state of Inuit's health and well being, on their needs and for service delivery. At this point in time, much money goes to southern establishments (in Quebec, Montreal, Val-d'Or) for services to the North without any control by our region.

We feel that our mandate in Community Health, planning and programming must be more clearly defined and the financial resources made available to the Regional Council to assume these responsabilities and to establish the links or contractual arrangements with a Community Health Department in order to do so.

Furthermore, it goes without saying, but in our experience it appears necessary to state it occasionnaly, the Regional Board cannot assume its responsibilities without minimal budget allocation for staff. At present, the Regional Board has six recognized positions including a clerical one and a communication officer. We request the responsibilities and the means to assume them.

Our concern for means to meet the needs of the population are even greater. If we find it necessary to stress the need for adequate staffing at the Regional level, it is much more so in regards to study of the needs of the population and to the delivery of services. While we must recognize that some efforts have been made at the ministry, much has to be done: we often feel forgotten in the budget allocation process. Sometimes, we find out that money is about to be distributed or as been distributed through all regions and the Kativik region is not included. Taking into account the characteristic of our region should not mean putting us aside from the allocation process or doing long studies that brings nothing to the region. We are pleased that our Minister of Health recognizes that the time for long studies is over and that it is time for decision and action. We count on this attitude to receive full recognition through the budget allocation process, a process that should still take into account our specific situation. In view of where we are at in terms of planning and delivery of services, the expectations in terms of objectives and results should be different from that of other regions.

In matters relating to Public Health, the Regional Board must be in a position to assist the Kativik Regional Government which has the mandate for Public Health in our region by providing professionnal expertise in matters relating to Public Hygiene and the prevention of disease and disability.

The Kativik Regional Board must be assigned specific funding for Human Resources Development to provide basic and a specialized training to Inuit aside from Human Resources Development programs established by Government. This training is a prerequisite to effective participation by Inuit in all level of delivery and development of health and social services. You have had a good example of what can be accomplished through the mid wife program at the Hudson Bay establishment.

As Inuit, we wish to establish that we agree generally with the modifications to the powers and responsibilities of a regional authority as provided for in the draft bill. We anxiously await ratification of these powers ans responsibilities. We have been prepared to take these on for some time as evidenced by our previous statements to government.

Quebec, March 14th, 1990

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ᐃᓄᓕᕆᓂᕐᒧᑦ ᑲᑎᒪᕕᖏᑦ
Kativik Regional Board of Health and Social Services
Conseil régional Kativik de la Santé et des Services Sociaux
P.O. Box 9 KUUJJUAQ (QUÉBEC) CANADA J0M 1C0

SUMMARY

The Kativik Regional Board of Health and Social Services welcomes the opportunity to address the Parliamentary Commission on the Draft Bill on the Act respecting health services and social services.

The Kativik Regional Board of Health and Social Services already meets the objectives of the Government's new orientations in that the Board is comprised of elected representatives from each municipality in the region. This unique composition established by decree no. 1020-79 resulted from the provisions of Chapter 15 in the James Bay and Northern Quebec Agreement.

Generally, Inuit feel that the proposed modifications to the powers and responsibilities of the regional authority will be a positive step towards improvements in the development and delivery of health and social services in the Kativik region.

Our region covers an area of 563 515 square kilometers in Québec north of the 55th parallel. The population, majoritarily Inuit, is divided among 14 communities linked only by air. The geographic and demographic particularities of the region have a great impact on development and delivery of services. We are a relatively young population with specific problems and concerns.

As Inuit, we feel that the process of regionalization and decentralization will enable us to further develop efficient and relevant services which will respond to the needs of our people in our region.

The Kativik Regional Board of Health and Social Services has recognized the importance of effective promotion and prevention in achieving an optimum level of health and well-being for Inuit. The development of culturally relevant information in Inuttitut, in conjunction with a comprehensive public education program would promote self-reliance in health matters and facilitate development and involvement by the population.

Our natural networks and families remain the basis of our communities. Strengthening and supporting these groups are an important aspect of our mandate.

We have met with government many times in the past to stress the importance of accountability and responsibility for and to Inuit by Inuit. In the development of the structures for the administration of our territory, we have provided already for a multisectorial approach as proposed by government on the regional and local levels. We look forward to increasing this cooperation and including the provincial partners in this exercise.

The modifications to the powers and responsibilities of the regional authority will enhance our ability to develop the orientations and activities required to meet specific objectives in our region. The potential for flexibility within programs will stimulate involvement by health care personnel and the population at large.

We feel that our mandate in Community Health, planning and programming must be more clearly defined and the financial resources made available to the Regional Council to assume these responsibilities and to establish the links or contractual arrangements with a Community Health Department in order to do so.

In matters relating to Public Health , the Regional Council must be in a position to assist the Kativik Regional Government which has the mandate for Public Health in our region by providing professional expertise in matters relating to Public Hygiene and the prevention of disease and disability.

The Kativik Regional Council must be assigned specific funding for Human Resources Development to provide basic and a specialized training to Inuit aside from Human Resources Development programs established by Government. This training is a pre-requisite to effective participation by Inuit in all level of delivery and development of health and social services..

As elected people, we wish to be accountable both to our population and to the Ministry. With accountability must come responsibility and the means to assume these.

As Inuit, we wish to establish that we agree generally with the modifications to the powers and responsibilities of a regional authority as provided for in the draft bill. We anxiously await ratification of these powers and responsibilities. We have been prepared to take these on for some time as evidenced by our previous statements to government.

Kuujjuaq, January 1990

ANNEX 4

ANNEX 4

ADDITIONNAL BRIEF TABLED TO THE PARLIAMENTARY COMMISSION ON DRAFT BILL 120

The Act respecting health services and social services

Kativik Regional Council of health and Social Services

(region 10A)

Kuujjuaq, January 1991

On November 11, 1975, the Inuit of Northern Québec signed together with the governments the James Bay and Northern Québec Agreement. This Agreement was laying the foundation of a new social contract and contemplated the setting up of many regional bodies to allow the northern Québec population to take on independently a significative share of the responsibilities for their administration and their development.

Chapter 15 of this Agreement deals with health and social services and contemplates the setting up of a regional Council of Health and Social Services called the Kativik Council of Health and Social Services having jurisdiction in the territory north of the 55th parallel except for Category 1A and 1B attributed to the Cree of Kuujjuaraapik.

While Inuit composed the majority of the population of the territory the Kativik Council of Health and Social Services is not an ethnic entity, its jurisdiction applies to all. The situation is the same for the establishments of the region.

Health and social services are provided in 14 communities which are dispersed on a territory having a superficy of 563,515 square kilometers.

The Kativik Council of Health and Social Services was erected by Order in Council 1020-79 of April 11,1979 in accordance with chapter 15 of the Agreement.

The Kativik Council of Health and Social Services appeared in March 1990 at the Parliamentary Commission on Health and Social services at the occasion of the review of the first version of the draft bill on health and social services reform. We then had the opportunity to clearly state our position on the main objectives of the reform. Generally we feel that the proposed modifications to the powers and responsibilities of the Regional Board will be a positive step toward improvements in the development and delivery of health and social services in our region.

The process of regionalization and decentralization would enable us to further develop efficient and relevant services to respond more adequately to the needs of our peoples in our land. As stated in our brief tabled at the Parliamentary Commission in January 1990:

> "The modifications to the powers and responsibilities of the regional board will enhance our ability to develop the orientations and activities required to meet specific objectives in our region. The potential flexibility within programs will stimulate involvement by health care personnel and the population at large."

According to the principles enunciated in the white paper concerning health and Social services for the aboriginal nations and the establishment of Regional Boards it is clearly stated that:

"In order to help aboriginal communities to manage their own health and social services, the Minister intends to:

- hand over to the Inuit and Cree nations the mandate to manage health and social services on the Kativik and James Bay, respectively."

"In order to adapt health and social services to the needs and regional specificities the Minister intends:

- to create a regional board of health and social services for each administrative region of Québec except for northern Québec where there will be two regional board to take into consideration the specificities of the Inuit and the Crees."

Contrary to these principles enunciated in the white paper draft bill 120 by its section 492 excludes the territory of the Kativik Council of Health and Social Services from the application of said proposed legislation. That interpretation is also confirmed by the content of the explanatory notes on that subject.:

SECTION 492:

"This Act replaces the Act respecting health services and social services (R.S.Q. Ch S-5) except to the extent that it applies to the territory of the James Bay Cree health and social services council and the territory of the Kativik health and social services council."

EXPLANATORY NOTES:

> "The bill also provides that the existing Act respecting health services and social services will continue to apply to the territory of the James Bay Cree health and social services council and the territory of the Kativik health and social services council"

It is true that the James Bay and Northern Québec Agreement contains some unique provisions which were included there to address some of the special needs and particularities of our region. Some sections of the Agreement regarding health and social services were included to take into consideration the unique situation of our territory with its 14 communities linked together only by air services. Our geographic and demographic situation had obviously to be addressed.

That being said, it should not be forgotten that one of the main objective of chapter 15 of the Agreement was to improve the quantity and quality of health and social services available to our population by confirming that, subject to some regional particularities, the law of general application concerning health and social services would be applicable to the territory of the Kativik council of health and Social services.

SECTION 15.0.1

> "The Kativik Health and Social Services Council and the establishments shall be governed, mutadis, mutandis, by the provisions of the Act respecting health services and Social Services (1971, c. 48) and all other laws of general application in the province, save where these laws are inconsistent with this section, in which event the provisions of this Section shall prevail."

SECTION 15 Schedule 1

> "This Section shall preserve and improve the scope, extent, conditions and availability of existing health and social services and related services but in way that does not inhibit mutually desirables changes in programs and their administration..."

The Kativik Council of Health and Social services has consequently fully exercised its competence and powers according to the law and over the years developed its collaboration with other CRSSS through participation with an organization such as the CRSSS Conference.

The Kativik Council of Health and Social services fears to be left out of the actual reform of health and social services if section 492 is implementation and put in effect as it presently exists. The Kativik Council could be marginalized and loose some of the important gains

it has made over the years. Furthermore, its development could be compromised of such an important reform which would give to the region essential tools for the improvement of the well being of its population.

As it presently exists, draft bill 120 would freeze the situation for two CRSSS while all the other regional Councils would be transformed into Regional Boards which would evolved and be administered under different rules and orientations.

We strongly believe that draft bill 120 with its objective of regionalization and decentralization do not depart from the spirit and in most part from the letter of chapter 15 of the James Bay and Northern Québec Agreement.

As an example, the replacement of CRSSS by Regional Boards would certainly respect the intent of the Agreement. Far from taking out responsibilities from the CRSSS the proposed new legislation would give to the Regional Boards additional responsibilities and powers which will add to the ones they already have. The intent of the James Bay Agreement was certainly not to prevent the development of health and social services for our territory.

The Inuit of Northern Québec have decided in 1975 to participate into the health and social services system as it exists at the time. Today they wish to continue to participate into the said

system and be able to receive their fair share of the available resources and to administer it as already expressed earlier, the whole without neglecting to protect the specificity of the territory and its population as recognized under the James Bay and Northern Québec Agreement.

The draft bill as proposed do not change the approach which has been taken fifteen years ago. For us It is important to have a regional body with powers enabling us to develop regional policies and regional criteria's of quality , availability and efficiency of services.

Because it feels that most of the provisions contained into draft bill 120 would represent in fact an important step forward for the improvement of its mandate and objectives the Kativik Council of health and social services would suggest that said draft bill would be modified to include a section which could offer at the same time protection to their rights under James Bay and Northern Québec Agreement and flexibility to continue to participate to the improvement of health and social services for its population in accordance with the general policies applicable to the entire population of Québec.

We would consequently suggest that amendments be brought to draft bill 120 which could substantially read as follows:

> "Sections 42 to 49 of the Act respecting health services and social services (Q.R.S. ch S-5) remain applicable to the territory of the Kativik Council of health and Social services subject to the following:

i) where in said sections reference is made to the "health and social services council" it should read as the "regional Board of health and social services" as established under the present Act."

"The present Act and the regulations thereunder apply in the territory of the Kativik Council of health and social services, however where any provisions thereof is incompatible with the provisions of section 42 to 49 of the Act respecting health and Social Services (Q.R.S. ch S-5), the latter prevails"

Such type of provisions would, we believe, provide sufficient flexibility for the Kativik region to participate in the reform of the health and social services and would not enter into conflict with the provisions of the James Bay and Northern Québec Agreement.

LPA
société Makivik corporation

January 28,1991

Mr Marc-Yvan Côté
Minister of Health and
Social Services
1075 Chemin Ste-Foy
Québec, Québec

Subject: Draft Bill 120 concerning health services and social services

Dear Sir,

We have been informed that the proposed new legislation concerning health and social services, draft bill 120, is scheduled to be reviewed in Parliamentary Commisssion starting January 28, 1991.

Our executive had the opportunity to review the additionnal brief presented by the Kativik Council of Health and Social Services concerning the above mentionned matter. By the present we wish to bring our support to the Kativik Coucil of Health and Social services brief and conclusions.

We remain sincerely yours,

Charlie Watt
President

c.c. Mr Paul Lamarche, Assistant deputy-minister

SIÈGE SOCIAL/HEAD OFFICE C.P. P.O. Box 179, Kuujjuaq, Qué. J0M 1C0 / Tél. (819) 964-2925
BUREAU / OFFICE 650 - 32e Avenue Lachine, Québec H8T 1Y4 / Téléphone (514) 634-8091
Inukjuak Québec J0M 1M0 / Téléphone: (819) 254-8878

ANNEX 5

ANNEX 5.

NOTES POUR LA PRÉSENTATION

DU MINISTRE DE LA SANTÉ ET DES SERVICES SOCIAUX

MONSIEUR MARC-YVAN CÔTÉ

LORS DE L'OUVERTURE DE LA COMMISSION PARLEMENTAIRE

SUR LE PROJET DE LOI 120

(ÉTUDE ARTICLE PAR ARTICLE)

LE 19 MARS 1991

* JE SOUHAITERAIS QUE L'OPPOSITION ET LE GOUVERNEMENT NE TOMBENT PAS DANS LES PIÈGES TRADITIONNELS:

  - RAPPELEZ-VOUS DES PARADOXES CONSTATÉS LORS DE LA COMMISSION PARLEMENTAIRE SUR L'AVANT-PROJET DE LOI;

  - EXAMINEZ LES REVUES DE PRESSE ET COMPAREZ LE MESSAGE DES CITOYENS ET CEUX QUI DÉFENDENT LEURS INTÉRÊTS;

> POUR LE GOUVERNEMENT, IL N'Y AURA QU'UN SEUL PRISME POUR ANALYSER LES DEMANDES: CELUI DU MIEUX-ÊTRE DES CITOYENS ET CITOYENNES DU QUÉBEC.

2. LES AMENDEMENTS

* PASSONS MAINTENANT AUX AMENDEMENTS, AUX PAPILLONS QUI FONT ÉTAT DE CORRECTIONS PROPOSÉES PAR LE GOUVERNEMENT.

* MADAME LA PRÉSIDENTE,

  JE VAIS PROPOSER 309 AMENDEMENTS AU PROJET DE LOI 120.

* CE CHIFFRE PEUT APPARAÎTRE ÉLEVÉ, MAIS PLUS DE 70% DE CES AMENDEMENTS SONT STRICTEMENT DE FORME, DE CONCORDANCE OU DE PRÉCISION.

  . QUI N'AFFECTE EN RIEN LA SUBSTANCE DU PROJET DE LOI.

* DES AMENDEMENTS PLUS SIGNIFICATIFS SONT AUSSI PROPOSÉS

  . QUI N'AFFECTENT EN RIEN NON PLUS LES PRINCIPES, LES ORIENTATIONS ET LES OBJECTIFS POURSUIVIS PAR LA RÉFORME ET LE PROJET DE LOI.

* 30% DES AMENDEMENTS REPRÉSENTENT DES BONIFICATIONS AU PROJET DE LOI.

DES GROUPES

* CES AMENDEMENTS FONT SUITE, POUR UNE BONNE PART D'ENTRE EUX, AUX COMMENTAIRES ET RECOMMANDATIONS DES 4 GROUPES SUIVANTS:

  - LA COMMUNAUTÉ ANGLOPHONE ET LES COMMUNAUTÉS CULTURELLES;
  - LES COMMUNAUTÉS CRIS ET INUIT;
  - LE RÉSEAU;
  - LES MÉDECINS.

3.1 LA COMMUNAUTÉ ANGLOPHONE ET LES COMMUNAUTÉS CULTURELLES

TOUT EN SOUSCRIVANT AUX ORIENTATIONS DE BASE DE LA RÉFORME, LA COMMUNAUTÉ ANGLOPHONE ET LES COMMUNAUTÉS CULTURELLES ONT ÉMIS CERTAINES RÉSERVES CONCERNANT:

- LE RESPECT DES DROITS ACQUIS PAR LEUR COMMUNAUTÉ QUANT À L'ACCESSIBILITÉ À DES SERVICES DE SANTÉ ET SERVICES SOCIAUX;

- LE MAINTIEN DE L'IDENTITÉ DES ÉTABLISSEMENTS ASSOCIÉS AUX COMMUNAUTÉS ANGLOPHONE ET CULTURELLES;

- LEUR REPRÉSENTATION AU SEIN DES CONSEILS D'ADMINISTRATION;

- LA NÉCESSITÉ POUR LES RÉGIES DE TENIR COMPTE DE LA PRÉSENCE DES COMMUNAUTÉS CULTURELLES ET LINGUISTIQUES DANS L'ORGANISATION DES SERVICES ET L'ALLOCATION DES RESSOURCES;

- LE PROJET DE LOI 120 PRÉVOIT DÉJÀ QUE L'ORGANISATION DES SERVICES DOIT TENIR COMPTE DES PARTICULARITÉS LINGUISTIQUES ET ETHNO-CULTURELLES DE LA POPULATION. DES AMENDEMENTS SONT SUGGÉRÉS À CETTE FIN.

- AFIN DE PRÉSERVER CET OBJECTIF, DES PAPILLONS ONT ÉTÉ PROPOSÉS AFIN:

. DE PRÉSERVER L'IDENTITÉ DES ÉTABLISSEMENTS ASSOCIÉS À CES COMMUNAUTÉS:

. UNIFICATION DES C.A. NON PAS UNIQUEMENT EN FONCTION D'UNE BASE TERRITORIALE, MAIS POSSIBILITÉ D'UNE UNIFICATION SUR UNE BASE D'UNE AFFILIATION LINGUISTIQUE ET CULTURELLE)

. CPEJ ANGLOPHONE (POUR MONTRÉAL).

. D'ASSURER UNE PRÉSENCE AU C.A. DES ÉTABLISSEMENTS DE LA RÉGIE VIA, LE CAS ÉCHÉANT, LA COOPTATION;

. D'OBLIGER LES RÉGIES À TENIR COMPTE POUR L'ORGANISATION DES SERVICES ET L'ALLOCATION DES RESSOURCES DE LA PRÉSENCE DES COMMUNAUTÉS CULTURELLES, DU PROGRAMME D'ACCÈS AUX SERVICES POUR LES ANGLOPHONES ET DES ÉTABLISSEMENTS DÉSIGNÉS COMME DEVANT OFFIR LES SERVICES EN ANGLAIS.

3.2 Les communautés Cris et Inuit

- Les Indiens Cris souhaitent la création d'une régie régionale qui aurait pour leur communauté les mêmes pouvoirs que les autres régies qui seront créées à travers le Québec. Les Inuit réclament également une régie régionale pour leur communauté.

- Ils souhaitent également que le projet de loi 120 puisse s'appliquer à eux, mais en l'adaptant pour tenir compte de leurs caractéristiques et de leurs besoins.

- Une régie régionale était prévue dans la réforme pour chacune des communautés.

- On ne pourra le faire dans le cadre du projet de loi 120,

  - car un arrangement doit intervenir entre les parties signataires de la Convention de la Baie James.

  - Je m'engage à ce que des négociations amorcent sous peu.

Gouvernement du Québec
Ministère de la Santé et des Services sociaux
Direction générale de la prévention et des services communautaires

UNOFFICIAL ENGLISH TRANSLATION OF A LETTER DATED OCTOBER 1, 1991, ADDRESSED BY MONSIEUR ROGER RICHARD, CHEF DU SERVICE DE LIAISON AVEC LES RÉGIONS NORDIQUES, TO MRS. LIZZIE EPOO-YORK, GENERAL MANAGER, KATIVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES, P.O. BOX 9, KUUJJUAQ (QC) J0M 1C0

Madam,

I refer here to your letter dated July 12, 1991, indicating to me the content of the resolution no. 91-07 seeking, Departmental approval for major changes in your organization plan.

The ministère de la Santé et des Services sociaux is in favour of the regions assuming full responsibility for such activities as they are likely to improve the population's health status.

Bill 120 respecting the reform of Health and Social Services has just been sanctioned by the National Assembly. We may now accede to the desire of the Minister, Marc-Yvan Côté, to conclude with you the initial agreement for creating a regional board.

Such undertaking will enable your organizaton to assume the entire mandate to be entrusted to it, along with seizing the opportunity to repatriate the structures and budgets accorded for those activities.

In that all the reform mechanisms resulting from Bill 120 have yet to be established, discussions are ongoing so as to define the legal context for allowing the Kativik Board to accede to the status of Régional Board.

As soon we have the results of the work now in progress, we shall promptly advise you of same.

I trust this is satisfactory.

ANNEX 6

ANNEX 6

UNE RÉFORME AXÉE SUR LE CITOYEN

Plan d'implantation

Québec

UNE RÉFORME AXÉE SUR LE CITOYEN

Plan d'implantation

PRÉAMBULE

J'ai le plaisir de présenter aux Québécoises et aux Québécois le plan d'implantation de la réforme de la santé et des services sociaux.

Ce document s'inscrit dans la démarche que j'ai entreprise pour replacer le citoyen au centre du système de santé et de services sociaux en tant que consommateur, décideur et payeur. En décembre 1990, je rendais publiques les orientations gouvernementales et les mesures à mettre en oeuvre pour atteindre cet objectif fondamental. Le 28 août 1991, le gouvernement du Québec adoptait en troisième lecture le projet de loi 120, Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives. Les orientations de la réforme étant définies et son cadre juridique adopté, le temps est venu de passer à son implantation en tenant compte de la politique de santé et de bien-être et des mesures touchant le financement du système qui seront bientôt connues.

Ce plan d'implantation présente les diverses mesures qui devront être mises en place au cours des prochains mois et des prochaines années pour réaliser la réforme. Il décrit tout d'abord les objectifs d'implantation poursuivis qui conditionnent l'échéancier de réalisation de la réforme, puis les mesures par phase et par axe d'intervention.

Je suis particulièrement fier de ce plan. Il permettra de réaliser, d'ici avril 1993, les changements les plus significatifs de la réforme grâce à la collaboration de la population, des organismes communautaires, des artisans du réseau de la santé et des services sociaux et du personnel du Ministère.

Le Ministre,

Marc-Yvan Côté

Québec, le 23 mars 1992

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1. LES DÉFIS DE LA RÉFORME

Le bien-fondé et la signification de la réforme ont été largement expliqués lors de la présentation du document Une réforme axée sur le citoyen, le 7 décembre 1990.

Il est maintenant clair pour tous que le système de santé et de services sociaux est confronté à trois défis majeurs qu'il doit simultanément relever:

- corriger les lacunes actuelles des services offerts à la population et faire face aux besoins de demain;
- assurer un fonctionnement qui rende le réseau plus efficient dans l'utilisation des ressources et plus efficace dans la solution des problèmes de santé et de bien-être;
- assurer un financement qui respecte la capacité de payer de l'État.

La réforme affronte ces défis en privilégiant le point de vue du citoyen, autant au plan de ses besoins que de ses intérêts, qu'il soit consommateur, décideur ou payeur.

2. LES ORIENTATIONS DE LA RÉFORME

Neuf orientations sont poursuivies pour replacer le citoyen au centre du système.

Pour le citoyen CONSOMMATEUR:

1. des citoyens dont les droits sont reconnus et respectés;
2. des citoyens qui bénéficient de services adaptés à leurs besoins;

3. des citoyens qui reçoivent des services le plus près possible de leur milieu de vie;

4. des citoyens accueillis, aidés et traités par un personnel dévoué et dédié à sa tâche.

Pour le citoyen DÉCIDEUR:

5. une prise de décision le plus près possible de l'action;

6. des citoyens au coeur de la prise de décision;

7. des citoyens imputables de leurs décisions.

Pour le citoyen PAYEUR:

8. des citoyens qui en ont pour leur argent;

9. des citoyens qui doivent assumer le coût des services.

3. LA MISE EN OEUVRE DE LA RÉFORME

Les orientations de la réforme sont supportées par un grand nombre de mesures dont la réalisation impliquait ou impliquera des actions législatives, réglementaires, financières et administratives. Ainsi, l'adoption du projet de loi 120, la tenue du débat public sur le financement du système, l'élaboration d'une politique de santé et de bien-être et la présentation d'une loi d'application constituent des éléments essentiels qui s'inscrivent dans le processus de mise en oeuvre de la réforme.

3.1 La Loi 120: une étape décisive de franchie

Un grand pas a été franchi le 28 août 1991 lorsque l'Assemblée nationale adoptait en troisième lecture le projet de loi 120, Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives.

Il s'agissait pour l'essentiel de redéfinir, à la lumière du document de la réforme, les droits des usagers et les façons de les faire respecter, les rôles et les fonctions des principaux intervenants dans le système de santé et de services sociaux et les différentes règles du jeu au regard de la gestion des ressources humaines, matérielles et financières. Ce projet de loi avait donc une portée très large et il était d'une importance capitale pour la mise en oeuvre de la réforme.

Des améliorations ont été apportées au projet de loi lors des travaux de la Commission parlementaire, au moment de l'étude article par article. Ces amendements ont permis de bonifier le projet de loi et de préciser les dispositions, sans remettre en cause les objectifs poursuivis ou les changements recherchés, tout en permettant un consensus élargi. Parmi les modifications apportées, il faut souligner:

1. le renforcement de la participation du corps médical à la gestion du système, dans le réseau d'établissements et au niveau régional, notamment par la création de commissions médicales;

2. la désignation d'un commissaire aux plaintes ayant pour mandat d'examiner les plaintes de citoyens insatisfaits d'une décision rendue par une régie en cette matière;

3. une plus grande représentation de l'expertise professionnelle au sein des conseils d'administration en permettant, entre autres, au personnel d'occuper les postes pouvant être comblés par voie de cooptation.

Au terme des échanges intervenus en marge de l'adoption du projet de loi 120, le ministre de la Santé et des Services sociaux s'était par ailleurs engagé à créer deux nouvelles instances chargées de le conseiller dans l'exercice de ses fonctions, à savoir le Conseil de santé et de bien-être et le Conseil médical du Québec, ce qui est maintenant réalisé.

3.2 Le débat public sur le financement du système: une nécessité

Du 4 au 12 février 1992, le Gouvernement a tenu une large consultation sur l'enjeu majeur du financement des dépenses de santé et de services sociaux dans le cadre des travaux de la Commission parlementaire des affaires sociales. Pour alimenter la discussion publique en marge de cette importante question, le ministre de la Santé et des Services sociaux avait rendu public, en décembre dernier, le document Un financement équitable à la mesure de nos moyens.

Ce débat a permis d'identifier les objectifs à poursuivre et les moyens à prendre pour contenir la progression des dépenses du secteur de la santé et des services sociaux à l'intérieur de la volonté et de la capacité des citoyens payeurs de les assumer sur une base individuelle et collective.

3.3 Une politique de santé et de bien-être: pour mieux fonder nos choix

La mise en oeuvre de la réforme s'inscrira dans la perspective d'une politique de santé et de bien-être dont la publication coïncidera avec la prochaine année budgétaire.

Cette politique vise essentiellement à rassembler les intervenants autour d'objectifs de résultats centrés sur la réduction des problèmes de santé et de bien-être. Elle a également pour objectif de mieux faire prendre conscience des facteurs agissant sur la santé et le bien-être et des possibilités de créer des conditions plus favorables à leur amélioration.

3.4 La loi d'application: l'entrée en vigueur du nouveau régime juridique

Une loi d'application, dont le dépôt est prévu en mars et l'adoption en juin 1992, viendra préciser les dates d'entrée en vigueur et les conditions transitoires d'application des dispositions du chapitre 42 (Loi 120) qui n'ont pas actuellement force de loi.

Le passage d'un régime juridique à l'autre s'effectuera une fois constitués les conseils d'administration des régies régionales, soit au début de l'automne 1992.

La mise en oeuvre de la réforme de la santé et des services sociaux résultera de la convergence des éléments essentiels suivants: la Loi 120, les mesures touchant le financement, la politique de santé et de bien-être, la loi d'application et le plan d'implantation.

4. LES OBJECTIFS ET LES PHASES D'IMPLANTATION

Avec ce plan d'implantation s'amorce l'étape cruciale de passer des intentions à l'action. Outre le fait qu'il s'agisse d'une réforme longuement désirée et attendue par les citoyens, l'adoption du projet de loi 120 permet enfin d'entreprendre concrètement les changements recherchés et d'initier les transformations prévues au chapitre de l'organisation des établissements et de la représentation au sein des structures décisionnelles du réseau.

Pour atteindre l'objectif fondamental de la réforme soit, replacer le citoyen au centre du système, le plan d'implantation propose:

1- de réaliser à court terme les éléments clés de la réforme;

2- de permettre de suivre la séquence logique d'implantation des mesures interreliées;

3- d'impliquer le plus grand nombre d'intervenants dans l'implantation tout en respectant la capacité du réseau et du Ministère d'absorber les changements;

4- et de respecter la capacité de payer de l'État.

L'échéancier d'implantation des mesures se subdivise en trois phases:

- d'ici avril 1993;
- d'avril 1993 à avril 1995;
- après avril 1995.

5. LA PHASE 1 (d'ici avril 1993)

Tout en n'excluant pas la possibilité de mise en place d'autres mesures ou actions, cinq axes d'intervention comportant quelque soixante-dix mesures ont été retenus, dès la première phase d'implantation, pour mettre en oeuvre de manière décisive les changements les plus significatifs de la réforme:

1- la protection des droits des usagers;

2- l'amélioration de l'accessibilité aux services en fonction de clientèles particulières;

3- la régionalisation;

4- l'amélioration du fonctionnement et de l'organisation du système de santé et de services sociaux;

5- la valorisation des ressources humaines.

Ces axes d'intervention reflètent une volonté aussi claire que nécessaire d'agir autant sur l'amélioration des services à la personne que sur le système lui-même pour corriger ses faiblesses et le rendre plus performant.

Une plus grande sensibilisation aux particularités locales et régionales et une meilleure adaptation des services sont attendues de la régionalisation qui s'engage. Sur le plan de l'efficience et de l'efficacité, la politique de santé et de bien-être, les changements aux modes d'allocation de ressources et les conseils d'administration unifiés pour les services à certaines clientèles fourniront, entre autres, de nouveaux leviers d'action pour rendre le système plus performant. La recherche d'une meilleure performance constitue d'ailleurs une obligation permanente de la gestion des ressources considérables dévolues au secteur de la santé et des services sociaux.

Même s'il a été, jusqu'à présent, relativement performant, le Québec se doit en effet de tout mettre en oeuvre pour que chaque dollar investi dans le secteur soit utilisé à bon escient et contribue au maximum à l'amélioration de la santé et du bien-être. Cette préoccupation majeure inspire bon nombre des mesures retenues pour la première phase d'implantation. Elle devra également se refléter dans la façon de gérer les ressources additionnelles que requerra le secteur au cours de la décennie.

5.1 La protection des droits des usagers

Le respect des droits des usagers implique une meilleure connaissance de ces droits de la part des usagers et du personnel du réseau et un renforcement des conditions favorables à l'exercice de ces droits et à l'utilisation des recours disponibles par les usagers. A cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:

1- l'adoption d'un code d'éthique par les établissements;

2- la désignation d'un cadre responsable du traitement des plaintes dans les établissements et les régies régionales;

3- la nomination d'un commissaire aux plaintes au niveau central;

4- la réorientation des comités d'usagers en matière de protection des droits;

5- la mise en place d'un service d'aide et d'accompagnement dans chaque région;

6- l'élaboration de programmes de sensibilisation du personnel aux droits des usagers, et aux pratiques pour les respecter.

5.2 L'amélioration de l'accessibilité aux services en fonction de clientèles particulières

La réforme vise à corriger des problèmes d'accessibilité à certains services ainsi qu'à mieux adapter l'ensemble des services aux besoins de groupes particuliers et d'une population changeante. Les jeunes et les personnes âgées, à cet égard, sont sources de préoccupations particulières et constituent une priorité du Ministère. A cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:

Orientation des citoyens dans le réseau

7- la mise en place graduelle, au niveau régional, d'un service téléphonique d'information et de référence, accessible 24 heures par jour, 7 jours par semaine;

Personnes âgées

8- l'élaboration d'un plan d'action pour une plus grande autonomie et une participation accrue des personnes âgées à la vie collective (Rapport Pelletier);

9- l'adoption d'une nouvelle politique de services à domicile;

10- le rehaussement des budgets alloués aux services à domicile et à l'alourdissement des clientèles ;

11- l'ajustement des budgets d'immobilisations eu égard à la sécurité, à la vétusté et à la rénovation fonctionnelle;

12- l'amélioration de l'encadrement professionnel dans les ressources intermédiaires et les autres ressources d'hébergement et un meilleur contrôle de la sécurité des édifices;

13- le dépistage par les CLSC des personnes âgées de leur territoire vivant dans des conditions sanitaires susceptibles de leur causer de graves préjudices;

14- l'adoption d'un plan de développement des lits de longue durée pour des personnes en perte d'autonomie, dont une partie servira à la réadaptation fonctionnelle intensive;

15- l'adoption d'un plan de développement des lits de courte durée;

Jeunesse

16- l'adoption d'un plan d'action pour venir en aide aux jeunes en difficulté (Rapport Bouchard);

17- l'adoption d'un plan d'action à l'égard de la protection de la jeunesse et des jeunes contrevenants (Rapport Jasmin);

18- la mise en oeuvre des recommandations pour l'amélioration des services de prise en charge en protection de la jeunesse (Rapport Harvey);

19- l'augmentation, d'une part, des effectifs sociaux en milieu scolaire et, d'autre part, de ceux affectés à la prise en charge en vertu de la Loi sur la protection de la jeunesse;

20- l'extension des services de médiation familiale à l'ensemble des régions;

21-[1] l'adoption et la mise en oeuvre du nouveau plan triennal et du programme de gratuité de médicaments pour les personnes atteintes du sida et des autres MTS;

22-[1] l'augmentation des budgets alloués aux établissements et aux organismes communautaires pour la prévention de la toxicomanie;

23-[1] l'accroissement des services de réadaptation offerts en externe et en milieu alternatif d'hébergement aux personnes alcooliques et toxicomanes;

24-[1] l'amélioration des facilités de désintoxication médicale et non médicale;

25-[1] l'implantation d'un mécanisme de reconnaissance des ressources privées et publiques, offrant des services de réadaptation aux personnes alcooliques et toxicomanes;

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[1] Ces mesures s'appliquent essentiellement aux jeunes mais elles peuvent également être destinées à d'autres clientèles.

Personnes handicapées

26- l'augmentation du nombre de personnes handicapées embauchées dans la Fonction publique québécoise et dans les entreprises;

27- la mise en place de services de répit et de dépannage à l'intention des familles de personnes handicapées;

Nations autochtones

28- la négociation avec les nations autochtones, autres que les Cris et les Inuit, pour leur confier la gestion des services;

29- l'implantation de régies régionales en territoires cri et inuit;

Communauté anglophone

30- la création du comité provincial et des comités régionaux aviseurs sur la prestation des services en langue anglaise;

31- la création d'un centre de protection de l'enfance et de la jeunesse (CPEJ), sur l'Ile de Montréal, à l'intention de la communauté anglophone;

Communautés culturelles

32- l'amélioration de l'accessibilité aux services par la constitution d'une banque d'interprètes sur l'Ile de Montréal, la formation interculturelle du personnel du réseau et la mise en place d'un programme d'information socio-sanitaire à l'intention des clientèles issues de ces communautés;

33- la mise en place de programmes d'égalité en emploi, au sein du réseau, pour les personnes issues de ces communautés.

5.3 La régionalisation

La régionalisation veut permettre d'adapter les services aux besoins des diverses clientèles et d'effectuer les arbitrages nécessaires à une organisation et à un fonctionnement efficients des services, compte tenu des particularités locales et régionales.

Pour l'atteinte de ces objectifs, la réforme rapproche la prise de décision le plus près possible de l'action et assure une participation majoritaire des citoyens au sein des structures décisionnelles qui seront mises en place. Un processus s'engage donc qui conduira à la création des régies régionales dans chacune des régions sociosanitaires du Québec, dès que les élections et les nominations aux conseils d'administration des établissements auront été complétées et que les assemblées régionales auront été formées.

La trajectoire suivie vise à faire passer le réseau de la santé et des services sociaux, et ce dès octobre 1992, de l'ancien au nouveau régime sur le plan des centres de décision. Tous les nouveaux conseils d'administration des établissements et des régies régionales entreront donc en fonction à compter de cette date. Ils commenceront alors à préparer la mise en place des conditions inhérentes à l'exercice des responsabilités que leur attribue la Loi 120. Toutefois, pour assurer la continuité des services offerts aux citoyens, la gestion des activités courantes qu'exerçaient les conseils régionaux sur les territoires appelés à se diviser, continuera d'être assumée par la régie de la région initiale jusqu'en avril 1993. Dans le cas de la régie régionale du Nord-du-Québec, cette gestion des activités courantes sera exercée par les régies régionales de la santé et des services sociaux du Saguenay-Lac-St-Jean et de l'Abitibi-Témiscamingue.

L'objectif poursuivi par le Ministère est de transférer le plus rapidement possible aux régies l'exercice des fonctions que leur confie le législateur quant à l'organisation et à la budgétisation des services sur leur territoire. Ce transfert de fonctions se reflétera dès avril 1993 par l'envoi d'enveloppes budgétaires aux régions. Il se traduira ultimement par la mise en oeuvre de plans régionaux d'organisation de services (PROS) approuvés par le Ministère. Entre-temps, c'est-à-dire tout au cours de la période transitoire que nécessitera la conversion graduelle de la gestion budgétaire et la mise en place des PROS, les choix des régions seront avalisés par le Ministère en fonction du cadre budgétaire gouvernemental, des priorités ministérielles et du respect des enveloppes accordées à chaque région.

A cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:

34- l'identification et le regroupement des établissements devant être dirigés par un même conseil d'administration (c.a. unifiés - les dérogations ont été approuvées par le Gouvernement en décembre 1991);

35- la création des nouveaux conseils d'administration des établissements, comprenant l'élection des représentants de la population par voie d'assemblées publiques;

36- la création des nouvelles régions socio-sanitaires de la Gaspésie-Iles-de-la-Madeleine, de Chaudière-Appalaches, de Laval, de Lanaudière et du Nord-du-Québec;

37- la constitution des assemblées régionales formées pour 40% de représentants des conseils d'administration d'établissements, pour 20% d'élus municipaux, pour 20% de représentants d'organismes communautaires et pour 20% de représentants des groupes socio-économiques et des autres secteurs d'activité;

38- la création des régies régionales dans l'ensemble des régions;

39- l'organisation de sessions de formation à l'intention des membres des conseils d'administration;

40- l'adaptation du Ministère à l'impact de la réforme sur son fonctionnement et son organisation;

41- la mise en place d'une nouvelle structure de programmes pour l'organisation des services au sein du réseau de la santé et des services sociaux en lien avec la politique de santé et de bien-être; ces programmes serviront à la gestion des services, à l'allocation des ressources ainsi qu'à la présentation du rapport d'activités des régies devant la Commission des affaires sociales;

42- l'adoption de nouvelles règles d'allocation budgétaire basées sur l'équité interrégionale, la performance des établissements, les objectifs et les clientèles prioritaires.

5.4 L'amélioration du fonctionnement et de l'organisation du système de santé et de services sociaux

Par cet axe d'intervention, la réforme vise à entreprendre dès maintenant les changements nécessaires pour traduire dans les faits les missions redéfinies des établissements, instaurer de nouveaux partenariats et susciter une contribution accrue des organismes communautaires.

D'autres mesures sont retenues pour améliorer l'accessibilité aux services médicaux et hospitaliers, réorganiser la mission de la santé publique, consolider la recherche et l'enseignement, et accroître l'efficience du système.

A cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:

Meilleur partenariat

43- la création du Conseil de santé et de bien-être (loi adoptée par l'Assemblée nationale en mars 1992);

44- la création du Conseil médical du Québec (loi adoptée par l'Assemblée nationale en décembre 1991);

45- la mise en place, dans les établissements, des conseils des infirmières et infirmiers et des conseils multidisciplinaires;

Services médicaux

46- la négociation des conditions devant conduire à une meilleure répartition des effectifs médicaux et à la participation des médecins des cabinets privés à des activités particulières dans le cadre des priorités de services déterminées par les régies;

47- la révision de la politique d'admission au niveau post-doctoral en accordant la priorité aux spécialités de base;

48- l'affiliation de chaque région à une faculté de médecine et la valorisation des spécialités de base en matière de rémunération;

49- l'élaboration d'un projet médical et d'une politique facilitant le recrutement des médecins en CLSC;

Santé publique

50- la réorganisation des responsabilités du Ministère en santé publique et la nomination du directeur provincial de la santé publique;

51- la nomination d'un directeur régional de la santé publique dans chaque région;

52- la conception d'un plan de réorganisation de la santé publique dans chaque région et l'amorce de sa mise en oeuvre;

Services sociaux

53- la réorientation des services sociaux de première ligne par:

a) le transfert administratif des travailleurs sociaux hospitaliers des centres de services sociaux aux centres hospitaliers;
b) le transfert de responsabilités et de ressources des centres de services sociaux aux CLSC;
c) la transformation des centres de services sociaux en centres de protection de l'enfance et de la jeunesse (CPEJ);
d) le transfert de responsabilités et de ressources, des centres de services sociaux à d'autres établissements, relativement aux familles d'accueil pour adultes et personnes âgées;

54- la création de centres de protection de l'enfance et de la jeunesse (CPEJ) dans les nouvelles régions socio-sanitaires de la Gaspésie-Iles-de-la-Madeleine, de Chaudière-Appalaches, de Laval et de Lanaudière.

Services pré-hospitaliers

55- l'adoption d'un plan global prévoyant notamment:

- l'accélération du programme de rénovation des salles d'urgence;
- l'implantation de centres de traumatologie;
- l'implantation de systèmes régionaux d'information sur les lits vacants et d'orientation des cas d'urgence vers ces lits, principalement pour l'accès à des soins tertiaires;
- la réorganisation du transport ambulancier;
- la permanence du Groupe tactique d'intervention et l'application des recommandations du Groupe de planification stratégique;

Thérapies alternatives

56- la tenue d'un débat public en commission parlementaire sur les thérapies alternatives;

Organismes communautaires

57- l'augmentation du montant total des subventions versées aux organismes communautaires;

Enseignement et recherche

58- la désignation des centres hospitaliers universitaires (CHU) et des instituts;

59- le développement de la recherche sociale et évaluative;

60- la consolidation du programme de chercheurs-boursiers de la Régie de l'assurance-maladie du Québec;

Maximisation des gains d'efficience associés à des mesures particulières

61- l'adoption d'un plan de développement des équipements ultraspécialisés pour l'ensemble du Québec;

62- le renforcement des achats de groupe interétablissements et l'achat centralisé de certains équipements ultraspécialisés;

63- l'élaboration d'un plan d'action ministériel relatif aux services pharmaceutiques et aux médicaments;

64- l'implantation d'un système de contrôle de qualité des laboratoires de biologie médicale;

65- la mise en route d'un projet expérimental de carte santé à microprocesseur intégré et l'émission d'une carte d'assurance-maladie avec photographie.

5.5 La valorisation des ressources humaines

La qualité des services aux citoyens passe obligatoirement par l'amélioration de la qualité de vie au travail des employés. Ainsi, la réforme attache une grande importance à la réduction des horaires difficiles, au développement du personnel, à sa participation au milieu de travail et à sa contribution réelle à la réalisation des objectifs de la réforme à l'égard du citoyen. A cette fin, les mesures suivantes seront mises en oeuvre d'ici avril 1993:

Conditions de travail

66- l'évaluation et le suivi de l'impact des mesures négociées en 1989 pour favoriser, d'une part, l'attraction et la rétention de la main-d'oeuvre en soins infirmiers, et d'autre part, la stabilisation de la main-d'oeuvre du réseau (augmentation du nombre d'emplois réguliers); l'examen conjoint des modalités de la décentralisation de la négociation des matières normatives;

67- l'adoption et la mise en oeuvre d'une politique de mobilité des directeurs généraux;

Planification de la main-d'oeuvre en soins infirmiers

68- l'élaboration d'une politique globale de la main-d'oeuvre en soins infirmiers couvrant notamment les besoins actuels et futurs de main-d'oeuvre, les modes d'organisation de soins et les mesures d'attraction et de rétention;

Qualification, formation et perfectionnement

69- l'augmentation des budgets de perfectionnement du personnel du réseau et des membres des conseils d'administration pour satisfaire, entre autres, les besoins de formation reliés à la réforme;

70- la mise en place du centre de référence pour la qualification des directeurs généraux;

Participation

71- la mise en place des mécanismes d'information et de consultation des employés sur les priorités et les orientations de l'établissement et la tenue d'une assemblée annuelle à leur intention.

Telles sont les mesures de la première phase d'implantation qui permettent aux nouvelles entités juridiques (régies régionales, établissements) et à leur conseil d'administration d'assumer les responsabilités actuelles tout en se préparant à assumer au 1er avril 1993 les responsabilités et fonctions prévues dans le chapitre 42.[1]

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[1] Voir annexe II: Le passage de l'ancien au nouveau régime juridique: faits saillants.

6. APERÇU DES PHASES II ET III

Au cours de la deuxième phase, soit d'avril 1993 à avril 1995, plusieurs mesures de la première phase seront consolidées et une quarantaine de nouvelles mesures seront implantées.[1]

Plusieurs actions seront entreprises ou poursuivies pour améliorer les services offerts aux personnes âgées, aux jeunes en difficulté et aux personnes handicapées. Le développement des services à domicile sera accéléré au cours de cette période. Il permettra, entre autres, d'offrir les services aux personnes âgées hébergées dans les résidences privées et les habitations à loyer modique. Une autre préoccupation du Ministère sera de favoriser la mise en place, par les CLSC et les organismes communautaires, de services courants auprès des jeunes en difficulté et de leur famille. Des services seront aussi développés pour répondre aux besoins des personnes handicapées, tout particulièrement dans les régions qui en sont actuellement dépourvues.

Des mesures seront mises en oeuvre pour continuer d'améliorer l'organisation et le fonctionnement du réseau, tant au niveau local que régional.

Ainsi, l'allégement de la réglementation actuelle donnera aux établissements une plus grande marge de manoeuvre. De plus, à compter d'avril 1993, les nouvelles régies exerceront toutes les responsabilités que leur confie la loi. Elles pourront dès lors assumer certains des mandats spécifiques prévus dans la deuxième phase, dont la formation d'une commission médicale dans leur région. Ces commissions favoriseront la concertation régionale avec les médecins ainsi que la participation des médecins des cabinets privés aux services médicaux identifiés par les régies régionales. La négociation avec les médecins sur les mesures à adopter pour permettre une meilleure répartition des effectifs devant alors être achevée, c'est aussi à compter de cette date que seront mis en place les moyens retenus pour corriger les disparités actuelles observées dans la répartition des effectifs médicaux.

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1 Voir annexe III: Les mesures de la phase II et de la phase III

Plusieurs nouvelles mesures seront aussi mises en oeuvre pour assurer un meilleur contrôle de l'évolution des coûts des services assurés. La Régie de l'assurance-maladie du Québec sera tout particulièrement mise à contribution aux niveaux de la révision de ses programmes et de la mise en place de modalités pour freiner la multiplication des services et pour informer les citoyens du coût des services assurés.

Les ressources humaines continueront d'être une préoccupation importante du Ministère. Des conditions seront mises en place pour favoriser une meilleure gestion de ces ressources dans les établissements et pour reconnaître la qualité des services rendus par le personnel du réseau.

Certaines des mesures qui requièrent des coûts de développement étalés sur plusieurs années seront finalisées pendant la phase III. Ce sont, entre autres, le rehaussement des budgets attribués aux services à domicile et aux organismes communautaires, le développement des lits pour l'hébergement et pour les soins de courte durée et le parachèvement du plan global des services pré-hospitaliers.

7. L'IMPACT FINANCIER DE LA RÉFORME

Ce ne sont pas toutes les mesures qui nécessitent des investissements nouveaux. Plusieurs seront financées par voie de réallocation budgétaire.

En 1992-1993, des crédits neufs de 71,6$ millions serviront à l'implantation de la réforme. La majeure partie de ces crédits, soit 72,9%, sera affectée à la mise en place de mesures pour favoriser l'exercice des droits des usagers et pour améliorer l'accessibilité des services offerts à des clientèles particulières, notamment, aux personnes âgées et aux jeunes en difficulté. La mise en place des nouvelles régies régionales s'accompagnera, quant à elle, d'une enveloppe budgétaire de 6,0$ millions.

Les choix budgétaires relatifs aux autres années couvertes par le plan d'implantation seront faits en tenant compte de la conjoncture économique, de la politique budgétaire et de la capacité de payer de l'État.

8. L'IMPACT SUR LES RESSOURCES HUMAINES

Certains des changements issus de la réforme auront un impact plus direct sur l'utilisation d'une partie du personnel du réseau et du Ministère. Ces changements résultent notamment des modifications apportées aux missions

des établissements, de la création de cinq nouvelles régions socio-sanitaires, de la mise en place des conseils d'administration unifiés et, en ce qui a trait au Ministère, des responsabilités confiées aux régies.

D'une part, il doit être entendu que les transferts d'effectifs requis pour s'ajuster aux vocations nouvelles des établissements et à la création de nouvelles régions constituent des mouvements de personnel dont la concrétisation s'effectuera conformément aux dispositions pertinentes des conventions collectives et des règlements, selon le cas.

D'autre part, l'unification des conseils d'administration qui a eu comme résultat de réduire de 189 le nombre de conseils d'administration, entraînera dès la nomination du nouveau directeur général et l'adoption par les nouveaux conseils d'administration des plans d'organisation des établissements sous leur juridiction, une rationalisation de l'ensemble des postes concernés. Ces modifications devront être réalisées conformément aux mesures appropriées prévues dans les règlements sur les conditions de travail des directeurs généraux et des cadres.

Enfin, certaines des fonctions du Ministère et son plan d'organisation font actuellement l'objet d'une réévaluation à la lumière de la création des régies régionales. Plus spécifiquement, une firme de consultants externes a, dans ce contexte, été chargée de mesurer l'impact des changements proposés par la réforme sur l'organisation et le fonctionnement du Ministère; elle devra déposer ses recommandations avant le prochain exercice financier. Dans toute cette opération, le Ministère a pris les dispositions pour informer et consulter les représentants du personnel. Les changements qui pourraient affecter les tâches ou les postes d'une partie du personnel seront réalisés dans le respect de la Loi sur la fonction publique et de ses règlements, des politiques du Conseil du trésor et des conventions collectives de travail applicables. Il faut aussi dire que des mesures seront mises en place afin de faciliter l'adaptation du personnel à l'exercice de nouvelles fonctions, au sein du Ministère et à l'intérieur des nouvelles régies de la santé et des services sociaux.

CONCLUSION

Avec ce plan d'implantation, une nouvelle étape est franchie dans la réalisation d'une réforme qui se veut avant tout au service du citoyen. C'est lui qui, plus que jamais, devra être au coeur des préoccupations de tous et chacun.

L'implantation de la réforme sera l'occasion pour tous les partenaires du système de santé et de services sociaux de renouveler leur engagement à l'égard du citoyen et de relever ensemble un stimulant défi de concertation. Il importe que tous se mettent résolument à cette tâche.

ANNEXE I

LE CHANGEMENT DES ACTEURS

	Activités	Échéancier
1.	**La création des régions**	
-	identification des territoires constituant les régions socio-sanitaires	Décembre 1991
2.	**Les conseils d'administration des établissements**	
-	élaboration par les CRSSS de propositions concernant la réorganisation des conseils d'administration découlant de la réforme	Octobre 1991
-	règlement établissant la procédure d'élection lors de l'assemblée publique tenue par un établissement public	Décembre 1991
-	règlement établissant la procédure pour l'élection et la nomination des membres des conseils d'administration des établissements publics de santé et de services sociaux	Décembre 1991
-	sanction par décrets gouvernementaux des cas de dérogation proposés par les CRSSS	Décembre 1991
-	nomination des présidents d'élection	Janvier 1992
-	tenue des assemblées publiques pour l'élection des représentants de la population	Mars 1992
-	élection ou nomination des autres membres des conseils d'administration	Mars-Avril 1992
-	nomination par le Ministre pour combler, le cas échéant, les postes laissés vacants	Avril 1992
-	nomination des cooptés	Mai 1992

3.	**Les assemblées régionales**	
-	détermination par le Ministre du nombre de membres de chaque assemblée et de la composition interne des groupes visés par la désignation des membres de l'assemblée régionale	Février 1992
-	règlement sur la procédure d'élection des membres de l'assemblée régionale	Mars 1992
-	désignation par le Ministre des organismes communautaires, des groupes socio-économiques et des autres groupes intéressés au domaine de la santé et des services sociaux	Avril 1992
-	nomination des présidents d'élection	Avril 1992
-	élection des membres des assemblées régionales	Juin 1992
4.	**Les conseils d'administration des régies**	
-	élection de 20 membres par l'assemblée régionale	Juillet 1992
-	sanction par le Ministre des cooptés choisis par les membres élus	Septembre 1992
5.	**Passage de l'ancien au nouveau régime juridique**	Octobre 1992

ANNEXE II

LE PASSAGE DE L'ANCIEN AU NOUVEAU RÉGIME JURIDIQUE: FAITS SAILLANTS

Le passage de l'ancien au nouveau régime juridique se réalisera en deux étapes:

En octobre 1992, les nouveaux conseils d'administration des établissements et des régies régionales entreront en fonction, en lieu et place des conseils d'administration actuels. Sauf pour les CPEJ et les régies régionales des nouvelles régions sociosanitaires, tous les nouveaux conseils exerceront alors un double rôle jusqu'au 1er avril 1993:

- administrer les affaires de l'établissement ou de l'organisme selon les fonctions et modalités prévues dans la loi actuelle (chap. S-5);

- se préparer à administrer les affaires de l'établissement ou de l'organisme selon les nouvelles fonctions et modalités prévues dans la Loi 120 (chap. 42).

Tout en contribuant à la mobilisation de tous les acteurs dans l'actualisation de la réforme, cette approche permettra aux nouveaux conseils d'administration de se préparer à administrer les changements prévus dans la Loi 120 (chap. 42) par l'adoption d'un plan d'organisation, la nomination d'un directeur général, le redéploiement des ressources humaines en lien avec les activités à réaliser et les nouvelles missions à assumer.

Cette période permettra à chaque entité corporative de se structurer et de mettre en place les conditions inhérentes à l'exercice des responsabilités que leur attribue la Loi 120 (chap. 42) tout en assurant la continuité des services aux citoyens.

Au 1er avril 1993, les nouvelles responsabilités et les fonctions seront prises en charge par les régies régionales et les établissements. Les régies régionales assumeront entre autres, l'élaboration des plans d'organisation de services, l'allocation des ressources aux établissements et aux organismes ainsi que les fonctions reliées aux droits des usagers. Pour leur part, les établissements assumeront en plus des fonctions reliées aux droits des usagers, leur mission respective avec les mécanismes de gestion et les structures prévues dans la Loi 120 (chap. 42).

De façon à illustrer ces changements. voici les fonctions qui devront être réalisées aux niveaux local, régional et central, d'ici le 1er octobre 1992, entre le 1er octobre 1992 et le 1er avril 1993 et après le 1er avril 1993.

1. **D'ici octobre 1992**

- **Niveau local:**

  . Formation des nouveaux conseils d'administration des établissements;

  . Identification des responsabilités et ressources qui feront l'objet d'un transfert inter-établissements.

- **Niveau régional:**

  . Formation de l'assemblée régionale;

  . Formation des conseils d'administration des régies régionales;

  . Identification des ressources de chaque CRSSS qui feront l'objet d'un transfert aux régies régionales des nouvelles régions sociosanitaires.

- **Niveau central:**

  . Détermination des objectifs de santé et de bien-être (publication de la première politique de santé et de bien-être);

  . Adoption de la loi d'application;

  . Adoption d'une nouvelle structure de crédits;

  . Nomination d'un commissaire aux plaintes;

  . Mise en place du Conseil médical du Québec; (loi adoptée en décembre 1991);

  . Mise en place du Conseil de santé et de bien-être (loi adoptée en mars 1992);

Adoption d'un nouveau plan d'organisation pour le MSSS et amorce de la restructuration;

Nomination d'un directeur provincial de la santé publique et adoption d'un plan global de réorganisation de la santé publique

2. <u>D'octobre 1992 au 1er avril 1993</u>

- **Niveau local:**

  Mise en fonction des nouveaux conseils d'administration des établissements avec un double rôle:

  - administrer les affaires de l'établissement selon les fonctions et modalités prévues dans la loi actuelle (chap S-5);

  - se préparer à administrer les affaires de l'établissement selon les nouvelles fonctions et modalités prévues dans la Loi 120, notamment:

    - nommer le directeur général (c.a. unifiés);

    - adopter un nouveau plan d'organisation (directions, services, départements, structures consultatives professionnelles, comité d'usagers);

    - désigner le cadre supérieur responsable de l'application de la procédure d'examen des plaintes et établir cette procédure;

    - adopter et procéder à l'actualisation du plan de transfert et d'accueil (selon le cas) des responsabilités et des ressources;

- plus spécifiquement concernant la santé publique:

  . maintien, via la loi d'application, des DSC et des fonctions du chef de DSC jusqu'au 1er avril 1993 (LSSS, Loi santé au travail, Loi protection de santé publique);

  . obligation faite aux 32 centres hospitaliers de faire entériner les décisions par la régie régionale;

- plus spécifiquement concernant les CPEJ:

  . actualisation des transferts de responsabilités et de ressources vers les centres hospitaliers et les CLSC;

  . redéploiement de ressources entre CPEJ, là où un CSS donne naissance à deux CPEJ;

- plus spécifiquement concernant les CHSLD:

  . réorganisation administrative et professionnelle lorsque les affaires de plusieurs établissements sont administrées par un même conseil;

Niveau régional

. Abolition des CRSSS, sauf ceux en territoires cri et inuit, (les régies régionales sont juridiquement créées depuis le 18 décembre 1991);

. Mise en fonction des nouveaux conseils d'administration (c.a.) des régies régionales avec un double rôle (sauf pour les c.a. des régies régionales énumérées plus bas):

- administrer les affaires de l'organisme selon les fonctions et modalités prévues dans la loi actuelle (chap. S-5) pour la population jusque-là desservie par le CRSSS;

- se préparer à administrer les affaires de la régie régionale selon les nouvelles fonctions et modalités prévues dans la Loi 120, notamment:

  - adopter des règlements de fonctionnement du conseil d'administration;

  - nommer le directeur général;

  - adopter un nouveau plan d'organisation;

  - nommer le directeur de la santé publique et adopter les modes d'organisation en santé publique;

  - adopter et procéder à l'actualisation d'un plan de transfert et d'accueil (selon le cas) des responsabilités et des ressources;

  - désigner le cadre supérieur responsable de l'application de la procédure d'examen des plaintes et établir cette procédure.

Les conseils d'administration des régies régionales suivantes se verront confier le second rôle décrit ci-dessus jusqu'au 1er avril 1993 soit celui de se préparer à administrer leurs affaires tel que prévu dans la Loi 120:

- Nord du Québec (région 10; décret 1825-91);
- Gaspésie-Iles-de-la-Madeleine (région 11; décret 1818-91);
- Chaudière-Appalaches (région 12; décret 1815-91);
- Laval (région 13; décret 1821-91);
- Lanaudière (région 14; décret 1819-91).

- **Niveau central**

  - Mise en place du commissariat aux plaintes et adoption d'une procédure d'examen des plaintes;

  - Mise en place de la structure de crédits, élaboration d'un nouveau processus budgétaire et modifications aux systèmes budgétaires et financiers;

  - Suivi des plans de redéploiement des ressources permettant à chaque entité corporative de restructurer sa permanence pour s'acquitter de ses nouvelles fonctions au 1er avril 1993

3. **À compter du 1er avril 1993**

   - Mise en oeuvre des fonctions confiées par la Loi 120 à tous les nouveaux acteurs, dont:

     - **au niveau des régies régionales:**

       - gestion budgétaire régionalisée;

       - planification de l'organisation des services;

       - traitement des plaintes selon nouveau régime;

       - fonctions de la commission médicale régionale.

     - **au niveau des établissements**

       - mise en opération du processus de traitement des plaintes;

       - mise en fonction des structures consultatives (CMPD, CII, Conseil multidisciplinaire);

       - mise en fonction des comités d'usagers.

ANNEXE III

LES MESURES DE LA PHASE II ET DE LA PHASE III

1. LES MESURES DE LA PHASE II (avril 1993 à avril 1995)

1.1 La protection des droits des usagers

- La concertation avec le ministre responsable de l'Office des professions et des corporations professionnelles concernant la représentation du public à ces instances et la mise en place de mécanismes plus adéquats de traitement des plaintes et d'assistance.

1.2 L'amélioration de l'accessibilité aux services en fonction de clientèles particulières

Personnes âgées

- L'extension des services à domicile fournis par les CLSC aux personnes âgées hébergées dans les résidences privées et les habitations à loyer modique;

- la réorientation, au sein d'une même région, des ressources rattachées au surplus de lits de longue durée.

Jeunesse

- Le développement dans les CLSC d'activités de prévention et de services de consultation auprès des jeunes et de leur famille aux prises avec des problèmes spécifiques;

- le soutien aux projets communautaires d'aide aux enfants, à leur famille ainsi qu'aux jeunes en difficulté;

- la révision des pratiques actuelles en matière d'adoption;

- la mise sur pied de ressources d'hébergement temporaire axées sur la réinsertion sociale;

- le suivi par les CLSC des familles et des jeunes dont le signalement n'a pas été retenu dans le cadre de l'application de la Loi sur la protection de la jeunesse mais qui méritent une attention particulière.

Personnes handicapées

- L'augmentation du nombre de places dans les programmes d'apprentissage au travail;

- l'augmentation du nombre de lieux d'hébergement adaptés aux adultes handicapés;

- la constitution d'équipes multidisciplinaires en réadaptation pour les personnes atteintes d'une déficience physique dans les régions dépourvues de services de base;

- la consolidation, dans les centres de réadaptation, des services externes de stimulation précoce des enfants et de développement des jeunes déficients intellectuels.

Nations autochtones

- L'assouplissement des règles d'admission des autochtones dans les institutions d'enseignement, après consultation avec le Ministre responsable;

- le perfectionnement du personnel allochtone travaillant en milieu autochtone.

Communautés culturelles

- L'assignation d'un pavillon ou d'une unité de certains CHSLD aux membres des communautés culturelles, lorsque le nombre le justifie.

1.3 L'amélioration du fonctionnement et de l'organisation du système de santé et de services sociaux

Réglementation

- La révision de la réglementation actuelle, y compris les normes et les pratiques de gestion, en matière de ressources humaines, financières et matérielles.

Services médicaux

- L'augmentation des heures d'ouverture et le développement des services diagnostiques et médicaux courants dans les CLSC;

- la création d'une commission médicale dans chaque région;

- l'autorisation par les régies régionales des activités particulières impliquant la participation volontaire des médecins des cabinets privés;

- l'inclusion dans les plans régionaux d'effectifs médicaux des médecins des cabinets privés participant aux activités particulières;

- l'inclusion, dans la résolution attribuant ou renouvelant un statut et des privilèges à un médecin, des obligations relatives aux activités de l'établissement;

- la mise en place de leviers d'action pour le respect des plans d'effectifs médicaux des établissements (annulation des privilèges accordés, embargo sur le développement immobilier et technologique);

- l'implantation progressive du ticket orienteur.

Services hospitaliers

- L'augmentation de l'enveloppe budgétaire destinée à l'acquisition des innovations technologiques;

- la diminution du nombre de lits occupés par les malades chroniques dans les centres hospitaliers de soins généraux et spécialisés.

Santé publique

- La révision de la Loi sur la protection de la santé publique;

- l'élaboration d'un programme global de santé publique;

- la mise en place de centres d'excellence dans différents domaines de santé publique;

- la réorganisation régionale des activités de santé publique, actuellement assumées par les départements de santé communautaire.

Ressources intermédiaires

- La détermination des fonctions et du rattachement des ressources intermédiaires aux établissements;

- l'élaboration d'une nomenclature des ressources intermédiaires et l'établissement de taux de rétribution gradués en fonction de l'intensité des services offerts.

Organismes communautaires

- La concertation avec le ministre des Finances pour accorder aux personnes qui contribuent financièrement à des organismes communautaires une déduction fiscale plus importante que leur contribution.

Enseignement et recherche

- Le développement de la recherche sociale, évaluative, clinique et épidémiologique.

Maximisation des gains d'efficience associés à des mesures particulières

- La révision des différents programmes administrés par la RAMQ;

- l'établissement d'un budget annuel fermé à la RAMQ pour couvrir le coût des services médicaux et l'évolution de ce budget en fonction des caractéristiques de la population et de l'état de santé de la population;

- La prévention de l'usage abusif des médicaments par le renforcement de la fonction clinique des départements de pharmacie, principalement dans les CHSLD et par le développement d'activités préventives par les CLSC;

- la transmission à la Corporation professionnelle des médecins du Québec d'une proposition l'invitant à établir pour ses membres des règles relatives à la prescription d'examens de laboratoire;

- la mise en application par la RAMQ de modalités pour freiner la multiplication des services et pour informer les usagers du coût des services médicaux qui leur ont été dispensés.

1.4 La valorisation des ressources humaines

- L'élaboration de politiques de main-d'oeuvre en réadaptation et dans le secteur social;

- l'élargissement des responsabilités des cadres en matière de gestion des ressources humaines;

- la réévaluation de la réglementation professionnelle dans la perspective d'un remplacement des champs d'exercice exclusif par des actes exclusifs et à partage restreint ou par des titres réservés;

- la création de prix d'excellence provinciaux, régionaux et locaux pour reconnaître la qualité des services rendus par le personnel et la qualité de la gestion des ressources humaines dans le réseau;

- la mise en place de mécanismes pour accroître la mobilité du personnel syndiqué.

2. LES MESURES DE LA PHASE III (après avril 1995)

- Le rehaussement des budgets attribués aux services à domicile;

- le développement de lits pour répondre d'une part, aux besoins d'hébergement et de soins de longue durée et d'autre part, aux besoins de soins de courte durée dans les régions insuffisamment pourvues;

- le parachèvement du plan global des services pré-hospitaliers;

- l'accroissement du montant total des subventions allouées aux organismes communautaires.

ANNEX 7

ANNEX 7

Gouvernement du Québec

Décret 1813-91, 18 décembre 1991

CONCERNANT la création de la Régie régionale de la santé et des services sociaux de l'Abitibi-Témiscamingue

ATTENDU QU'en vertu de l'article 339 de la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives (1991, c. 42), le gouvernement institue, pour chaque région qu'il délimite, une régie régionale de la santé et des services sociaux;

ATTENDU QU'il y a lieu d'instituer une régie régionale de la santé et des services sociaux pour la région administrative de l'Abitibi-Témiscaminque décrite au paragraphe 14 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 08 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes de Pikogan, du Lac-Simon, de Kebaowek et de Timiscaming et les établissements indiens de Winneway, du Grand-Lac-Victoria et de Hunters Point;

IL EST ORDONNÉ, en conséquence, sur la recommandation du ministre de la Santé et des Services sociaux:

QUE soit créée la Régie régionale de la santé et des services sociaux de l'Abitibi-Témiscamingue, pour la région administrative de l'Abitibi-Témiscamingue décrite au paragraphe 14 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 08 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes de Pikogan, du Lac-Simon, de Kebaowek et de Timiscaming et les établissements indiens de Winneway, du Grand-Lac-Victoria et de Hunters Point;

QUE la Régie régionale de la santé et des services sociaux de l'Abitibi-Témiscamingue ait son siège social à Rouyn dans le district judiciaire de Rouyn-Noranda.

Le greffier du Conseil exécutif,
BENOÎT MORIN

15279

Gouvernement du Québec

Décret 1814-91, 18 décembre 1991

CONCERNANT la création de la Régie régionale de la santé et des services sociaux du Bas-Saint-Laurent

ATTENDU QU'en vertu de l'article 339 de la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives (1991, c. 42), le gouvernement institue, pour chaque région qu'il délimite, une régie régionale de la santé et des services sociaux;

ATTENDU QU'il y a lieu d'instituer une régie régionale de la santé et des services sociaux pour la région administrative du Bas-Saint-Laurent décrite au paragraphe 2 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 01 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes de Cacouna et de Whitworth;

IL EST ORDONNÉ, en conséquence, sur la recommandation du ministre de la Santé et des Services sociaux:

QUE soit créée la Régie régionale de la santé et des services sociaux du Bas-Saint-Laurent décrite au paragraphe 2 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 01 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes de Cacouna et de Whitworth;

QUE la Régie régionale de la santé et des services sociaux du Bas-Saint-Laurent ait son siège social à Rimouski dans le district judiciaire de Rimouski.

Le greffier du Conseil exécutif,
BENOÎT MORIN

15280

Gouvernement du Québec

Décret 1815-91, 18 décembre 1991

CONCERNANT la création de la Régie régionale de la santé et des services sociaux de Chaudière-Appalaches

ATTENDU QU'en vertu de l'article 339 de la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives (1991, c. 42), le gouvernement institue, pour chaque région qu'il délimite, une régie régionale de la santé et des services sociaux;

ATTENDU QU'il y a lieu d'instituer une régie régionale de la santé et des services sociaux pour la région administrative de Chaudière-Appalaches décrite au paragraphe 5 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 12 en vertu du décret 1389-89 du 23 août 1989;

IL EST ORDONNÉ, en conséquence, sur la recommandation du ministre de la Santé et des Services sociaux:

QUE soit créée la Régie régionale de la santé et des services sociaux de Chaudière-Appalaches, pour la région administrative de Chaudière-Appalaches décrite au paragraphe 5 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 12 en vertu du décret 1389-89 du 23 août 1989;

QUE la Régie régionale de la santé et des services sociaux de Chaudière-Appalaches ait provisoirement son siège social à Charny dans le district judiciaire de Québec.

Le greffier du Conseil exécutif,
BENOÎT MORIN

15281

Gouvernement du Québec

Décret 1816-91, 18 décembre 1991

CONCERNANT la création de la Régie régionale de la santé et des services sociaux de la Côte-Nord

ATTENDU QU'en vertu de l'article 339 de la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives (1991, c. 42), le gouvernement institue, pour chaque région qu'il délimite, une régie régionale de la santé et des services sociaux;

ATTENDU QU'il y a lieu d'instituer une régie régionale de la santé et des services sociaux pour la région administrative de la Côte-Nord décrite au paragraphe 15 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 09 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes de Betsiamites, de la Romaine, des Escoumins, de Mingan, de Natashquan, de Matimekosh, de Maliotenam et de Sept-Îles, la terre réservée de Kawawachikamach et l'établissement indien de Pakuashipi;

IL EST ORDONNÉ, en conséquence, sur la recommandation du ministre de la Santé et des Services sociaux:

QUE soit créée la Régie régionale de la santé et des services sociaux de la Côte-Nord, pour la région administrative de la Côte-Nord décrite au paragraphe 15 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 09 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes de Betsiamites, de la Romaine, des Escoumins, de Mingan, de Natashquan, de Matimekosh, de Maliotenam et de Sept-Îles, la terre réservée de Kawawachikamach et l'établissement indien de Pakuashipi;

QUE la Régie régionale de la santé et des services sociaux de la Côte-Nord ait son siège social à Baie-Comeau dans le district judiciaire de Baie-Comeau.

Le greffier du Conseil exécutif,
BENOÎT MORIN

15282

Gouvernement du Québec

Décret 1817-91, 18 décembre 1991

CONCERNANT la création de la Régie régionale de la santé et des services sociaux de l'Estrie

ATTENDU QU'en vertu de l'article 339 de la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives (1991, c. 42), le gouvernement institue, pour chaque région qu'il délimite, une régie régionale de la santé et des services sociaux;

ATTENDU QU'il y a lieu d'instituer une régie régionale de la santé et des services sociaux pour la région administrative de l'Estrie décrite au paragraphe 7 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 05 en vertu du décret 1389-89 du 23 août 1989;

IL EST ORDONNÉ, en conséquence, sur la recommandation du ministre de la Santé et des Services sociaux:

QUE soit créée la Régie régionale de la santé et des services sociaux de l'Estrie, pour la région administrative de l'Estrie décrite au paragraphe 7 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 05 en vertu du décret 1389-89 du 23 août 1989;

QUE la Régie régionale de la santé et des services sociaux de l'Estrie ait son siège social à Sherbrooke dans le district judiciaire de Saint-François.

Le greffier du Conseil exécutif,
BENOÎT MORIN

15283

QUE soit créée la Régie régionale de la santé et des services sociaux des Laurentides, pour la région administrative des Laurentides décrite au paragraphe 9 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 15 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour la réserve indienne de Doncaster et l'établissement indien de Kanesatake;

QUE la Régie régionale de la santé et des services sociaux des Laurentides ait son siège social à Saint-Jérôme dans le district judiciaire de Terrebonne.

Le greffier du Conseil exécutif,
BENOÎT MORIN

15286

Gouvernement du Québec

Décret 1821-91, 18 décembre 1991

CONCERNANT la création de la Régie régionale de la santé et des services sociaux de Laval

ATTENDU QU'en vertu de l'article 339 de la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives (1991, c. 42), le gouvernement institue, pour chaque région qu'il délimite, une régie régionale de la santé et des services sociaux;

ATTENDU QU'il y a lieu d'instituer une régie régionale de la santé et des services sociaux pour la région administrative de Laval décrite au paragraphe 12 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 13 en vertu du décret 1389-89 du 23 août 1989;

IL EST ORDONNÉ, en conséquence, sur la recommandation du ministre de la Santé et des Services sociaux:

QUE soit créée la Régie régionale de la santé et des services sociaux de Laval, pour la région administrative de Laval décrite au paragraphe 12 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 13 en vertu du décret 1389-89 du 23 août 1989;

QUE la Régie régionale de la santé et des services sociaux de Laval ait provisoirement son siège social à Laval dans le district judiciaire de Laval.

Le greffier du Conseil exécutif,
BENOÎT MORIN

15287

Gouvernement du Québec

Décret 1822-91, 18 décembre 1991

CONCERNANT la création de la Régie régionale de la santé et des services sociaux de la Mauricie-Bois-Francs

ATTENDU QU'en vertu de l'article 339 de la Loi sur les services de santé et les services sociaux et modifiant diverses dispositions législatives (1991, c. 42), le gouvernement institue, pour chaque région qu'il délimite, une régie régionale de la santé et des services sociaux;

ATTENDU QU'il y a lieu d'instituer une régie régionale de la santé et des services sociaux pour la région administrative de la Mauricie-Bois-Francs décrite au paragraphe 6 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 04 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes d'Obedjiwan, de Weymontachie, de Odanak, de Wôlinak et de Coucoucache;

IL EST ORDONNÉ, en conséquence, sur la recommandation du ministre de la Santé et des Services sociaux:

QUE soit créée la Régie régionale de la santé et des services sociaux de la Mauricie-Bois-Francs, pour la région administrative de la Mauricie-Bois-Francs décrite au paragraphe 6 de l'annexe I du décret 2000-87 du 22 décembre 1987, et dont la codification numérique est 04 en vertu du décret 1389-89 du 23 août 1989, ainsi que pour les réserves indiennes d'Obedjiwan, de Weymontachie, de Odanak, de Wôlinak et de Coucoucache;

QUE la Régie régionale de la santé et des services sociaux de la Mauricie-Bois-Francs ait son siège social à Trois-Rivières dans le district judiciaire de Trois-Rivières.

Le greffier du Conseil exécutif,
BENOÎT MORIN

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ANNEX 8

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IMPACT DE LA RÉFORME SUR LE

PLAN D'ORGANISATION DU M.S.S.S.

ET

ORIENTATIONS

Ministère de la santé et
des services sociaux

1. PRÉAMBULE

L'implantation de la Réforme est une entreprise d'envergure. Elle amène le Ministère à intervenir sur plusieurs fronts à la fois. Certaines de ces interventions sont législatives et réglementaires: adoption de la Loi 120 sur les services de santé et les services sociaux, adoption avant le 24 juin prochain de la Loi d'application de la Loi 120, révision de la réglementation actuelle et harmonisation avec les nouvelles lois.

D'autres interventions ont un caractère administratif. Elles visent l'adoption de la politique de santé et de bien-être. Elles portent sur l'élaboration du plan d'implantation de la Réforme. Elles suggèrent au gouvernement de nouvelles façons de faire concernant le financement des services de santé et des services sociaux. Elles proposent de mettre en place un cadre de gestion et un nouveau plan d'organisation du Ministère à la suite de ces changements.

L'implantation de la Réforme est une opération d'une grande ampleur et complexité. C'est aussi une intervention dont l'importance stratégique est déterminante pour l'avenir et l'état de santé et de bien-être des générations futures.

La mise en place de cette vaste entreprise de changements ne peut se faire sans la collaboration de tous et en particulier du personnel du Ministère.

La présente rencontre vise justement à mettre à la disposition de tous les intervenants l'information disponible sur la nature des changements qui vont affecter le nouveau plan d'organisation du Ministère. Cette rencontre sera elle-même suivie d'autres échanges au fur et à mesure que des précisions nouvelles viendront s'ajouter aux données disponibles.

2.- IMPACT DE LA RÉFORME SUR LE M.S.S.S.

- **La Réforme confirme le maintien des grandes fonctions exercées par le Ministère.**

  Celui-ci demeure l'ultime responsable des objectifs fixés par le législateur. Comme principal mandataire de la régulation du régime, il est chargé d'en définir et d'en contrôler les grands paramètres et les règles de fonctionnement. Son titulaire en répond, au nom du gouvernement, devant l'Assemblée nationale et la population.

- **La Réforme n'ajoute ni n'enlève de grandes fonctions à la mission du Ministère.**

  Elle en change plutôt l'exercice et le poids relatif dans sa structure et son fonctionnement. Elle met de l'emphase ou atténue la portée de certaines d'entre elles. Elle en change l'orientation ou encore les modalités d'exécution.

- **Le M.S.S.S. conserve sa mission essentielle qui est celle de s'assurer que le système répond aux besoins de l'ensemble de la population.**

  Le M.S.S.S. est confirmé dans son rôle principal d'agent régulateur du régime et, pour ce faire, il doit mettre l'emphase sur les fonctions d'orientation et d'évaluation du système. L'essentiel de sa mission sera désormais concentré sur l'exercice de ces grandes fonctions. Il mettra la plus grande part de ses énergies à intervenir dans "**l'avant**" et "**l'après**" et délaissera progressivement le champ du "**pendant**" au profit d'autres acteurs dans le système.

- **La politique de Santé et de Bien-être qui sera publiée au printemps devrait fournir au Ministère l'encadrement et l'infrastructure de support nécessaires pour s'acquitter de cette mission.**

  La politique précisera les orientations et les objectifs à atteindre, proposera les stratégies d'intervention appropriées, statuera sur les moyens jugés les plus efficaces pour agir sur les déterminants de la santé et

du bien-être, finalement, identifiera les indices de mesures des objectifs retenus. Ce sont des objectifs de résultat plutôt que de production de services qui serviront désormais à mesurer les progrès accomplis.

- **La Réforme rapproche la prise de décision de l'action et amène le Ministère à partager la gestion du régime avec les régies régionales.**

  Ainsi le M.S.S.S. s'associe aux régies régionales pour l'organisation et le développement des services de santé et des services sociaux sur leur territoire. Cette association touche également l'allocation des ressources aux établissements et organismes communautaires de même que l'utilisation efficiente de ces ressources.

- **La fonction liaison demeure, mais elle se concrétise dans la relation M.S.S.S.-Régies plutôt que M.S.S.S.-Établissements.**

  Le M.S.S.S. n'est plus directement impliqué dans l'organisation des services au niveau local et régional. Il alloue les ressources aux régies en fonction des besoins de la population de leur territoire respectif et sur la base de l'équité interrégionale. Les régies, quant à elles, deviennent responsables de l'allocation budgétaire et des contrôles financiers à exercer auprès des établissements. Ultimement, le M.S.S.S. s'assure que la situation est sous contrôle et que le tout s'est fait dans le respect des règles établies.

- **La Réforme attribue une marge de manoeuvre plus grande aux établissements.**

  La mission des établissements a besoin d'être clarifiée et il est devenu nécessaire d'accorder aux décideurs locaux une plus grande latitude dans la gestion de leurs ressources. L'allégement de la réglementation actuelle, l'adoption de structures internes plus souples et mieux adaptées, l'association des principaux intervenants à la prise de décision sont autant d'éléments à considérer pour favoriser cette orientation.

- **La Réforme met l'accent sur les besoins des bénéficiaires plutôt que sur les pressions exercées par les producteurs.**

  Le nouveau plan d'organisation du M.S.S.S. devra refléter cette approche et s'éloigner d'une structure définie en fonction des catégories d'établissements.

- **La Réforme entend clarifier le rôle et les responsabilités du Ministère en matière de santé publique.**

  L'organisation de la santé publique en 32 départements, sans lien formel de coordination et d'autorité a engendré une dispersion de l'expertise, un éparpillement des efforts, une absence de priorités claires et communes ainsi que des difficultés de concertation en situation de crise. Cette situation appelle des correctifs à tous les niveaux et en particulier au niveau central dans le but de permettre au Ministère d'assurer un plus grand leadership en matière de santé publique.

- **Les débats qui ont eu cours en Commission parlementaire sur le financement des services de santé et des services sociaux ont mis en évidence la nécessité d'une utilisation plus efficiente des ressources investies dans la distribution des services.**

  La nouvelle structure à mettre en place devra refléter cette préoccupation et trouver les moyens d'exercer un meilleur contrôle sur l'utilisation de ces ressources.

- **La Réforme insiste sur la mobilisation des ressources humaines du réseau et ce facteur est perçu comme un élément critique du succès de l'entreprise.**

  L'approche actuelle du M.S.S.S., centrée sur les relations de travail malgré les efforts consentis sur la formation et le développement de la main d'oeuvre, doit être élargie et contribuer davantage au développement du capital humain.

- **La Réforme crée une nouvelle dynamique entre le M.S.S.S. et les régies mais n'élimine pas les rapports entre le M.S.S.S. et les associations d'établissements.**

  Le Ministère continue d'entretenir des relations avec les associations d'établissements même s'il partage désormais la gestion du régime avec les régies régionales, lesquelles deviennent ses partenaires privilégiées d'intervention auprès des établissements.

- **Toutes ces modifications devront transparaître dans le cadre de gestion et la nouvelle structure à mettre en place.**

  L'ensemble de ces changements vont, bien sûr, influencer le plan d'effectifs du M.S.S.S.: la quantité des postes, la nature des responsabilités et les compétences nécessaires à l'exercice des nouveaux rôles.

3.- PRINCIPES DIRECTEURS

1) Le cadre de gestion et le nouveau plan d'organisation du M.S.S.S. devront être cohérents avec la Réforme et permettre de solutionner certains problèmes organisationnels

Ainsi, le projet devra:

- accentuer les fonctions d'orientation et d'évaluation du système;
- assurer la régionalisation;
- permettre l'établissement d'une saine relation avec les régies;
- accorder une importance moindre aux demandes des établissements;
- créer une marge de manoeuvre véritable pour les établissements;
- favoriser l'approche besoins de la population;

- faire disparaître la structure par catégorie d'établissements;
- éliminer le cloisonnement entre unités administratives;
- encourager l'économie, l'efficience et l'efficacité;
- insister sur le développement des systèmes d'information nécessaires;
- faire une place plus importante à la santé publique;
- susciter la mobilisation des ressources humaines du réseau.

2) **Le cadre de gestion et le nouveau plan d'organisation du Ministère devront tenir compte de l'environnement externe du M.S.S.S.**

Ainsi, le projet devra:

- favoriser un ajustement des règles en vigueur aux nouveaux modes de fonctionnement à développer;
- permettre une plus grande ouverture vers l'intersectorialité;
- modifier la dynamique des relations avec les associations d'établissements et les organismes de professionnels.

3) **Le cadre de gestion et le nouveau plan d'organisation du M.S.S.S. devront donner au gouvernement l'assurance que les équilibres financiers seront respectés**

4) **Le cadre de gestion et le nouveau plan d'organisation du M.S.S.S. devront favoriser l'implantation de la Réforme**

- permettre une identification des responsables et de leurs modes de fonctionnement;
- susciter une mobilisation du personnel dans la poursuite de ces objectifs.

5) <u>La mise en place du nouveau plan d'organisation et, ultimement de la Réforme, requierrera l'adhésion et la collaboration de tout le personnel du M.S.S.S.</u>

Dans le but de rendre accessible à tous l'information la plus récente et la plus adéquate sur le Réforme, et incidemment, de permettre une implication plus grande du personnel, il a été décidé de mettre sur pied un feuillet d'information entièrement consacré à l'évolution de ce dossier.

Les coordonnées relatives à la publication de ce nouveau bulletin vous seront communiquées incessamment.

Québec, le 26 février 1992

ANNEX 9

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LE PASSAGE DE L'ANCIEN AU NOUVEAU RÉGIME JURIDIQUE:

FAITS SAILLANTS

Ministère de la Santé et des Services sociaux
26 février 1992

LE PASSAGE DE L'ANCIEN AU NOUVEAU RÉGIME JURIDIQUE: FAITS SAILLANTS

Le passage de l'ancien au nouveau régime juridique se réalisera en deux étapes:

En octobre 1992, les nouveaux conseils d'administration des établissements et des régies régionales entreront en fonction, en lieu et place des conseils d'administration actuels. Sauf pour les CPEJ et les régies régionales des nouvelles régions sociosanitaires, tous les nouveaux conseils exerceront alors un double rôle jusqu'au 1er avril 1993:

- administrer les affaires de l'établissement ou de l'organisme selon les fonctions et modalités prévues dans la loi actuelle (chap. S-5);

- se préparer à administrer les affaires de l'établissement ou de l'organisme selon les nouvelles fonctions et modalités prévues dans la Loi 120 (chap. 42).

Tout en contribuant à la mobilisation de tous les acteurs dans l'actualisation de la réforme, cette approche permettra aux nouveaux conseils d'administration de se préparer à administrer les changements prévus dans la Loi 120 (chap. 42) par l'adoption d'un plan d'organisation, la nomination d'un directeur général, le redéploiement des ressources humaines en lien avec les activités à réaliser et les nouvelles missions à assumer.

Cette période permettra à chaque entité corporative de se structurer et de mettre en place les conditions inhérentes à l'exercice des responsabilités que leur attribue la Loi 120 (chap. 42) tout en assurant la continuité des services aux citoyens.

Au 1er avril 1993, les nouvelles responsabilités et les fonctions seront prises en charge par les régies régionales et les établissements. Les régies régionales assumeront entre autres, l'élaboration des plans d'organisation de services, l'allocation des ressources aux établissements et aux organismes ainsi que les fonctions reliées aux droits des usagers. Pour leur part, les établissements assumeront en plus des fonctions reliées aux droits des usagers, leur mission respective avec les mécanismes de gestion et les structures prévus dans la Loi 120 (chap. 42).

De façon à illustrer ces changements, voici les fonctions qui devront être réalisées aux niveaux local, régional et central, d'ici le 1er octobre 1992, entre le 1er octobre 1992 et le 1er avril 1993 et après le 1er avril 1993.

1. <u>D'ici octobre 1992</u>

- **Niveau local:**

  . Formation des nouveaux conseils d'administration des établissements;

  . Identification des responsabilités et ressources qui feront l'objet d'un transfert inter-établissements.

- **Niveau régional:**

  . Formation de l'assemblée régionale;

  . Formation des conseils d'administration des régies régionales;

  . Identification des ressources de chaque CRSSS qui feront l'objet d'un transfert aux régies régionales des nouvelles régions sociosanitaires.

- **Niveau central:**

  . Détermination des objectifs de santé et de bien-être (publication de la première politique de santé et de bien-être);

  . Adoption de la loi d'application;

  . Adoption d'une nouvelle structure de crédits;

  . Nomination d'un commissaire aux plaintes;

  . Mise en place du Conseil médical du Québec;

  . Adoption de la Loi du Conseil de la santé et du bien-être;

  . Adoption d'un nouveau plan d'organisation pour le MSSS et amorce de la restructuration;

  . Nomination d'un directeur provincial de santé publique et adoption d'un plan global de réorganisation de la santé publique

2. D'octobre 1992 au 1er avril 1993

- **Niveau local:**

. Mise en fonction des nouveaux conseils d'administration des établissements avec un double rôle:

- administrer les affaires de l'établissement selon les fonctions et modalités prévues à la loi actuelle (chap S-5);

- se préparer à administrer les affaires de l'établissement selon les nouvelles fonctions et modalités prévues à la Loi 120, notamment:

. nommer le directeur général (c.a. unifiés);

. adopter un nouveau plan d'organisation (directions, services, départements, structures consultatives professionnelles, comité d'usagers);

. désigner le cadre supérieur responsable de l'application de la procédure d'examen des plaintes et établir cette procédure;

. adopter et procéder à l'actualisation du plan de transfert et d'accueil (selon le cas) des responsabilités et des ressources;

- plus spécifiquement concernant la santé publique:

. maintien, via la loi d'application, des DSC et des fonctions du chef de DSC jusqu'au 1er avril 1993 (LSSS, Loi santé au travail, Loi protection de santé publique);

. obligation faite aux 32 centres hospitaliers de faire entériner les décisions par la régie régionale;

- plus spécifiquement concernant les CPEJ:

. actualisation des transferts de responsabilités et de ressources vers les centres hospitaliers et les CLSC;

. redéploiement de ressources entre CPEJ, là où un CSS donne naissance à deux CPEJ;

- plus spécifiquement concernant les CHSLD:

  . réorganisation administrative et professionnelle lorsque les affaires de plusieurs établissements sont administrées par un même conseil;

Niveau régional

. Abolition des CRSSS, sauf ceux en territoires cri et inuit, (les régies régionales sont juridiquement créées depuis le 18 décembre 1991);

. Mise en fonction des nouveaux conseils d'administration (c.a.) des régies régionales avec un double rôle (sauf pour les c.a. des régies régionales énumérées plus bas):

- administrer les affaires de l'organisme selon les fonctions et modalités prévues à la loi actuelle (chap. S-5) pour la population jusque-là desservie par le CRSSS;

- se préparer à administrer les affaires de la régie régionale selon les nouvelles fonctions et modalités prévues à la Loi 120, notamment:

  . adopter des règlements de fonctionnement du conseil d'administration;

  . nommer le directeur général;

  . adopter un nouveau plan d'organisation;

  . nommer le directeur de la santé publique et adopter les modes d'organisation en santé publique;

  . adopter et procéder à l'actualisation d'un plan de transfert et d'accueil (selon le cas) des responsabilités et des ressources;

  . désigner le cadre supérieur responsable de l'application de la procédure d'examen des plaintes et établir cette procédure.

Les conseils d'administration des régies régionales suivantes se verront confier le second rôle décrit ci-dessus jusqu'au 1er avril 1993 soit celui de se préparer à administrer leurs affaires tel que prévu à la Loi 120:

. Nord du Québec (région 10; décret 1825-91);
. Gaspésie-Iles-de-la-Madeleine (région 11; décret 1818-91);
. Chaudière-Appalaches (région 12; décret 1815-91);
. Laval (région 13; décret 1821-91);
. Lanaudière (région 14; décret 1819-91).

- **Niveau central**

. Mise en place du commissariat aux plaintes et adoption d'une procédure d'examen des plaintes;

. Mise en place de la structure de crédits, élaboration d'un nouveau processus budgétaire et modifications aux systèmes budgétaires et financiers;

. Suivi des plans de redéploiement des ressources permettant à chaque entité corporative de restructurer sa permanence pour s'acquitter de ses nouvelles fonctions au 1er avril 1993.

3. **À compter du 1er avril 1993**

. Mise en oeuvre des fonctions confiées par la Loi 120 à tous les nouveaux acteurs, dont:

- **au niveau des régies régionales:**

. gestion budgétaire régionalisée;

. planification de l'organisation des services;

. traitement des plaintes selon nouveau régime;

. fonctions de la commission médicale régionale.

- **au niveau des établissements**

. mise en opération du processus de traitement des plaintes;

- mise en fonction des structures consultatives (CMDP, CII, Conseil multidisciplinaire);

- mise en fonction des comités d'usagers.

ANNEX 10

ANNEX 10

FUNCTIONS OF A REGIONAL HEALTH AND SOCIAL SERVICES BOARD

The functions which shall be assumed by the Nunavik Regional Health and Social Services Board under the new legislations are enumerated in sections 343 to 385 of (1991, Ch. 42). They are namely:

1. Functions in respect of the population and the rights of users
2. Functions relating to priorities in matters of health and welfare
3. Functions relating to the organization of services
4. Functions relating to the allocation of financial resources
5. Functions relating to the coordination of health services and social services
6. Functions relating to public health
7. Functions relating to human, material and financial resources management.

The Kativik CRSSS is presently hiring 15 persons who are the minimal number of persons required to fulfil mandates under the actual law.

The new Nunavik Regional Health and Social Services Board will require additional resources to fulfil the mandate which will be given to it as a result of reform implementation.

1. Functions in respect of the population and the rights of users

- see that mecanism for public participation are implemented;
- see that annual meetings take place;
- inform users in the territory about health and social services available and about rights, recourses and obligations;
- ensure that each institution establish a complaint ezxamination procedure.

2. Functions relating to priorities in matters of health and welfare

- see that priorities approved by AGM are respected and health and welfare objectives achieved;
- ensure that information on the healt of the population in the region is up to date and accessible;
- identify the needs of the population;
- inform the Minister of the needs of the population;

- assess the effectiveness of health and social services and the degree of satisfaction of the users;
- prepare and implement assessments of tghe programs of service in which the institutions participate;
- carry out specific mandates entrusted by the Minister.

3. Functions relating to the organization of services

In collaboration with institutions and community organizations, the Regional Board shall develop and implement service organization plans to identifythe services required to respond to the needs of the population

These plans must be submitted to the Minister for approval

4. Functions related to the allocation of financial resources

- allocation of financial resources put at its disposal for the implementation of the "Regional service organization plans";
-allocation of operating budget to the public institutions;
-granting of subsidies to community organizations
-management of funds relating to special mandate entrusted by the Minister;
- ensure control over the budgets allocated and subsidies granted.

5. Functions relating to the coordination of health services and social services

- take the necessary measures to coordinate the work of institutions and community organizations and the special activities of physicians under agreement pursuant to section 360;
- ensure rational utilization and equitable distribution of resources between institutions
- eliminate duplication of services;
- allow the setting up of joint services
- cooperate with other bodies (Municipalities, school board, socio-economic organizations, government departments) in activities conducive to improving the health and welfare of the population
- determine the general rules governing access to the various services offered by the institutions;
- ensure the coordination of access to services offered by residential and long term care centres, rehabilitation centres, family type resources;
- ensure rational utilization of child placement services;

- ensure that the institutions carry out their functions of reception, assessment and referrals of users
- ensure that intermediate resources and family type resources are developed in harmony with the capacity of population concerned;
- establish a list of specific medical activities based on its service organization plans;
- authorize physician to participate an agreement entered into under par. 6 of section 19 of the Health Insurance Act and ensure follow up of these decisions;

6. Functions relating to public health

- Manage the public health program and for such purpose, establish priorities, organize services and allocate resources;
- establish a public health department;
- appointment of a public health director

7. Functions relating to human, material and financial resources management

- draw up a regional human resources development plan;
- coordinate personnel development activities within the scope of the regional service organization plans;
- coordinate personnel development activities for members of board of directors of institutions;
-assist community organizations wiith regard to human resources development activities;
- assist the institutions in preparing their plans of action for personnel development;
- prepare a regional medical staffing plan;
- Once its regional medical plan is approved, it shall approve each organization plan submitted to it by an institution;
- examine the institutions' requests relating to material resources;
- ensure that institutions are grouped for the joint procurement of goods and services it determines;
- once a year, hold a public meeting at which every institution called by the Regional Board must answer questions put to it in respect of its management.

ANNEX 11

ANNEX II

6000 02 04

IMPACTS DE LA RÉFORME SUR LA GESTION DU PERSONNEL

AU MINISTERE DE LA SANTÉ ET DES SERVICES SOCIAUX

D.R.H.
1992-02-27

IMPACTS DE LA RÉFORME SUR LA GESTION DU PERSONNEL

AU MINISTERE DE LA SANTÉ ET DES SERVICES SOCIAUX

Dans le cadre du processus d'implantation de la Réforme, certaines fonctions exécutées au Ministère seront désormais assumées régionalement. En conséquence, un certain nombre d'employées et employés du MSSS verront leurs tâches modifiées ou transférées aux régies régionales.

Afin de minimiser l'impact de cette réorganisation administrative sur la carrière des employées et employés du Ministère, je désire vous présenter certaines orientations que nous entendons privilégier en matière de gestion de nos ressources humaines. Il va de soi qu'à la fin de cette rencontre, des interrogations peuvent demeurer quant à certains aspects techniques tel le processus de mise en disponibilité ou l'engagement de personnel volontaire du MSSS par les régies régionales. C'est en collaboration avec vos représentants syndicaux ou d'associations que nous chercherons les réponses à celles-ci au cours des prochaines semaines et tenterons d'aplanir les difficultés que suscitera la réorganisation du Ministère. Nous voulons amorcer avec vous l'implantation de la Réforme et gérer son impact sur les employées et employés du Ministère selon les règles de l'art.

1. Moratoire temporaire sur la dotation des postes dans les CRSSS

Afin que soit accordée une priorité aux employées et employés volontaires du MSSS qui envisagent de poursuivre leur carrière dans une régie régionale, nous avons demandé aux autorités des CRSSS de ne plus combler leurs postes vacants par du personnel régulier. Ce moratoire, en vigueur jusqu'au 30 septembre 1992, pourra être prolongé.

2. Rencontres patronale-syndicale

Au cours des prochaines heures, le Secrétariat du Conseil du trésor et le Ministère rencontreront des représentants de tous les syndicats et associations de cadres de la fonction publique.

Lors de cette rencontre, les représentants du Secrétariat du Conseil du trésor et du Ministère feront part à leurs vis-à-vis, des mêmes informations que celles que je vous communique cet avant-midi.

De plus, la Direction des ressources humaines du Ministère a déjà mis en place trois comités en matière de placement, de formation et de relations de travail et elle a demandé aux représentants syndicaux des fonctionnaires et professionnels leur participation à ces comités. Un quatrième comité est en voie d'implantation pour le personnel d'encadrement.

Ces comités formuleront des recommandations quant à l'application de la directive concernant la mise en disponibilité de certains employés lors de surplus ministériel et la résorption du personnel en surplus.

Au cours des prochains jours, d'autres rencontres permettront également de sensibiliser les syndicats et associations de cadres du réseau au transfert volontaire des employées et employés du MSSS vers les futures régies régionales.

Ce travail en commun s'avère essentiel pour établir des règles de jeu claires, faire preuve de transparence et maintenir un climat de confiance entre toutes les parties concernées par la réorganisation du Ministère.

3. Négociation et consultation sur les conditions de transfert

Des négociations et consultations seront rapidement amorcées afin de protéger certaines conditions de travail des employées et employés mis en disponibilité qui accepteront d'oeuvrer dans les régies.

Il est déjà possible de prévoir que les conditions de travail suivantes seront protégées:

- Aucune employée ou aucun employé ne sera obligé d'aller travailler dans les régies régionales;

- Maintien du taux de traitement;

- Transfert des banques de congés tels que les journées de vacances et de maladie;

- Conservation du régime de retraite;

- Remboursement des frais de déménagement sans qu'il ne soit nécessaire, le cas échéant, de déménager toute la famille;

- Protection du service continu [ancienneté].

D'autres conditions de travail pourront s'ajouter à cette liste après entente entre les parties impliquées.

4. Droit de retour dans la fonction publique

Il est également de notre intention d'inclure dans la Loi d'application un droit de retour dans la fonction publique aux personnes du MSSS qui seront à l'emploi des régies régionales lorsqu'elles désireront réintégrer la fonction publique par mutation, promotion ou suite à une mise en disponibilité.

Ce droit de retour ne sera cependant valable que si l'employée ou l'employé travaille toujours pour la même régie que celle qui l'a engagé lors de son départ du Ministère et ce, sans période d'interruption.

5. Obligation d'embauche par les régies régionales

Les régies régionales ont déjà été sensibilisées au fait qu'elles devront embaucher les fonctionnaires et professionnels du MSSS mis en disponibilité lorsque le profil de ceux-ci correspondra à celui d'un emploi vacant. Nous demanderons également aux régies d'accorder, à compétence égale, une priorité d'embauche au personnel d'encadrement du MSSS en surplus. Cette obligation ou priorité d'embauche devrait s'appliquer à tout emploi vacant relié directement ou non au transfert des responsabilités du Ministère vers les régies.

6. Placement des employées et employés volontaires du MSSS dans les régies régionales

En avril ou mai 1992, un nouveau plan d'organisation du Ministère sera rendu public, ce qui permettra de connaître les unités administratives et les effectifs touchés par la réorganisation découlant de la Réforme.

Dans un premier temps, les employées et employés en surplus seront mis en disponibilité.

Dans un deuxième temps, les postes vacants au Ministère seront offerts en priorité aux employées et employés en disponibilité ayant le plus de service continu dans la fonction publique et ce, en fonction de leur classement et de la détermination du niveau de l'emploi à pourvoir.

En dernier lieu, les employées et employés qui demeureront en disponibilité seront invités à manifester leur intérêt pour occuper un poste dans une régie.

Quant aux employées et employés qui ne seront pas mis en disponibilité, ces personnes ne pourront bénéficier d'un droit de retour dans la fonction publique ni des autres garanties précédemment mentionnées si elles optaient d'aller oeuvrer dans une régie.

7. Processus d'identification des employées et employés mis en disponibilité

Tel que mentionné précédemment, quelques semaines après l'approbation du plan d'organisation administrative supérieure par les autorités du Ministère et du Secrétariat du Conseil du trésor, les employées et employés affectés par le nouveau plan d'organisation administrative seront informés de leur mise en disponibilité.

En vertu de la directive du Conseil du trésor concernant la mise en disponibilité de certaines employées et certains employés lors de surplus ministériel, les employées et employés qui sont mis en disponibilité sont ceux de la classe d'emploi où il y a surplus et, le cas échéant, du secteur d'activités de cette classe qui, dans l'unité administrative visée par le surplus d'effectifs, ont le moins de service continu dans la fonction publique.

Au MSSS, il nous apparaît que la notion d'unité administrative devrait correspondre à celle de «service». Il est toutefois possible, pour des raisons d'efficacité administrative, d'élargir la notion d'unité administrative à celle de «direction».

En résumé, une personne pourrait être mise en disponibilité, si elle travaille actuellement dans un service dont les effectifs diminuent ou dont le mandat est aboli ou modifié par le nouveau plan d'organisation administrative et si, dans ce dernier cas, sa classe d'emploi ne correspond plus aux classes d'emploi des postes apparaissant dans la nouvelle structure.

Une personne déclarée en surplus dans une unité administrative ne pourra donc solliciter le poste occupé par une employée ou un employé permanent dans une autre unité administrative qui n'est pas affectée par la réorganisation.

L'exemple qui suit illustre quatre situations possibles.

Ancienne structure

Unité administrative A

Décision

. Mandat totalement modifié

. Fermeture de l'unité administrative A

. Création d'une nouvelle unité administrative

Résultat

. Tout le personnel est mis en disponibilité

. Les nouveaux postes sont occupés par les employés en disponibilité au Ministère ayant le plus de service continu dans la Fonction publique

Unité administrative B

Décision

. Mandat demeure le même

. Aucun surplus

Résultat

. Aucun changement parmi le personnel de l'unité B

Unité administrative C

Décision

. Mandat partiellement modifié

. Abolition de trois postes d'AGF

. Création de deux postes de techniciens

Résultat

. Les trois AGF de l'unité C ayant le moins de service continu dans la Fonction publique sont mis en disponibilité et au besoin, les tâches des AGF qui demeurent en place sont réaménagées

. Les deux postes de techniciens sont offerts aux techniciens en disponibilité au Ministère ayant le plus de service continu dans la Fonction publique

Unités administratives D, E, F

Décision

. Fusion des unités administratives D, E, F
. Un inventaire des postes requis pour la nouvelle structure est établi: maintien de 6 postes d'ARPSÉ et abolition de trois postes d'ARPSÉ
. Possibilité de deux alternatives

Notion d'unité administrative élargie de façon à englober les unités administratives D, E, F 1. Dotation 2. Mise en disponibilité **Résultat** Les trois ARPSÉ des unités D, E, F réunies ayant le moins de service continu dans la Fonction publique sont mis en disponibilité et, au besoin, les tâches des ARPSÉ qui demeurent dans la nouvelle unité sont réaménagées.	Notion d'unité administrative restreinte; les unités D, E, F demeurent distinctes 1. Fixation de quotas dans chacune des unités administratives (2 ARPSÉ/unité administrative) 2. Transfert des 6 postes d'ARPSÉ dans nouvelle unité administrative 3. Dotation 4. Mise en disponibilité **Résultat** - Un ARPSÉ en surplus dans chaque unité administrative - L'ARPSÉ le plus jeune dans chaque unité est mis en disponibilité.

Il est utile de vous rappeler qu'un professionnel ou un fonctionnaire mis en disponibilité bénéficie d'une période de stabilité d'emploi de douze mois [professionnel] ou six mois [fonctionnaire] au cours de laquelle il ne peut être muté ou affecté à plus de 50km de son port d'attache ou son lieu de résidence. Quant au personnel cadre en surplus, celui-ci fait l'objet d'une période de ressourcement de dix-huit mois, laquelle se termine par l'attribution d'un nouveau classement ou son inscription sur une liste de placement prioritaire de cadres.

Après avoir été identifiée comme personne en surplus, le traitement de l'employée ou de l'employé est protégé et celle-ci ou celui-ci continue à travailler au Ministère dans l'attente d'une nouvelle affectation ou mutation.

Quant aux employées et employés temporaires, elles ou ils sont susceptibles, selon les règles actuelles, d'être mis à pied afin d'assurer la sécurité d'emploi d'une employée ou d'un employé permanent mis en disponibilité dans le Ministère. L'employée ou l'employé temporaire ainsi mis à pied voit son nom placé sur une liste ministérielle de rappel pour une période de quarante-huit mois consécutifs s'il s'agit d'un fonctionnaire et de trente-six mois s'il s'agit d'un professionnel. Le rang de chaque employée ou employé sur une liste de rappel est déterminé par la date de mise à pied; si sur une même liste plusieurs employées et employés ont été mis à pied à la même date, le service continu prévaut. Lorsque l'emploi occupé par une employée ou un employé temporaire n'est plus requis, celle-ci ou celui-ci est automatiquement inscrit sur la liste de rappel susmentionnée. Pour figurer sur ladite liste de rappel, l'employée ou l'employé temporaire doit avoir réussi son stage probatoire dont la durée est de six mois dans le cas d'un fonctionnaire et douze mois dans le cas d'un professionnel.

Nous sommes conscients des inconvénients que subira le personnel temporaire. C'est pourquoi, lorsque le nouveau plan d'organisation sera connu, nous réexaminerons cette situation et verrons si des solutions peuvent y être apportées.

8. Sensibilisation des ministères et organismes

Afin de favoriser la mobilité du personnel au sein de la fonction publique, les autorités de tous les ministères et organismes seront sensibilisées à la mise en disponibilité d'une partie des effectifs du MSSS et ce, le plus rapidement possible.

9. Programme de départ volontaire

Il faut se rappeler que notre démarche vise d'abord à inciter notre personnel en surplus à faire bénéficier les régies régionales de son expertise à défaut de quoi, nos efforts porteront sur le replacement de ces mêmes personnes dans le Ministère et, au besoin, dans les autres Ministères et organismes.

A la fin de ces activités de dotation, il se peut que certaines situations particulières nous conduisent à mettre en place un programme visant à faciliter le départ volontaire des employées et employés en surplus. Si des mesures en ce sens sont instaurées, celles-ci seront circonscrites à une clientèle bien définie et devront s'autofinancer.

10. Mesures transitoires

Afin de l'aider à assumer de nouvelles responsabilités, le personnel déclaré en surplus aura accès à divers programmes de support et d'assistance personnelle, de formation et d'aide à la carrière administrés par la Direction des ressources humaines. De plus, les programmes actuels de développement seront réorientés pour permettre aux personnes qui demeureront à l'emploi du Ministère d'assumer leurs nouvelles responsabilités.

CONCLUSION

Nous voulons que tout le personnel du MSSS passe de l'ancienne à la nouvelle structure de façon harmonieuse.

C'est pourquoi, nous réitérons notre intention de travailler en collaboration avec les syndicats et associations de cadres afin de protéger à la fois les intérêts du public et ceux des employées et employés.

Je vous suggère donc de transmettre à vos représentants syndicaux les interrogations qui seront toujours présentes à votre esprit après la présente rencontre. Ceux-ci pourront sans doute y trouver réponses auprès des comités de la Direction des ressources humaines précédemment mentionnés. D'autres séances d'information seront, au besoin, organisées à l'intention du personnel.

Vous pourrez compter, au cours des prochains mois, sur la disponibilité de tout le personnel de la Direction des ressources humaines.

En terminant, je vous remercie pour l'intérêt que vous démontrez actuellement à l'égard de votre travail. Soyez assuré que votre appui à la Réforme est grandement apprécié par vos supérieurs et le public en général.

ANNEX 12

McGill University

School of Social Work
Wilson Hall

McGill School of Social Work: Teaching Social Work in the North A Report of Activities

This document represents a summary of McGill's activities since 1982 in teaching social work to Inuit community Workers. It includes the history of our program, factors influencing content and educational objectives, brief course descriptions, and suggestions for revisions of the previous program. Suggested revisions are based on the experience of the McGill University School of Social Work in offering courses to Inuit community workers between May 1982 and November 1984. Although no formal evaluation of the previous educational efforts was conducted, consultation with community workers during and after that period led us to conclude that the increased involvement of community workers, Centre de Service Social, Inuit organizations, and elders would strengthen the courses and the learning process. In short, it is essential that social service training and delivery be anchored in the cultural context of the Inuit lifestyle, particularly the vast changes which are taking place.

OBJECTIVES

The aim of the McGill Certificate Program in Northern Social Work Practice is to develop the knowledge and skills which

community workers can use to contribute to the betterment of their communities. The program accepts the challenge of helping workers to achieve the knowledge and skills required of Southern social workers while simultaneously supporting their endeavors to develop social welfare procedures and social service methods and programs which suit the needs and values of their own communities. Learning will begin with discussion and analysis of workers' personal experiences with social situations and problems in their work. Information and materials to develop course content will come from the university as well as from the communities. Follow-up in the form of assignment and field instruction will be built into the program.

BACKGROUND

In December 1981 the McGill School of Social Work was approached by the then-Director of Social Services, Cecile Bertrand, for collaboration in delivering a social service training program for Inuit community workers in Nouveau Quebec. Preliminary discussions in Montreal with the director of the McGill School of Social Work, Dr. Myer Katz, and some McGill School of Social Work staff were followed by a visit to Kuujjuaq by Dr. Katz and Prof. Liesel Urtnowski in order to meet again with Cecile Bertrand. In early 1982, in order to familiarize herself with the needs of community workers, Liesel Urtnowski spent a week in Kuujjuaq at a series of staff meetings at which all community workers from both coasts were present. The subsequent preparation of course content and teaching methods reflected her understanding that Southern social work education

would need to be adjusted and even redeveloped to reflect Northern realities.

Factors Influencing Content & Educational Objectives

A number of considerations influenced educational objectives and determined the choice of course content:

1) the educational needs of the Inuit community workers;
2) the requirements of the Social Service Centres, which employ community workers and expect them to function with relative autonomy in their communities;
3) the requirements of the McGill School of Social Work, which closely parallel those of all other professional schools of social work in Quebec;
4) the necessity to develop a broad knowledge about social welfare and social services which would facilitate eventual control of social services by the Inuit themselves.

Prof. Urtnowski also identified a number of questions which were kept in mind while developing course content and teaching methods.

--- What is the history, philosophy and lifestyle of those groups who would be affected by our educational efforts?

--- What are the cultural and social characteristics of Inuit society which must be supported throughout our educational project?

--- What are the existing methods of help and intervention among the Inuit, and how are these changing or threatened by rapid economic, technological, and social change? What present

social practices are working quite well, and what Southern skills and knowledge might contribute to an improvement in Inuit community life?

--- What are the Inuit ways of teaching and of learning?

--- What are the culturally defined goals and interests of Inuit and what are culturally acceptable approaches to attaining such goals?

--- What can be the contribution of elders and community leaders to the educational process in social work?

Previous Courses

The first course, Introduction to Social Work, was delivered in early May of 1982, in Kuujjuaq. Barbara Kemp, t.s.p., who had lived for a year in the Arctic, joined Prof. Urtnowski as teacher. Ten community workers and one school counsellor attended the two week intensive course. In December 1982 the course was repeated in Povungnituk for four new workers and two others who repeated the course.

In 1983 and 1984 the following additional courses were offered, each for approximately two-week periods, in Salluit, Kuujjuaq, Montreal, and POV: Introduction to the Welfare State (241); Methods of Community Development, Social Action (374); Seminar in Social Work Practice with Families (441); Community Organization (475).

A total of 27 different community workers attended some or all of the above courses.

In addition to the above, Prof. Urtnowski spent six to eight weeks during the Spring and Summer months of '82, '83, and '84

with individual community workers (Practicum course, 255) in their own communities (Kuujjuaq, Aupaluk, Kangirsuk, Quaqtaq, Kangirsujuaq, Salluit, Povungnituk, Inukjuaq, and Kuujuarapik). By working side by side with the workers on the actual problems they were currently dealing with, she was able to test the usefulness of concepts and methods taught in the early courses. During the practicum, each community worker and Prof. Urtnowski met jointly with families, individuals, and community social service advisory committees. This provided an opportunity for each to observe the other's way of working, and made it possible for workers to evaluate Southern skills, as used by Prof. Urtnowski, and allowed Prof. Urtnowski to understand both the problems the workers experienced and their views about acceptable approaches and solutions. Prof. Urtnowski observed that the community workers sought to achieve a blend of Inuit + Southern helping approaches, and that the local community is a resource and decision-making system complementing the resources of the Centre de Service Social and hospital system.

SUGGESTIONS FOR FUTURE COURSE CONTENT

During this period some issues pertinent to further curriculum development were identified by community workers + staff. Some of these were as follows:

1. Ways of dealing with child protection cases: How one may gain the confidence and cooperation of the family; relationship-building techniques; conducting family problem-solving sessions.

2. When and how to call on other community members to assist in solving a problem, either through consultation or by direct intervention.

3. How one can work with people much older than oneself who traditionally have been the ones to give advice and counsel.

4. How to approach people who have been referred by someone else for undesirable behaviour.

5. How to respond to people who seem to be depressed, who are talking about suicide, or who seem to be out of control.

6. How to deal with the tensions of the job and the common expectations that community workers will be able to solve all problems at any time of day and night; how to keep the community informed about one's work.

7. How to involve the community in prevention plans and activities; how to organize and run a meeting; how to follow-up on items raised at a meeting.

8. How to conduct a survey of community opinion about a social issue or problem; how to find out what people want; what to do with the results.

REVISIONS IN PROGRAM FORMAT

Based on our teaching experience, the work side by side with community workers during the practicum periods, and from many informal contacts with community workers and other members of various Inuit communities, we have concluded that revisions are necessary to both the content and the format of social work courses.

1. We have reached a stage in the teaching and learning process where community workers who have completed a number of courses, including the practicum, are ready to become teaching assistants who participate in the preparation and teaching of courses for the beginning workers. These teaching assistants will be workers who have had some years experience in their jobs and have demonstrated increasing competence. One of them has successfully taught content on child abuse in a Kativik Teacher Training course given in Akulivik in the summer of '86.

2. With time, substantial parts of the courses will be taught in Inuktitut as those with more training and experience take on more and more teaching responsibility. This will not only support Inuktitut as a legitimate language of professional instruction, but will produce as well a genuine Inuit way of working, a blend of Southern and Inuit approaches to community work. During the period where social work concepts and principles are presented in English, there will be substantial periods of discussion in Inuktitut to ensure that the material is understood and evaluated for use in practice.

3. The Inuit teaching assistants will be able to communicate course content to those workers who are unilingual

Inuktitut speakers, lead classroom discussions in Inuktitut, direct role plays, help with classroom assignments, as well as keep the McGill instructors informed of the learning needs of student community workers.

4. The teaching assistants will be involved in the preparation of each course. This will require that McGill instructors and teaching assistants meet for a few days prior to the presentation of the course in the North. Such preparation must ensure that the content and teaching materials are relevant to the current issues which workers confront in their work. It will also prepare the assistants to become instructors and to develop their confidence and capacity for leadership in the area of social services.

5. There will be an increased involvement of elders in the teaching of course content. It has become apparent to us during a total of seven months amongst Inuit in the North that there is a clear body of knowledge, though unwritten, about social welfare practice amongst the Inuit. There is much agreement about methods of helping, about rules of communication, about the procedures for decision-making, the characteristics of a good helper, and about ways to deal with depressed people. Althugh many aspects of life have changed immeasurably, and though there are new and more severe social problems demanding solutions, the traditional helping processes are still alive. Community workers have invited community elders to previous courses to speak on certain topics and have found these sessions to be extremely useful. It is our view that knowledge offered by elders should be legitimated and made an integral part of each course. It

forms the basis of the workers' identity as Inuit helpers, a role which, historically, has been highly valued. Exposure to the history of Inuit social welfare practices will encourage a sense of continuity between older and newer methods. Workers can test out traditional methods along with newly learned Southern methods. In short, presentation and discussions with elders will contribute to the self understanding necessary to social work competence, and will facilitate a blending of Southern and traditional Inuit knowledge and methods.

6. It is important that white social service personnel in the North attend the courses. It is essential that feedback between McGill instructors and teaching assistants and the supervisory personnel be structured into the program until such time as Inuit personnel develop supervisory competence.

7. Depending on the nature of the course, there will be follow-up visits to the home communities of the workers for evaluation of what has been learned. These will be handled in part by the Inuit teaching assistants and in part by CSS employees and McGill instructors.

8. An advisory group to oversee the program and to evaluate its progress is necessary in order to assure feedback between McGill instructors and participants in the program. We suggest that this advisory group consist of the following members: representatives of community workers from each coast, representatives of supervisory personnel from each CSS, and representative(s) from the CRSSS.

FORMAT

Location: Courses will be given in the Inuit communities to facilitate involvement of local resource people such as elders, council and committee members, and local professionals. It is expected that community awareness of community work will be heightened by this arrangement.

Credit: Each course offers 3 McGill University credits toward the 30 credit certificate in Northern Social Work Practice.

Scheduling: Subject to agency, community, and family responsibilities, we anticipate that three courses will be offered per year. The entire program may be completed in 3 years.

Duration of Each course will be approximately two weeks in length and will require a homework assignment of a practical nature.

Instructors: In addition to McGill staff there will be two Inuit teaching assistants who will also act as advisors to new students.

Evaluation: Instructors will evaluate community workers, and students will evaluate each course with the teaching assistant during the final session of each course. General plans for content and preparation of the next course will also be outlined at that time.

Certificate Program in Social Work
McGill University School of Social Work

COURSE DESCRIPTIONS

Introduction to Social Work #407-240

The aim of this course will be to develop in the student the sensitivity and skills required to identify and deal with the various personal, family, cultural and environmental situations which present problems or stress for Inuit people. Students will identify Inuit philosophy and values in relation to practical day to day life and social relationships. There will be an examination of the appropriateness of "southern" principles of good communication and counselling techniques. An attempt will be made to modify them when necessary to assure their relevance to casework in the Inuit context.

Emphasis will be placed on the development of basic interviewing and counselling skills. Using case material from their practice, students will learn and practice basic skills in:

- preparing for sessions
- opening the interview
- use of basic communication principles
- establishing relationship with client
- developing conscious awareness of non verbal communication
- listening attentively before giving guidance or making judgements
- helping clients to express their feelings and thoughts
- maintaining a focus on the client's needs, problems, feelings
- how to question effectively and confront appropriately
- encouraging client to take independent decisions and actions
- etc.

Some basic skills in organizing groups whose aim is the prevention or amelioration of community social problems will also be presented and practiced.

The course will also address the issues around being an effective helper and social service centre employee who may need to exercise authority. There will be an attempt to find some solutions to these dilemmas through the use of role play and group discussion.

INUIT COMMUNITY WORKERS EDUCATION PROGRAM

This education program for Inuit Community Workers was developed to increase the ability of the Social Services Centres in the region to deliver comprehensive social services adapted to the needs of Inuit workers and in the context of isolated homogenous communities.

An investment in education for Inuit in the Social Services sector is recognised as having the potential for reducing the costs associated with social services delivery in the long term.

This document was prepared after lengthy consultation both within the region and outside by:

- Hélène Béchamp, Director of Professional Services, Ungava Social Services Centre
- Richard Dufresne, Director of Professional Services, Hudson Bay Social Services Centre
- Mary Kaye May, Assistant General Manager, Kativik Regional Board of Health and Social Services

DEVELOPMENTAL OBJECTIVES

The relationship between the particular role of the Community Worker and the other intervenors in social services delivery must be clearly described, and development can not be limited to only one component of the network (i.e. the community worker). A clear perception by the trainees as well as motivation and incentives by management is required if continuous and progressive development is to be realized.

The education program can be seen as a pivotal component of this development process but must be coupled with:

- **1. on the job orientation: for non-native and associated personnel related to the development of trainees;**
- **2. on-going in-service education : to ensure integration of new skills and professional ethic;**
- **3. employer assistance for professional development : related to particular in the context of isolated and homogenous communities.**

IMMEDIATE OBJECTIVES

1. to provide Inuit Community Workers with a program which will enable them to learn about social work practise and principles;

2. to develop their own skills and techniques to apply this knowledge;

3. to be comfortable as professionals and prepared to assume leadership.

ACTIVITIES RELATED TO IMMEDIATE OBJECTIVES

1. A formal accredited education program which offers the trainees access to a 30 credit certificate in Social Work from McGill University:

   a. a series of nine theoretical modules prepared by McGill University School of Social Work in collaboration with Northern establishments and based on the following curricula:

      - INTRODUCTION TO SOCIAL WORK PRACTISE - (6 credits) 407-353
      - INTRODUCTION TO PRACTICUM - (3 credits) - 407-255
      - INTODUCTION TO THE WELFARE STATE - (3 credits) - 407-241
      - INTRODUCTION TO SOCIAL WORK RESEARCH - (3 credits) - 407-270
      - THEORITICAL APPROACH TO SOCIAL WORK INTERVENTION WITH FAMILY - (3 credits) - 407-341
      - CASEWORK WITH INDIVIDUALS AND FAMILIES - (3 credits) - 407-473
      - COMMUNITY ORGANIZATION - (3 credits) - 407-475
      - SOCIAL SERVICES IN HEALTH FIELD - (3 credits) - 407-354
      - METHODS OF COMMUNITY DEVELOPMENT, SOCIAL ACTION - (3 credits) - 407-374

2. Accredited practicum in the North:

   The present structure of the Social Services Centres is such that trainees cannot be provided with supervision for student social work practise designed to integrate knowledge and apply

skills taught in theoretical modules.

The supervisory capacity of the Social Services Centres is limited to offering support and supervision for interventions linked to the caseload in question. Until such times as organization and structural changes in the Social Services Centres provides for a redifinition of tasks associated with the social workers assigned supervisory duties, outside consultants will be required to provide practicum supervision.

The high rate of turnover of non-native personnel and the needs to offer adequate orientation to new personnel is such that if we assume an eventual takeover of practicum supervision by the establishments we could undermine the effectiveness of the program.

An option will be retained however for a delegation of responsibilities for the supervision should the establishments be able or prepared to do so.

The first practicum is an integral part of 407-353. The following two practicum offered as part of a supporting program.

ORGANIZATIONAL FRAME

1. Courses will be given in the North by McGill University, three times a year - for two weeks. These will be rotated among different communities to enhance community awareness of social services development.

2. Senior Community workers who have already completed credits toward a certificate program will be used as trainers. These workers (one for each coast), will spend two weeks in preparatory work with McGill Instructors before each session. The actual courses will be given in Innuttitut to enhance active participation by trainees.

3. Arrangements will be made with the Adult Education Department of the Kativik School Board to evaluate the verbal skills of all participants in English in order to offer complimentary support programs for language skill development in the communities.

4. Prospective participants from the Ungava and Hudson Social Services Centres are majoritarily mature women with one or more dependants. Allowances for home care services when attending sessions outside the community and day-care facilities on site are considered as essential accessories to the program.

INUIT COMMUNITY WORKERS EDUCATION PROGRAM

ESTIMATED ACTUALIZED BUDGET (based on 1987 prices)

No.	Activities	1st year 1987-1988	2nd year 1988-1989	3rd year 1989-1990	Sub-total	Main component TOTAL
A	Tuition fees					
A-1*	Instructor/years salary	14 000$	22 050$	7 350$	43 400$	
A-2	Registration fee (25 students)	7 813$			7 813$	
A-3	Teaching material	3 125$	4 922$	1 640$	9 687$	
A-4*	Other expenses (photocopies)	833$	1 378$	437$	2 648$	
A-5	University Administration fee	2 242$	2 242$	2 242$	6 726$	
	SUB-TOTAL					70 274$
B	Practicum Supervision					
B-1	Instructor salary (contract)	26 000$	26 000$	26 000$	78 000$	
	SUB-TOTAL					78 000$
C	Transport					
C-1*	Instructor	4 170$	4 195$	2 232$	10 597$	
C-2*	Supervisory practicum	4 880$	7 686$	2 562$	15 128$	
C-3*	25 students	36 540$	57 550$	19 183$	113 273$	
	SUB-TOTAL					138 998$
D	Accomodations					
D-1	Instructor	1 870$	2 805$	935$	5 610$	
D-2	Supervisor	4 880$	7 320$	2 440$	14 640$	
D-3	25 students	46 666$	70 000$	23 333$	139 999$	
	SUB-TOTAL					160 249$

INUIT COMMUNITY WORKERS EDUCATION PROGRAM

ESTIMATED ACTUALIZED BUDGET (based on 1987 prices)

No.	Activities	1st year 1987-1988	2nd year 1988-1989	3rd year 1989-1990	Sub-total	Main component TOTAL
E	Family aid					
E-1	Baby sitting	10 500$	15 750$	5 250$	31 586$	
E-2	Day-care on training premises	10 500$	15 750$	5 250$	31 586$	
	SUB-TOTAL					63 000$
F	Co-teaching preparation					
		11 000$	16 500$	5 500$	33 000$	
	SUB-TOTAL					33 000$
	Total per year	185 019$	254 148$	104 354$	543 521$	543 521$
	Unforeseen 5%	9 250$	12 707$	5 217$	27 174$	27 174$
	TOTAL	194 469$	266 855$	109 571$	570 695$	570 695$

* indexation 5%

Annex 1

TERMS OF REFERENCE FOR BUDGETING

A. Tuition fees

A-1	Instructor/year salary 21 days per session x 200,00$ plus indexation of 5% per year	43 400$
A-2	Registration fee 125,00$ x 25 students per 25 years, certificate duration	7 813$
A-3	Teaching material 25 students x 150,00$ x 2.5 Year plus indexation 5% per year	9 687$
A-4	Other expenses (photocopies, etc.) 1 000,00$/year x 2.5 plus index	2 648$
A-5	University Administration fee (10%)	6 726$

B. Practicum supervisory

- one practicum = 2 weeks per community
  2 weeks x 13 communities = 26 weeks
  3 practicum = 390 days x 200,00$ — 78 000$

C. Transport

C-1	Instructor Montréal-Povungnituk = 1 500,00$ Montréal-Kuujjuaq (transit) = 1 000,00$ 5 sessions each coast	10 597$
C-2	Supervisor 1 round trip to Hudson Coast= 4 400,00$ 1 round trip to Ungava Coast= 4 100,00$	15 128$
C-3	Students (25) 1 session: 10 962,00$ x 10 plus indexation	113 273$

D. Accomodation

1 session = 14 days
14 days x 40,00$ x 10 sessions
1 instructor
1 supervisor
25 students — 138 998$

E. Family Aid

E-1 We estimated 15 children for whom some community workers have to pay baby sitting fees because they will be away from their community during the sessions — 31 500$

E-2 Day-care on training premises for an estimated number of 15 children accompanying their mother — 31 500$

F. Co-Teaching - Preparation

Two experienced community workers, one for each coast, will participate in the preparation of the course according to a model of co-teaching which has been experiences before by the Kativik School Board and McGill University

The duration of this preparation will be of 20 days.

Estimated cost:

- Hudson Bay Coast: 1 900,00$/session/10 days
- Ungava Bay Coast: 1 400,00$/session/10 days — 33 000$

Certificate Program in Social Work
McGill University School of Social Work

COURSE DESCRIPTIONS

1 - Introduction to Social Work #407-240

The aim of this course will be to develop in the student the sensitivity and skills required to identify and deal with the various personal, family, cultural and environmental situations which present problems or stress for Inuit people. Students will identify Inuit philosophy and values in relation to practical day to day life and social relationships. There will be an examination of the appropriateness of "southern" principles of good communication and counselling techniques. An attempt will be made to modify them when necessary to assure their relevance to casework in the Inuit context.

Emphasis will be placed on the development of basic interviewing and counselling skills. Using case material from their practice, students will learn and practice basic skills in:

- preparing for sessions
- opening the interview
- use of basic communication principles
- establishing relationship with client
- developing conscious awareness of non verbal communication
- listening attentively before giving guidance or making judgements
- helping clients to express their feelings and thoughts
- maintaining a focus on the client's needs, problems, feelings
- how to question effectively and confront appropriately
- encouraging client to take independent decisions and actions
- etc.

Some basic skills in organizing groups whose aim is the prevention or amelioration of community social problems will also be presented and practiced.

The course will also address the issues around being an effective helper and social service centre employee who may need to exercise authority. There will be an attempt to find some solutions to these dilemmas through the use of role play and group discussion.

2 - Social Work Practice with Families #707-341

This course will begin with an examination of the ways in which the Inuit family traditionally operates (values, decision making, rules of communication, division of labour, etc.). It will explore both the normally functioning family as well as the family under stress. Attention will be given to the husband/wife relationship, the parent/child relationship, as well as to the extended family network. The demands society places on the Inuit family and the stresses of parenting under changing conditions will be examined. Currently useful parenting skills will be identified. A further objective will be to develop in the students an awareness of their own personal reactions and responses to given family situations.

The second part of this course is designed to introduce concepts and techniques of family counselling reinforced through case presentation and role-play. Concepts to be introduced are the; 1) transmission of family values and role relationships through the generations; 2) the developmental stages of family life and their associated tasks which Inuit families have to contend with at various stages of family life and 3) the ways in which social and economic changes affect family relationships. Family interviewing techniques will be introduced in some detail:

1) Arranging the first interview (especially focussed on involuntary clients).
2) Use of existing records and information.
3) conducting the first family interview (four stage process).
4) Gathering information and reaching consensus about what behaviour the family wishes to change.
5) "Joining" the family: learning how to balance caring with authority of the community workers role. How to establish a non-threatening relationship with the family. Further skills to develop are the following:

- how to support individual and family strengths
- how to clarify mutual expectations and consequences
- how to assist families in dealing with other social agencies, schools, court, Social Aid Office, hospital, etc.

3 - Social Work with Individuals and Families in Crisis 407-473

The aim of this course will be to develop in the student the awareness and skills required to identify and deal with Inuit people in situations of acute distress. Content will include an exploration of subjective definitions of stressful situations and events, types of crisis, approaches to crisis intervention, and the initial steps in dealing with crisis situations. By building on the content of courses Introduction to Social Work and Social Work Practice with Families, this course will further develop intervention skills in response to depression and suicide, wife abuse, sexual assault, child sexual abuse, losses through death and separation and the effects of drug and alcohol abuse. Attention will be given to developing skills necessary to mobilize individual, family and community resources and strengths in dealing with the crisis.

It will be essential to arrange for the involvement of an elder who has had experience in dealing with crises in order that traditional methods and skills be presented, discussed, and integrated as part of the process of skill development.

4 - Childrens Needs and Social Services 407-351

The content of this course will include the identification and analysis of the needs of Inuit children and their families in the present northern context. It will provide a perspective on how and why the present services developed and the direction of services which are currently being developed (e.g. foster family care, group home care, day care). Students will explore the relevant legislation, policies and procedures and critically examine their suitability in the northern Inuit context. Special attention will be given to an examination of physical, sexual and emotional child abuse, to the identification of abuse, case management as well as to the principles of the helping relationship in cases involving the exercise of statutory authority. A further topic for examination will be the special needs of children with temporary and permanent disabilities. This will be addressed by examination of causes, behaviour, physical and medical care, community support and the effects of the handicapped child on the family.

There will be a focus on the development of skills in assessing social and personal needs, making referrals, working with the child and the family, linking with professionals, follow up work and the principles of preventive work.

Social Services in The Health Field #407-354

6 - ~~Health and Social Services~~

This course aims to help the student to identify community health issues and to understand the social components of mental and physical illness. Various concepts of mental illness will be presented as well as the symptoms and current treatment approaches applied by psychiatric health professionals. There will be an examination of health promotion projects in northern and rural communities and attention to methods of teamwork and liaison with health committees, community professionals and metropolitan health centres. Attitudes and values related to sexuality, family planning, and abortion will be explored and discussed.

Approaches and intervention skills with individuals who are sick and with families who are dealing with illness will be an important part of this course. Offering support and information, mobilizing strengths in the family and community, evaluating the need for C.S.S. home-care services, facilitating communication between the patient, family and health care professionals, preparing patient and family for separation when treatment in southern medical centres is required are all skills which contribute to the rehabilitation of patients in the community.

Members of the health committee and health professionals in the community in which the course is located will be asked to contribute some of their time and expertise to the course through presentation of their role in health promotion and their views on the role of the community worker in this area of work. It will also be essential that an elder be available to present traditional perspectives on health care, in particular regarding definition and treatment of mental illness (e.g. depression, manic states, etc.)

6 - Social Work Practice with Groups

This course will focus on the interaction process of small groups and on the social worker's role in organizing and facilitating the tasks of small groups. This will include an understanding of variables affecting the behavior of members as they interact around the purpose for which the group is formed. While concepts based on southern knowledge of group dynamics will be presented and discussed, an aim of the course will be to aid students in identifying concepts of group dynamics which are pertinent in the Inuit context. Attention will also be given to issues around the interaction among white and Inuit group members in cross cultural committees and other planning groups.

The student will be aided in the acquisition of skills related to the use of groups as a teaching tool in prevention programs (e.g. health education), in the use of groups to identify, and work towards community and regional goals and tasks; and in the development of groups to provide mutual aid and self-help to individuals.

Students will be asked to describe and analyze the functioning of a group with which they have been associated. This might be an ongoing group such as the health or education committee in their community, or a group whose purpose is/was the development of a program or policy.

7 - Community Organization Practice Method of Community Development 407.374

This course will begin with a study of the student's community: how it is organized, its structure and dynamics, the understanding of its key community institutions, its interest groups and the meaning and use of power. Various approaches and models of planning processes and practices as they relate to preventive programs, resource development, and delivery of social services in northern communities will be examined. Students will be encouraged to develop their own practice models and perspectives and draw upon their own work experience in order to relate theory to practice.

There will be a focus on the acquisition of skills in community intervention including: the diagnosis of community problems, defining the issues, defining the constituents, forming groups, running a meeting, sustaining efforts, developing strategy, making decisions about timing and choosing goals, examining ethics and values.

Depending on the community in which the course is held, students will be asked to study and write about an organizing process in which they have been involved or one with which they are familiar, or perhaps one which is currently taking place in the community.

8 - Community-based Research 407-270

This course provides an introduction to the kinds of research questions found in social work and to some of the methods that can be used to get answers to these questions. The objective of the course is to help students learn to conduct simple research projects, or to participate in larger studies related to social welfare issues. Students will also receive a beginning familiarity with reading and making use of published research reports. During the period of the course, students will begin to investigate one or two current issues in the community in which the course is held.

9 - Introduction to the Welfare State 407-241

This subject involves an examination of Quebec and Canadian social welfare policies and program: chapter 48; the role of the Ministere des Affaires Sociales, the James Bay and Northern Quebec Agreement and their implications for social welfare. The course will include attention to the complexity of problems associated with economic and social equalities and injustices, the role and responsibilities of federal and Provincial governments in redistribution of goods and services, and issues around native self government and the implications for social services. The impact of criminal and civil law on Inuit people would also be included.

The study of the above legislation, policies and programs would use as a point of departure social issues presently of public concern in the North such as concerns around unemployment, housing provision, day-care, the rationale for, and changes in, Social Aid legislation and regulations, etc. It is hoped that this course could be given in Kuujjuag so that the teachers could draw on appropriate resource people located in this administrative centre to offer information and further explanation around the course topics. Students will become involved in the course topics as they develop their own questions on social policies, and learn where to seek out information. The course teacher will present frameworks for analysis of information; student will evaluate policies as they apply to the population in their region.

10 - ~~The Praticum~~ Field Practice 407-355

The supervision of student social work practice is designed to integrate and apply the skills taught in the courses. The practicum teacher will spend a total of two weeks (at least 10 working days) in the student's community.

Concepts and principles learned in courses will be reviewed and applied in work with clients and groups. The worker and supervisor will have the opportunity to discuss in detail the process of the worker's meetings with individual clients, families, groups, community leaders, professionals, etc. so that theory learned in class can be tested and refined, practiced and integrated. The practice teacher will keep in touch with the workers supervisor in order to maintain clear lines of administrative responsibility. The worker's supervisor will also be welcome to be present at field practicum sessions if she/he is in the community. Practicum teachers will offer the student the opportunity to watch her/him work if the client and worker agree and the client is comfortable in English.

LU/smb
June 18, 1987

ANNEX 13

ANNEX 13

MAY 16 RECD

Gouvernement du Québec
Ministère de l'Éducation
Coordination des activités en
milieux Amérindien et Inuit

Québec, le 16 mai 1991

Madame Annie Popert
Directrice générale
Commission scolaire Kativik
305, avenue Mimosa
DORVAL (Québec)
H9S 3K5

Madame la Directrice générale,

Une récente rencontre avec Mme Pauline Lapointe du ministère de l'Enseignement supérieur et de la Science me permet de vous transmettre des éléments d'information concernant votre intérêt et celui des partenaires Inuit pour le perfectionnement dans le secteur des services sociaux au Nunavik.

La lettre de M. Georges Ittoshat, président de la commission scolaire, en date du 27 avril 1990, avait été portée à la connaissance du ministre de l'Enseignement supérieur et des suites avaient commencé à lui être données. Toutefois, des circonstances incontrôlables ont empêché que le dossier parvienne encore à terme.

Il est toutefois dans l'intention des responsables, au MESS, de donner suite de façon globale aux besoins en santé et en services sociaux. Comme vous le savez, le mode de financement des établissements universitaires diffère totalement de celui des commissions scolaires. Des démarches sont en cours pour faire en sorte que des établissements universitaires puissent, le cas échéant, obtenir des crédits particuliers leur permettant de répondre à la demande concernant la prestation des services sociaux.

Dès que la chose sera possible, vous serez informée des modalités qui auront été retenues en réponse à la demande des milieux sociaux de la communauté Inuit.

Veuillez agréer, Madame la Directrice générale, l'expression de mes sentiments les meilleurs.

D. Olivier

Denis Olivier

DO/rt

1035, rue De La Chevrotière (12e)

Government of Québec
Ministry of Education
Coordination of Activities
among the Indians and Inuit

Québec, 16 May, 1991

Ms. Annie Popert
Director General
Kativik School Board

Madam Director General,

A recent meeting with Ms. Pauline Lapointe of the Ministry of Superior Education and Science allows me to give you some information pertaining to your interest and that of Inuit interveners in upgrading in the social services sector in Nunavik.

The letter dated 27 April 1990 from Mr. Georges Ittoshat, president of the school board, had been conveyed to the Minister of Superior Education and some follow-up had been undertaken. However, circumstances beyond our control made it impossible to bring this file to its completion.

However, MESS officers are still planning a general follow-up of the health and social services needs. As you know, the financing mode for universities differs totally from that of school boards. Representations are in progress in order for universities to be able to obtain, as the case arises, special credits to allow them to meet the demand pertaining to social services.

As soon as this will be possible, you will be informed of the procedures determined to meet the demand of the Inuit community social sector.

Yours truly,

Denis Olivier

Dorval, February 1st, 1991

Mrs. Lizzie Epoo York
General Manager
Kativik Board of Health
Kuujjuaq (Québec)
J0M 1C0

Re: Community Workers Education Program

Dear Lizzie,

As per my telephone conversation with you today, this is to confirm that ever since the Kativik School Board made the funding request to the Ministry of Education for the training of community workers almost two years ago, no response either positive or negative has been received to date.

It is obvious that the project is stalled somewhere in the bureaucracy. Time and time again, I have tried to find out the status of this project through the co-ordinator of CAMAI (Co-ordination des activités en milieux amérindien et Inuit) of the Ministry of Education, Mr. Denis Olivier, but he has been unable to tell me anything. All his answers have been very vague,

Also Pauline Lapointe, from the Ministry of Superior Education and Science, who was responsible for the preparation of the submission to Treasury Board has been off work due to sickness so its even harder to get any information at all.

Considering how long it has taken to get a response and knowing how important the program is, we should perhaps jointly set up a meeting with the Ministers of Education and Social Affairs.

I will discuss this with you further during the week of February 18th while I am in Kuujjuaq.

Yours truly,

Annie Popert
Director General

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ᓴᐃᓪᓕᓐᓂ SAIBAI (CHISASIBI)

331 MIMOSA,
DORVAL, QUE. H9S 3K3
TEL.: (514) 636-8120

Gouvernement du Québec
Ministère de l'Enseignement supérieur
et de la Science
Direction générale de l'enseignement et de la recherche universitaires

NOTE À: Monsieur Guy Demers

DE: Martin Desmeules

DATE: Le 16 février 1989

OBJET: Certificat en travail social en milieu nordique dispensé par l'Université McGill à un groupe d'étudiants de la communauté inuit

En réponse à votre note du 18 janvier dernier adressée à monsieur Léonce Beaupré sur le sujet ci-haut mentionné, je vous transmets l'estimation de la contribution financière du MESS pour la formation de 15 ou 20 étudiants.

Le coût moyen réseau pour un tel certificat est de 3 057 $ par étudiant équivalent temps complet. C'est un certificat de 30 crédits échelonnés sur une période de 3 ans. Chaque étudiant suivra donc 10 crédits par année. Le calcul pour le financement est le suivant:

1o- pour 15 étudiants suivant 10 crédits/année, on obtient 5 étudiants équivalence temps complet. Le financement est de 15 285 $, soit 5 EETC x 3 057 $;

2o- pour 20 étudiants suivant 10 crédits/année, on obtient 6,7 étudiants équivalence temps complet. Le financement est de 20 380 $, soit 6,7 EETC x 3 057 $.

.../2

De plus, selon les règles budgétaires, l'Université recevra le financement de cette clientèle additionnelle un an après le démarrage du programme.

En ce qui concerne les modalités d'imputation des dépenses au budget de la Commission scolaire Kativik, l'Université McGill devrait conclure elle-même une entente avec la Commission scolaire par l'entremise du CRSSS et ce, afin d'être conforme aux articles régissant la "Convention de la Baie James et du Nord québécois.

Salutations !

Martin Desmeules

Martin Desmeules

N/B : chaque unité de 15 crédits = 30 570,00 $
item budgétaire : Prestation de l'Enseignement.
15 cr. par session → 2 sessions/année.
∴ 30 cr = ETC

X1 200

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Katívik Regional Board of Health and Social Services
Conseil régional Kativik de la Santé et des Services Sociaux
P.O. Box 9 KUUJJUAQ (QUÉBEC) CANADA J0M 1C0

July 3, 1989

Mrs. Thérèse Lavoie-Roux
Minister
Ministère de la Santé et
des Services sociaux
1075 Ste-Foy
Québec (Québec)
G1S 2M1

Madam,

I would like to take this opportunity to thank you for your recent visit.. Although short, we were able to clarify certain issues. I would like to review the areas discussed.

We have already participated with the CRSSS Conference in the planning of activities related to the implementation of the new orientations. We will continue to "privilege" mechanisms whereby we work in collaboration with other regional authorities through this process. The recognition of the Kativik region as a distinct socio-sanitary region has enabled us to participate fully with our provincial partners in recent years, and we will continue to do so.

You have made it clear that although no financial resources are being made available to facilitate the implementation process, the human resource development needs of the Kativik Regional Board of Health and Social Services have been retained as a priority by your Department. We anticipate concrete assistance in this area in the very near future.

We also look forward to receiving your letter establishing the status of the Kativik Regional Board of Health and Social Services as the regional authority for Kativik territory in matters of health and well-being in regard to your new orientations. The continued confusion in this regard is felt to be a major stumbling block.

We feel it would also be pertinent to outline your understanding of the implication of the proposed changes to the structure of Boards of Directors of establishments on our region as this too has created some confusion in the territory.

The discussions we had on region authority powers in terms of budgetary control would in effect establish that the regional authority would be responsible for the allocation of new monies within the region. In

terms of planning, however, we would request clarification as to recurrent funding, i.e. would the regional authority continue to have budgetary control once new monies have been allocated on a recurrent basis?

The decentralization and regionalization already initiated and clearly established in the new orientations is clearly related to the primary goals of the Kativik Regional Board of Health and Social Services. This process increases regional autonomy and promotes regional participation and responsibilization. We have demonstrated our willingness to participate in this process, and as you know, it has been our wish to do so for several years. The fact that our region was not included in the provincial programs for AIDS and the Status of Women (although we made the formal request to be included), as well as the serious financial problems at the Ungava Hospital establish clearly that the region must be more autonomous and responsible. Our situation today indicates clearly that decisions taken on our behalf have not necessarily advantaged the region in terms of growth. We will now attempt to make the changes required to develop and deliver programs and services which will concretely improve the health and well-being of our population.

Training and human resource development is a shared concern. We thank you for your assurance that you will work with your colleagues in the Ministry of Education, Higher Learning and Sciences in regard to financing for the Community Worker Education Program. The financial resources in this area are very limited, and we will not be able to continue with this program after December 1989.

Human Resource Development generally is seriously lacking, as you mentioned, the recurrent financing recently announced by your department for our region is a concrete step in the right direction. However, the 75 000$ per annum cannot be expected to alleviate the problems faced by the establishment and the personnel (one two-week training session for 23 participants in the Social Services area was provided at a cost of 82 000$ approximately). The magnitude of the training needs in the health and social services sector makes it clear that an important financial commitment will be required if concrete advancement in this area is to be realized. We will continue to work in collaboration with our provincial partners in this area, and look for the creative and dynamic solutions which would most benefit our region.

The specialized training for outpost nursing will respond to some of the needs in this area, and we anxiously await further developments in this regard.

The special attention to Natives and Elders which you have noted we applaud, but are concerned with the lack of precisions. You referred to the new spaces being planned for elders in loss of autonomy, we would request that our region be taken into consideration in this regard.

In order to assure the "better adapted" services which are clearly the goal of the orientations, it must be understood that our communication potential with your department must be improved. We did receive the English translation of the new orientations shortly after your visit (three days in fact), but these were not sent to us directly, but rather routed through the Service de Liaisons avec les régions nordiques. It must be clear that we wish to deal directly with your Departments and favor this rather than relying on the Service de Liaison avec les régions nordiques. It was also clear in our discussion that our potential for "liaison" with the establishments in our region is seriously underestimated. We can and do provide this liaison with the establishments, other intervenors in this area only create confusion and misunderstanding.

We would ask you to clarify your position in regard to the request made by Innulitsivk for recognition as a Training Centre.

In conclusion, there are areas where the region can and should begin exercising more authority as the mechanisms in place at this time are a serious handicap. We refer specifically to activities related to recruiting and negotiating.

The time permitted for our discussions was very short, and we include a summary of areas we would like to discuss more fully. We would be ready to set a date for further consultation and discussion with one of your deputy ministers in the fall.

Please be assured of my cooperation and support in the implementation process of these new orientations as well as the participation of the region in the development of the policy for Health and Well-being for Québec. I look forward to hearing from you in the near future

Sincerely,

Tikie Kleist
Chairman

TK/MKM/lc

Gouvernement du Québec
Ministère de la Santé et des Services sociaux
Cabinet du sous-ministre

Québec, le 27 octobre 1989

Monsieur Tikila Kleist
Président
Conseil régional Kativik de la
Santé et des Services sociaux
Case Postale 9
Kuujjuaq (Québec)
J0M 1C0

Monsieur,

La présente fait suite à la lettre que vous avez envoyée à la ministre, madame Thérèse Lavoie-Roux, relativement aux discussions que vous avez eues lors de sa visite à Kuujjuaq, le 10 juillet 1989.

Je veux vous assurer que les autorités ministérielles ont pris bonne note des observations que vous avez formulées concernant les difficultés que vous rencontrez dans l'exercice des fonctions qui vous sont confiées à titre de Conseil régional de la Santé et des Services sociaux. A ce sujet, vos demandes de développement des ressources humaines feront l'objet d'un examen attentif et nous vous informerons ultérieurement de notre capacité d'y donner suite à l'intérieur des enveloppes budgétaires qui nous seront consenties.

Quant au statut du Conseil régional Kativik de la Santé et des Services sociaux, il ne pourra pas être modifié par la mise en oeuvre des Orientations "Pour améliorer la santé et le bien-être au Québec", ce dont je vous ai informé le 10 juillet 1989. Comme vous le savez, le chapitre 15 de la Convention de la Baie James et du Nord québécois en définit de façon précise la structure, les rôles et fonctions.

La Convention, ayant primauté sur les lois d'application générale, ne nous permet pas d'y apporter des modifications, à moins de le faire dans le respect des mécanismes prévus à cet effet.

.../2

1075, chemin Ste-Foy, Québec, QC - G1S 2M1

Pour ces raisons, les établissements et organismes du réseau de la Santé et des Services sociaux des régions nordiques demeureront soumis à la Loi sur la santé et les services sociaux (chapitre S5) et ils ne seront d'aucune façon touchés par les orientations proposées et les législations qui seront ultérieurement adoptées par le Gouvernement du Québec pour leur application.

Par ailleurs, ceci ne signifie pas que des discussions ne puissent avoir lieu avec les autorités concernées du Ministère pour trouver de nouvelles façons de faire qui pourraient vous assurer d'une plus grande autonomie dans le respect de celles des établissements de votre région.

Suite à l'engagement qu'avait pris la Ministre à l'effet de contacter le Ministre de l'éducation, monsieur Claude Ryan, pour lui signifier l'importance et la nécessité d'assurer la continuité du programme de formation des travailleurs communautaires, les résultats des démarches qui ont été faites sont à l'effet que le ministère de l'Éducation est toujours en attente de la demande d'approbation des programmes de formation et du budget requis pour sa réalisation.

Si cela n'est pas déjà fait, il y aurait lieu que vous interveniez auprès des autorités de la Commission scolaire Kativik dans les meilleurs délais, afin qu'elles puissent déposer le programme et discuter du budget requis.

En matière de développement des ressources humaines, votre demande a fait l'objet d'une analyse et les résultats de cette dernière ont permis de vous accorder une subvention de 75 000 $, par année, pour une période de trois ans.

Je reconnais que cette contribution financière ne répond pas à tous les besoins auxquels vous êtes confrontés. C'est pourquoi vous devrez faire appel à la Direction de l'éducation des adultes de la Commission scolaire Kativik qui a la compétence en cette matière et qui serait sans doute fort intéressée à participer à votre plan de développement des ressources humaines.

Les relations et les communications que vous avez avec le Ministère, via le Service de liaison avec les régions nordiques, constituent, à mon avis, une excellente façon de vous permettre la meilleure représentation régionale de tous les jours au sein de la structure ministérielle. Il est bien entendu que ce dernier ne vous empêche pas d'administrer vos services et de participer aux différentes tables de concertation régionale qui relèvent de la compétence de la conférence des Conseils régionaux.

.../3

Aux fins de mieux définir vos préoccupations à ce sujet, j'ai demandé au sous-ministre adjoint, monsieur Maurice Boisvert, de discuter de ce sujet avec vous lors d'une prochaine rencontre.

En ce qui a trait à la demande de reconnaissance d'Inuulitsivik à titre de "Centre de formation", il n'est pas possible d'accorder un tel statut à un établissement du réseau à moins qu'il soit reconnu à titre d'institution d'enseignement collégial ou universitaire. Le Centre hospitalier de la Baie d'Hudson peut, comme tous les autres établissements, réaliser des activités de perfectionnement pour son personnel mais il doit recourir aux institutions d'enseignement pour les programmes de formation académique.

Pour ce qui est des sujets énumérés dans l'annexe de votre lettre, je vous recommande de les discuter avec monsieur Maurice Boisvert, lors de votre prochaine rencontre.

En terminant, je vous souhaite, ainsi qu'aux membres de votre équipe, beaucoup de succès dans les efforts que vous déployez afin d'assurer à la population inuit la meilleure qualité de vie possible.

Veuillez agréer, Monsieur, l'expression de mes meilleurs sentiments.

Le Sous-ministre,

André Dicaire

Gouvernement du Québec

La ministre de la Santé et des Services sociaux

Québec, le 31 mars 1987

Monsieur Siméonie Nalukturuk
Président
Administration régionale Kativik
Kuujjuaq (QC)
J0M 1C0

Monsieur Nalukturuk,

Dans le cadre des discussions que nous avons eues lors de ma visite à Kuujjuaq le 22 février 1987, vous m'avez fait part de certaines de vos préoccupations concernant l'administration et la prestation des services sociaux et de santé.

A ce sujet, vous m'avez informé de votre volonté de voir s'organiser des programmes de formation pour les inuit aux fins de leur permettre une participation significative dans le fonctionnement des établissements de santé et de services sociaux et d'assurer le développement harmonieux du conseil régional Kativik qui désire assumer ses responsabilités relativement aux fonctions que lui confie la Loi sur les services de santé et services sociaux.

Je désire vous informer que je partage entièrement vos attentes et que j'ai demandé à monsieur Roger Richard, le coordonnateur des Affaires autochtones de mon Ministère, d'accorder une attention toute spéciale aux projets de formation des professionnels de la santé et des services sociaux autochtones afin que ces cours soient organisés dans les meilleurs délais et dans le cadre d'une organisation académique qui garantira les meilleures chances de succès aux personnes qui s'inscriront à ces programmes de formation.

Quant aux autres emplois qui pourraient être offerts à des inuit dans le cadre d'un programme de formation en cours d'emploi, ils seront favorisés et assurés de la plus étroite collaboration du ministère auprès du Conseil Kativik.

Pour ce qui est de l'implantation de la structure régionale que constitue le Conseil Kativik, je crois que nous avons fait des progrès réels depuis quelques années. Nous continuerons à promouvoir son leadership en l'assurant de notre collaboration et en l'associant à toutes nos actions dans la région. D'ailleurs, la récente demande de budget de 399 760$ que nous avons faite au Conseil du trésor témoigne de notre volonté à faire tout ce qui est possible pour répondre au mieux aux besoins des vôtres afin de les assurer des services de santé et des services sociaux adéquats.

Je veux aussi vous dire que mon équipe et moi avons été sensibles à l'accueil chaleureux qui nous a été réservé par les autorités de l'Administration régionale Kativik et le Conseil régional Kativik de la Santé et des Services sociaux.

Croyez, monsieur Nalukturuk, que je garde un excellent souvenir de cette mission et je vous prie d'accepter et de transmettre à vos collègues, l'expression de mes meilleurs sentiments.

La Ministre,

Thérèse Lavoie-Roux

Chapitre M-15.1.1

LOI SUR LE MINISTÈRE DE L'ENSEIGNEMENT SUPÉRIEUR ET DE LA SCIENCE

CHAPITRE I

ORGANISATION DU MINISTÈRE

Direction.

1. Le ministère de l'Enseignement supérieur et de la Science est dirigé par le ministre de l'Enseignement supérieur et de la Science, nommé en vertu de la Loi sur l'exécutif (chapitre E-18).

1985, c. 21, a. 1; 1988, c. 41, a. 58.

Sous-ministre.

2. Le gouvernement nomme, conformément à la Loi sur la fonction publique (chapitre F-3.1.1), une personne au titre de sous-ministre de l'Enseignement supérieur et de la Science.

1985, c. 21, a. 2; 1988, c. 41, a. 59.

Administration.

3. Sous la direction du ministre, le sous-ministre administre le ministère.

Fonctions.

Il exerce, en outre, toute fonction que lui assigne le gouvernement ou le ministre.

1985, c. 21, a. 3.

Autorité.

4. Dans l'exercice de ses fonctions, le sous-ministre a l'autorité du ministre.

1985, c. 21, a. 4.

Délégation de fonctions.

5. Le sous-ministre peut, par écrit et dans la mesure qu'il indique, déléguer à un fonctionnaire ou au titulaire d'un emploi l'exercice de ses fonctions visées par la présente loi.

Subdélégation.

Il peut dans l'acte de délégation autoriser la subdélégation des fonctions qu'il indique; le cas échéant, il identifie le titulaire d'un emploi ou le fonctionnaire à qui cette subdélégation peut être faite.

1985, c. 21, a. 5.

Personnel.

6. Le personnel du ministère est constitué des fonctionnaires nécessaires à l'exercice des fonctions du ministre; ceux-ci sont nommés et rémunérés conformément à la Loi sur la fonction publique (chapitre F-3.1.1).

Devoirs des fonctionnaires.

Le ministre détermine les devoirs de ces fonctionnaires, pour autant qu'il n'y est pas pourvu par la loi ou par le gouvernement.

1985, c. 21, a. 6.

CHAPITRE II

FONCTIONS ET POUVOIRS DU MINISTRE

Exercice des fonctions.

7. Le ministre exerce ses fonctions dans les domaines de l'enseignement de niveau universitaire et de niveau collégial ou post-secondaire, à l'exception d'un enseignement relevant d'un autre ministre.

Domaines.

En outre, il exerce ses fonctions dans les domaines de la recherche et du développement scientifique.

1985, c. 21, a. 7; 1988, c. 41, a. 60.

Élaboration de politiques.

8. Le ministre élabore et propose au gouvernement des politiques relatives aux domaines de sa compétence, en vue notamment:

1° de contribuer, par la promotion, le développement et le soutien de ces domaines, à l'élévation du niveau scientifique, culturel et professionnel de la population québécoise et des personnes qui la composent;

2° de favoriser l'accès aux formes les plus élevées du savoir et de la culture à toute personne qui en a la volonté et l'aptitude;

3° de contribuer à l'harmonisation des orientations et des activités avec l'ensemble des politiques gouvernementales et avec les besoins économiques, sociaux et culturels.

Application des politiques.

Il dirige et coordonne l'application de ces politiques.

Application des lois.

Le ministre a également charge de l'application des lois confiées à sa responsabilité.

1985, c. 21, a. 8.

Autres fonctions.

9. Dans les domaines de sa compétence, les fonctions du ministre consistent plus particulièrement à:

1° favoriser la consultation et la concertation des ministères, organismes et personnes intéressées;

2° adopter des mesures propres à contribuer à la formation et au développement des individus;

3° favoriser et coordonner le développement et la diffusion de

l'information, y compris l'information scientifique, et de la culture scientifique et technologique;

4° promouvoir l'analyse, l'évaluation et la maîtrise des incidences du développement scientifique et technologique sur les personnes et la société;

5° procéder, en collaboration avec les ministres concernés, à l'évaluation des programmes relatifs à la science des ministères et organismes.

1985, c. 21, a. 9; 1988, c. 41, a. 61.

Pouvoirs du ministre.

10. Aux fins de l'exercice de ses fonctions, le ministre peut notamment:

1° fournir à toute personne, groupe ou organisme les services qu'il juge nécessaires;

2° accorder, aux conditions qu'il croit devoir fixer, une aide financière sur les sommes mises à sa disposition à cette fin;

3° contribuer au développement d'établissements d'enseignement ou de recherche;

4° conseiller le gouvernement, les ministères et les organismes et, le cas échéant, leur faire des recommandations;

5° conclure, conformément à la loi, une entente avec un gouvernement autre que celui du Québec, l'un de ses ministères, une organisation internationale ou un organisme de ce gouvernement ou de cette organisation;

6° participer, avec les ministres concernés et dans le cadre de la politique en matière d'affaires intergouvernementales canadiennes et de celle en matière d'affaires internationales, à l'élaboration et à la réalisation de programmes de coopération avec l'extérieur dans les secteurs où les échanges favorisent le développement des domaines de sa compétence;

7° collaborer à l'application de l'article 24 de la Loi sur le ministère des Affaires internationales (chapitre M-21.1) et de l'article 3.12 de la Loi sur le ministère du Conseil exécutif (chapitre M-30) pour toute question relative à l'enseignement supérieur et à la science;

8° exécuter ou faire exécuter des recherches, des études ou des analyses;

9° obtenir des ministères et organismes les renseignements nécessaires;

10° compiler, analyser et publier les renseignements disponibles.

1985, c. 21, a. 10; 1988, c. 41, a. 62.

Administration d'établissements d'enseignement.

11. Le gouvernement peut, aux conditions qu'il détermine, autoriser le ministre à organiser, administrer et exploiter, seul ou avec d'autres, des établissements d'enseignement de niveau collégial ou post-secondaire.

Chapter M-15.1.1

AN ACT RESPECTING THE MINISTÈRE DE L'ENSEIGNEMENT SUPÉRIEUR ET DE LA SCIENCE

CHAPTER I

ORGANIZATION OF THE DEPARTMENT

Direction.

1. The Ministère de l'Enseignement supérieur et de la Science is under the direction of the Minister of Higher Education and Science appointed under the Executive Power Act (chapter E-18).

1985, c. 21, s. 1; 1988, c. 41, s. 58.

Deputy Minister.

2. The Government, in accordance with the Public Service Act (chapter F-3.1.1), shall appoint a person as Deputy Minister of Higher Education and Science.

1985, c. 21, s. 2; 1988, c. 41, s. 59.

Duties.

3. Under the direction of the Minister, the Deputy Minister shall administer the department.

Duties.

He shall, in addition, perform any other duties assigned to him by the Government or the Minister.

1985, c. 21, s. 3.

Authority.

4. In the performance of his duties, the Deputy Minister has the authority of the Minister.

1985, c. 21, s. 4.

Delegation.

5. The Deputy Minister may in writing and to the extent he indicates delegate the exercise of his duties contemplated by this Act to a public servant or the holder of a position.

Subdelegation.

He may, in the instrument of delegation, authorize the subdelegation of the duties he indicates, and in that case shall name the title of the holder of the position or the public servant to whom they may be subdelegated.

1985, c. 21, s. 5.

Staff. **6.** The staff of the department shall consist of the public servants required for the performance of the duties of the Minister; they shall be appointed and remunerated in accordance with the Public Service Act (chapter F-3.1.1).

Duties. The Minister shall determine the duties of the public servants where these are not determined by law or by the Government.

1985, c. 21, s. 6.

CHAPTER II

DUTIES AND POWERS OF THE MINISTER

Duties. **7.** The Minister shall perform his duties in the fields of education at the university and college or postsecondary levels, except any field of education within the competence of another Minister.

Duties. In addition, he shall perform his duties in the fields of research and scientific advancement.

1985, c. 21, s. 7; 1988, c. 41, s. 60.

Policies. **8.** The Minister shall devise policies relating to the fields within his competence and propose them to the Government, with a view to, in particular,

(1) contributing, by means of promotion, development and support programs in those fields, to the enhancement of the scientific, cultural and professional level of the population of Québec as a whole and of individuals;

(2) giving access to the higher forms of learning and culture to any person who wishes to have access thereto and has the necessary ability;

(3) contributing to the integration of the orientations and activities of his department with the general government policy and with economic, social and cultural needs.

Supervision. The Minister shall supervise and coordinate the carrying out of the policies.

Responsibility. The Minister shall also be responsible for the administration of the Acts assigned to him.

1985, c. 21, s. 8.

Duties. **9.** In the fields within his competence the duties of the Minister shall be, more particularly, to

(1) foster consultation and cooperation between the departments, agencies and interested persons;

(2) adopt measures designed to further the training and development of individuals;

(3) promote and coordinate the development and diffusion of information, including scientific information, and of scientific and technological culture;

(4) promote the study, assessment and control of the repercussions of technological progress on persons and on society;

(5) in cooperation with the ministers concerned, evaluate the programs of departments and bodies relating to science.

1985, c. 21, s. 9; 1988, c. 41, s. 61.

Powers.

10. For the purposes of the carrying out of his duties, the Minister may, in particular

(1) furnish any person, group or agency with the services he considers necessary;

(2) grant any financial assistance out of the sums put at his disposal, on the conditions he may fix;

(3) contribute to the development of educational or research institutions;

(4) advise the Government, departments and agencies and, where necessary, make recommendations to them;

(5) enter into an agreement according to law with any government other than that of Québec, any department of such a government, any international organization or any agency of such a government or organization;

(6) participate, with the ministers concerned and within the scope of the policy on Canadian intergovernmental affairs and the policy on international affairs, in devising and implementing programs for cooperation with persons outside Québec in sectors where exchanges favour the development of the fields within his competence;

(7) facilitate the application of section 24 of the Act respecting the Ministère des Affaires internationales (chapter M-21.1) and section 3.12 of the Act respecting the Ministère du Conseil exécutif (chapter M-30) for any matter relating to higher education and science;

(8) carry out investigations, studies or analyses or cause them to be carried out;

(9) obtain any necessary information from departments and agencies;

(10) compile, analyze and publish available information.

1985, c. 21, s. 10; 1988, c. 41, s. 62.

Establishment of educational institutions.

11. The Government may on such conditions as it determines, authorize the Minister to establish, administer and operate, alone or jointly with others, educational institutions at the college or postsecondary level.

Acquisition of immovables.

It may also, for such purpose, and on such conditions as it determines, authorize the Minister to acquire immovables by

agreement or expropriation, to erect and equip the buildings required and to lease and alienate the immovables of which he has become the owner.

Expropriation. The power of expropriation does not apply to immovables belonging to private institutions and used for instruction.

1985, c. 21, s. 11.

Corporations. **12.** The Government may, by letters patent under the great seal, establish corporations for the advancement of research and technology.

Letters patent. The Minister shall table in the National Assembly an order authorizing the issue of letters patent contemplated in the first paragraph within 30 days of making the order if the Assembly is sitting or, if it is not sitting, within 30 days of the opening of the next session or resumption.

Parliamentary committee. The competent standing committee of the National Assembly shall be called in order to consider the order within 90 days of its tabling.

Name and organization of corporation. The name of a corporation and its organization, the appointment of its members and their terms of office, remuneration, social benefits and other conditions of employment shall be determined by the Government.

Publication. Notice of the establishment of a corporation under this section shall be published in the *Gazette officielle du Québec.*

1985, c. 21, s. 12.

Report of activities. **13.** The Minister shall table in the National Assembly a report of the activities of the department for each fiscal year within six months after the end of the year if the Assembly is sitting or, if it is not sitting, within thirty days after the opening of the next session or resumption.

1985, c. 21, s. 13.

CHAPTER III

DOCUMENTS OF THE DEPARTMENT

Signature. **14.** The signature of the Deputy Minister gives effect to any document emanating from the department.

1985, c. 21, s. 14.

Authenticity of documents. **15.** No deed, document or writing is binding on the Minister or may be attributed to him unless it is signed by him, by the Deputy Minister or by a member of the staff of the department and only, in the case of such a member, to the extent determined by regulation of

the Government published in the *Gazette officielle du Québec.*

1985, c. 21, s. 15.

Automatic device.

16. The Government, by regulation published in the *Gazette officielle du Québec*, may, on the conditions it determines, allow a signature to be affixed by means of an automatic device to the documents it determines.

Facsimile.

The Government may also allow a facsimile of the signature to be engraved, lithographed or printed on the documents it determines. The facsimile must be countersigned by a person authorized by the Minister.

1985, c. 21, s. 16.

Authenticity.

17. Any document or copy of a document emanating from the department or forming part of its records, signed or certified by a person referred to in section 15, is authentic.

1985, c. 21, s. 17.

CHAPTER IV

MISCELLANEOUS AND TRANSITIONAL PROVISIONS

18. *(Amendment integrated into c. A-29, s. 65).*

1985, c. 21, s. 18.

19. *(Omitted).*

1985, c. 21, s. 19.

20. *(Amendment integrated into c. C-11, s. 118).*

1985, c. 21, s. 20.

21. *(Amendment integrated into c. C-11, s. 128).*

1985, c. 21, s. 21.

22. *(Amendment integrated into c. C-59, s. 7).*

1985, c. 21, s. 22.

ANNEX 14

ANNEX

Government of Québec
Ministry of Higher Education and Science

Office of the Deputy Minister

Québec, 7 April 1992

Mr. Putulik Papigatuk
President
Kativik School Board

Mister President,

The training of community workers in Nunavik was the subject of a sustained correspondence over the last several years. Unfortunately, I must admit that an adequate solution has still not been achieved. Recently, you solicited a meeting with the Minister of Higher Education and Science in order to iron out any difficulty that could have prevented a follow-up to your request.

The Minister is quite aware of the increasing demand for postsecondary training services in native communities. Indeed she pointed out this situation recently to her colleague the Minister responsible for Native Affaires. She informed him of the requests made by your school board notably in the areas of health and social services. At that time, she informed Mr. Christos Sirros that the Ministry of Higher Education and Science would support these requests as far as circumstances would permit.

Further to this development, I am asking McGill University to let me know the additional financial support required for students in your community to be able to complete their program; I would like to know when this project will be carried out. It will then be up to McGill University to make all necessary arrangements with you.

Yours truly,

Léonce Beaupré
Assistance Deputy Minister for
University Instruction and Research

ANNEX 15

ANNEX 14

DOSSIER CONCERNING THE RECYCLING OF INUIT AUXILIARY NURSES

1. Introduction

2. The issue

   A. Review of the existing situation

      - Nursing care in Ungava
      - Turnover of nursing personnel
      - Factors influencing the recruitment and the retention of nursing personnel
      - The impact of turnover of nursing personnel

   B. The need for Inuit nurses

   C. Principal obstacles to be overcome

      - Level of schooling of the candidates
      - Housing and teaching premises
      - Language

3. Steps taken and organizations involved

   a. The Ungava Hospital
   b. Kativik School Board
   c. John Abbott College
   d. Regional Health and Social Services Board
   e. Makivik Corportation
   f. Kativik Regional Government
   g. College Education Branch, Ministry of Education (Direction Générale de l'Enseignement Collégial)

4. Evaluation of Costs

INTRODUCTION

The project for a recycling course for the Inuit auxiliary nurses developed from the desire of three (3) individuals who are presently working as auxiliary nurses to upgrade their qualifications in order to be more autonomous in the practice of their profession. The goal they are seeking is to become qualified professionals, authorized to fill all the roles normally assigned nurses in remote regions. They are all women over 30 years of age with families and deep roots within the community. They want to follow the recycling program in Kuujjuak, the village where they werer born and where they still live. Their motivations are expressed in an annexed letter.

We should note that the original auxiliary nursing course also took place in Kuujjuak in 1977-78, with some sessions in the South. There were 13 graduates from the course. Unfortunately, this training program was not repeated. In 1984, a nursing course for Cree and Inuit was prepared and candidates were recruited. It was to be given in Rouyn in the Abitibi. Even though it raised great hopes, in the end the course never took place (cf. reasons annexed).

These three individuals, as well as being auxiliary nurses and family members, are involved at different levels in their community. It is fair to say that being part of the first group of Inuit nurses to graduate is only one of many challenges that they have faced in their lives. In fact, we know that the 30-40 year old's among the Inuit, with a foot in both the traditional and modern worlds, are in great demand to fill the political and social roles required by a society in transition. They are the first, for example, to have had access to a certain level of schooling and to have a second language.

Having had discussions with them, we know that they are aware of the numerous obstacles raised by this project. We consider these obstacles in the following pages. We also mention solutions that have already been proposed and the first steps that have been taken. The goal of this document is not only to demonstrate the importance of training Inuit nurses but also to show the feasibility of such a project by offering some alternatives for financing.

The first pages that follow are designed to situate the reader in the context of the professional and cultural milieu in order to provide a better understanding of the issue.

2. THE ISSUE

A. Review of the existing situation:

Nursing care in Ungava:

A short-term hospital centre, the Ungava Hospital in Kuujjuak, along with six nursing stations, one in each of the coastal villages, offers health services to the Inuit population of Ungava Bay (10-A Region).

It is the nurse who assumes most of the responsibility for care-giving. She[1] represents the single most important resource both in the hospital setting and in the nursing station where, in fact, she is the only health professional.

At the moment there are 27 nursing positions including the supervising nurses. Twelve of these positions are in the nursing stations while the 13 others cover the nursing services in different departments of the hospital: outpatient clinic/emergency, medicine, hygiene,etc. There are also two auxiliary nurse positions.

All the nursing positions are presently filled by non-native personnel hired in the "south". At the Quebec Order of Nurses (OIIQ), with its 62,000 members, there is still no Inuit nurse registered!

Turnover of nursing personnel:

The Ungava Hospital Centre is continually recruiting nursing personnel.

According to the latest data, the length of stay of nursing personnel usually varies from 12 to 18 months. In 1989, the Director of Nursing put at 39 the number of individuals who had filled the 13 positions at the hospital (three people per position). In 1990, 58 individuals filled the 25 nursing positions (hospital and nursing stations). Already for 1991 we can predict that at least two individuals will be required to fill each nursing position full time... In brief, the organization's shortage of nursing personnel is related to the considerable mobility of the resource.

Despite the numerous improvements in working and living conditions of the nursing personnel, the objective of a three-year retention of this resource, as established in the James Bay and Northern Quebec Agreement in 1975, is seldom attained. (Article 15.0.21:

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[1] For ease of reading, the feminine form has been used and should be considered to include the masculine.

"Working conditions and benefits should be sufficiently attractive to encourage competent people from the exterior of the 10-A Region to accept positions for a period of three (3) to five (5) years.")

Factors influencing the recruitment and retention of nursing personnel:

Beyond the recruiting difficulties common to the entire Quebec health establishment and that are mainly related to the crisis within the nursing profession (OIIQ, 1989 and Poirier, 1989), the Ungava Hospital Centre has identified some specific factors influencing its own recruitment of nursing personnel.

In the following lines we describe some of these factors:

- A non-existant regional pool of nursing personnel. In fact, unlike the other regions of Quebec, there is no school for the training of nurses in the 10-A region. All nursing personnel are by necessity recruited in other regions of Quebec. It goes without saying that all nursing personnel present in the region are either already employed by the hospital or else are not seeking employment as nurses.

- Recruiting difficulties related to language. We know that the majority of nurses registered with the OIIQ are francophone. In the North, the second language of the Inuit population is English. According to our source [2], it is estimated that over a third of the nurses applying for a position in the North are eliminated because they cannot express themselves in English. Bilingualism is required for a francophone nurse wishing to work for the Ungava H.C.

- The shortage of housing for families is another factor incluencing recruiting. It seems that some nurses are interested in going North with their families. The number of units with 2 or 3 bedrooms and suitable for families is insufficient and many of these nurses therefore look elsewhere for work.

- The nature of a nurse's work in the North also influences the number of acceptable candidates. The practice of nursing, particularly in the nursing stations, requires a broadened vision of the role of the nurse. As the single resource in a different cultural milieu, the nurse has an autonomous clinical practice and must also be involved in health-promotion activities. Not all nurses have the experience, competence and interest to practise such polyvalent nursing.

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2 Projet Nord, DSC, CHUL, unpublished data

- The difficulty for a nurse returning from work in a remote region to reintegrate professionally.

However, other realities are more important in influencing the length of stay of nursing personnel in the North.

We should mention, among other things, the career plan of a nurse for whom experience in a northern region represents a professional choice. In fact, there are several motivations for the "southern" nurse to seek this temporary experience. According to Phillie (1985), nurses head North to work for one or another of the following reasons:

-to get a full-time position;
-to gain a different kind of professional experience;
-to learn about a different culture;
-to enjoy a higher income than in the South;
-to accept a professional challenge in the nursing stations;
-to have a new adventure, make a dream come true;

The lack of understanding of Inuit culture acts negatively on the length of stay of nursing personnel. In the beginning, the nurse may perceive the difference between her own culture and that of the Inuit in a very positive, if not folkloric manner. Eventually she understands that in order to have a lasting influence on health, her intervention has to cross the cultural barrier. To be able to conceive of projects that are adapted to the needs of the clientèle, it must be understood that culture gives a meaning to events and behaviour (Dufour, 1990). Unfortunately, it is often at the very moment when the nurse realizes the necessity of a having an open attitude towards the culture that she also understands the amount of work that remains to be done to achieve specific objectives: at this point some choose to get involved, most to withdraw...

We should also note that the nurses employed by the Ungava H.C. identify themselves more as non-natives and as workers than as local residents (Phillie, 1985). This feeling of not belonging may justify the departure of certain nurses who feel they have "done their bit"...

We could recite several other factors that have a direct or indirect influence on the retention of nurses in Ungava. What is fundamental to remember is that at the present, turnover of nursing personnel in Ungava greatly exceeds that of the province as a whole, that the situation has not improved in the last ten years and that the Ungava H.C. has to continually recruit its nursing personnel in the South.

Impact of the turnover of nursing personnel:

On the level of service of clientèle, the effects of the mobility of nursing personnel are very significant. We note:

- The lack of a community-based approach which includes knowledge of the culture and aims at health promotion;
- The lack of continuity of care which affects the quality of service;
- The requirement for the patient to repeat his/her health history to several individuals several times a year;
- Difficulties of understanding between the aid-giver and receiver because of their different frames of reference;
- The lack of a long-term view of education and prevention;
- The lack of credibility of intervenors;
- The lack of appropriate tools, i.e. the tendancy to want the clientèle to adapt to the nurse's projects;
- Difficulty of giving help, particularly at the level of psycho-social problems (psychiatry, family dynamics, values, attitudes towards people, etc);
- The lack of recognition and/or rejection of traditional medicine;
- The inability of non-native nurses to develop self-sufficiency among the population in health matters;
- A curative approach favoured at the expense of a preventative one;
- The loss of motiviation among community members to get involved in projects supervised by constantly changing professionals (the same person has to adapt to several individuals, to the prolongation of the length the project, etc.
- Etc.

On the financial level:

Costs attributable to hiring a nurse from the South are not limited to her salary and employers' contributions. The cost of employment consists of the salary determined by the collective agreement in

force[3] as well as fringe benefits and a northern allowance.

BENEFITS: Employee and dependants

Costs of transportation, personnel effects (Kg /year/ person)

Motor vehicle

Storage of furniture throughout the length of stay in the North

Costs of trips/year: (4 without dependants, 3 with dependants) including expenses in transit

Transportation of food (kg/year varying with number of dependants)

Housing

Northern allowance: depending on the sector (III, IV, V)

As an example, and without taking into account costs related to the selection of personnel, in 1990 the expenses generated by the hiring of one nurse with three dependants for the nursing station in Kangirsuk amounted to $ 103,000, made up of:

$68,000 in salary and employer's contributions;
$7,800 food cargo;
$3,400 personal effects cargo;
$5,000 moving and storage;
$2,000 transportation of vehicle;
$17,000 annual trips.

Expenses for the hiring of one nurse without dependants for Kuujjuak amount to $ 54,000, made up of:

$44,000 in salary and employer's contributions;
$1,000 food cargo;
$600 personal effects;
$3,000 moving and storage;
$1,000 transportation of vehicle;
$4,400 annual trips;

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[3] Collective agreement between the negotiating committee for employers in the health and social service sector, the employer's sub-committee for public hospital centres, representing a group of establishments who are members of the Quebec Hospital Association and the Quebec Nurses Federation (FIIQ).

In order to make a comparison, we will retain only the expenses related to salary and employer's contributions for the hiring of nurse in the South (about $38,000 for a nurse at the sixth echelon).
It is reasonable to believe that the hiring of an Inuit nurse, as long as she was recruited within a 50 km radius, would considerably reduce the expenses other than salary.

The need for Inuit nurses:

It is generally recognized that nurses are the intervenors closest to the beneficiaries; they ensure a presence 24 hours a day, seven days a week. Nurses, more than other health professionals, know what beneficiaries require in terms of care and services: how their health is progressing, their reactions to treatment and the factors that influence the process of health and sickness. Nurses also have the role of enlarging the participation and the autonomy of their clients in relation to their health needs and of teaching them and their family to look after themselves and to take the means needed to improve their health and quality of life.

However, the lack of understanding of the Inuit culture on the part of Southern intervenors puts this affirmation in doubt. In fact, in practice, it seems evident that the methods familiar to nurses are not always adapted to the clientèle. Nurses recognize that the clientèle's participation should be encouraged, its potential developed and the available community resources mobilized: the cultural barrier here takes on its full force and nurses have difficulty in applying these principles.

The Inuit auxiliary nurses are essential resources for the establishment. Nevertheless, their role is limited to "providing nursing care that is required in the treatment of patients" (Professional code, Art. 37p). Whereas the need is for autonomous resources, the role of the auxiliary nurse is subject to medical prescription and to the plan of care as prepared by the nurse. To go beyond this specific function could conceivably be considered as the illegal practice of nursing.

The interest of some of the Inuit auxiliary nurses in receiving upgrading to the position of nurse involves a change of role (letter from the auxiliary nurses annexed). To better serve their population, they should be able to identify that population's health needs. They want to broaden their role so as to contribute to methods of diagnosis as well as provide and control the care required for health promotion, prevention of illness, treatment and rehabilitation. As members of the community, they believe that in fulfilling the role of the nurse they will become the best resources for educating the population about health problems.

With a global approach to health that takes into consideration the experience and perceptions of the beneficiary, they would have the

advantage of being able to intervene among the population and do so in their own language. Inuit nurses would have more influence on the population in teaching, for example. Their knowledge of the milieu would encourage greater collaboration on the part of the population.

The Ungava Hospital, in the context of its policy of having native-run services, seeks to integrate Inuit personnel at all levels of service (see the Michaud Report, June 1991). The centre wants to correct the existing situation where the Inuit in the organization always fill non-professional positions. The upgrading of the Inuit auxiliary nurses is part of putting this policy into practice.

Scolarity:

We should note that the schooling of the Inuit is recent, dating from the end of the 1970's (Singer, 1990). A study carried out by the Kativik Regional Government (KRG) in 1987 estimated that 42% of the population of the Ungava region was under 15 years of age and that a low proportion of the population was of working age. Approximately 60% of the population has completed Grade 9 and 43% of the population has never been integrated into the school system. This last percentage is made up mainly of individuals over 35 years of age. (KRG, in Singer,1990)

As well, according to the KRG study, individuals having completed their Secondary V are rare and as a result the pool of candidates with the prerequisites for post-secondary training is also small.

The same holds true for the three (3) candidates who, although they have obtained an auxiliary nursing diploma, have never in fact completed the 5 years usually required to obtain a Secondary Diploma. They are presently taking upgrading in Science and English in order to have the prerequisites for admission to college-level courses.

As they are already studying full-time, we are presently looking for the means of providing the students with a certain level of remuneration. Various steps have been taken by the Commission de Formation Professionelle (CFP) and the Ungava Hospital so as to provide the students either with a bursary (cf. letter to the Kuujjuamiut annexed), a deferred salary, or Unemployment Insurance benefits. We hope to find a solution shortly.

We have also looked at the question of housing for the teachers and for possible candidates for certain courses other than college-level nursing. For the coming year, Kativik School Board has rented a building from the Landholding Corporation in Kuujjuak to house students in Adult Education, including those in the Course 180-21. Accommodation has also been found for the Science teacher working for Kativik at the moment and who will be hired by JAC for the first session in January (cf.letter from JAC annexed). As a result,

no new buildings or even renovations will be required for the course. The Ungava Hospital is willing to reserve a room in the newly-renovated section of the hospital which will be completed soon. We have, however, planned some rental expense for teaching premises for courses other than nursing.

As for accessibility to adequately-equipped laboratories, the team from JAC found the existing labs and material at the school and the hospital adequate when they visited last September. The small number of students will make the organization of practical sessions in the lab easier.

Another obstacle to overcome for the students is that of language. We will not undertake here a description of the historical context that led the first schools in the North to offer services in Enlish only. Moreover, the situation is now very different. In the last six years, the percentage of students registered in French school has gone from 35% to 45%. At the moment our students do not have a knowledge of French "sufficient for the practice of their profession" and have been advised that they will have to pass the French test as required by the "Charte de la langue française" (Article 35-37). It is obviously a major challenge for them to learn a 3rd language. We reserve the right to apply Articles 37 and 38 of the same law to obtain a temporary permit should they not pass the test on the first attempt. This is in order to avoid any delay in their entry into the job market once they have obtained their diploma.

This official recognition with a diploma is of prime importance for the future Inuit nurses because it not only rewards their efforts but also ensures a greater degree of credibility for them among the hospital personnel and among the population as a whole. They have often suffered during their years of practice by being considered and used as interpreters by the non-native personnel who are constantly handicapped by their ignorance of Inuttitut. This pattern obviously influenced the way the population perceived their role, since their responsabilities were limited.

To sum up, for this recycling course there are three (3) candidates who, while both mature and very determined, will be required to take college-level course in a second language, this after some intensive academic preparation, and at the same time carrying parental and other responsibilities. This will continue for a period of at least 3 years. It is obvious that there will be difficult moments and that appropriate support and counselling will be required. These elements must be considered both in the choice of professionals and from the point of view of finances. This last aspect is dealt with in greated detail in the section "Evaluation of Costs" below.

First of all we look at the organizations involved so far, the steps taken and the next stages to be reached in order for the project to succeed.

3. Organizations involved and steps undertaken

a. Ungava Hospital

Although it was the interim Director of the Ungava Hospital who first asked us to work on this dossier, our mandate actually comes directly from the hospital board of directors (document attached). We of course have the complete support of the administrative personnel of the hospital and in particular of its new Director, Minnie Grey. We have seen her involvement in finding funding for the students and her spirit of collaboration in providing hospital premises and lab material. Several meetings have already taken place between the various partners in this project (JAC, KSB, CFP, DGEC) and the Ungava Hospital employees, always with the goal of combining our efforts to solve the problems that arise. In the letter annexed to this document, we can see that the Hospital has committed itself to employing the nurses once they have obtained their diplomas and to changing their current personnel structure by converting what are now auxiliary nursing positions into full nursing jobs.

In brief, the Ungava Hospital is the leading player in this dossier and will be one of the principal collaborators throughout the course both in its organization and in providing technical support.

b. Kativik School Board, Adult Education.

This is one of the first organizations that we turned to for help in evaluating the feasibility of the project. It is thanks to them that the upgrading course could begin in September,1991. They found the teachers and provided housing for them. The teaching premises are those of Adult Education in Kuujjuak. We have already mentioned their help in the organization of housing for the students. KSB will also sponsor the college-level course to be given by John Abbott College. An agreement has already been reached for all college-level courses given in the Nunavik region to be overseen by KSB. Kativik School Board, in the person of its Director of Adult Education, Mr. Jim Delaurier, officially supports the project and lays out, in a letter annexed, the role it expects to play.

c. John Abbott College

We also contacted the members of the Department of Nursing of John Abbott College at the start of our work. This anglophone CEGEP in the Montreal region has the advantage of having developed an expertise with a Cree clientèle and specifically with the course Nursing Techniques 180-01. In fact, about ten students are presently completing this course in Ste-Anne de Bellevue. Having experienced the various problems of adaptation of the Cree students, the people we met at JAC immediately understood the reasons leading us to request that the recycling course for the Inuit take place in the North. Furthermore, their Adult Education Department has a similar request from the Mohawk auxiliary nurses in Akwasasne. They have gone ahead with this project and a recycling course to produce graduate nurses will begin in February, 1992. The Adult Education service and, in particular, Phyllis Blaukopf, are at the moment involved in intensive preparation of the course 180-21 which will be given for the most part on the reserve.

Since the 3-day visit of the JAC team to Kuujjuak in September we have begun to plan in very concrete terms the organization of a nursing course to be given in the North, starting in January, 1992. The goal of the visit was to check what laboratory installations were available so as to be able to determine what part of the course could be given in the North, and what sessions would have to be planned for Montreal. Various meetings and visits allowed the involvement of individuals and organizations to be measured and several problems were solved on the spot. It is understood that even though the course is to be given in Kuujjuak, JAC's usual criteria will be respected, both in the admission of students and in the choice of teachers. Dierdre Greene, a Science teacher already working in Kuujjuak, satisfied their requirements. Following an interview and consultation of her CV, it was agreed that she would be qualified to teach Biology (117), Chemistry (211) and Math (311).

Since the visit, we have obtained cost estimates for the three (3) years of the course. They appear in the section "Evaluation of Costs", point 3. A letter annexed also gives an official commitment on the part of Mr Paul Stubbs, Director of Academic Services at JAC, to provide the services required to complete the course.

d. KATIVIK-CRSSS

In a presentation to the parliamentary commission on the draft Bill 120 (January, 1990), the CRSSS clearly expressed its priorities concerning the development of human resources in the health sector. They insisted on the urgency of training Inuit health professionals. They requested "educational programs conceived to respond to the needs of the region and which provide

for the development of the skills required for professional practice in the special context of Nouveau-Québec." In the same vein, the Kativik CRSSS supports the nursing project, as shown by the annexed letter from its General Manager, Lizzie Epoo-York.

e. Makivik Corporation

We have also received a letter of support from Makivik Corporation (annexed), which has had a long-standing concern with the lack of Inuit professionals trained in the health sector. If we refer in particular to Sections 15.0.21 (b) as well as Annex 1 (1) of the James Bay and Northern Quebec Agreement, we can see that this concern is a legitimate one; what was written in 1975 was that Quebec "should take into account, as much as possible, the exceptional difficulties of maintaining installations and services in the North by:... b) providing employment and possibilities for advancement to natives in health and social services and by providing special training programs to help them overcome obstacles that could hurt their chances of employment or advancement."

f. Kativik Regional Government

The "Commission de Formation Professionnelle" (CFP) is involved in the requests for financing for the college-level nursing courses. They may also provide some remuneration for the students. Exchanges and meetings have already taken place between the CFP personnel in Kuujjuak and Quebec as well as with Kativik School Board.

g. College Education Branch (Direction Générale de l'Enseignement Collégial - DGEC), Ministry of Education

On Oct.16,1991, we met with the Director of Education Services and a number of other people interested in the project. An official request for the authorization of the course 180-21 will be made shortly by JAC.

To sum up, we have motivated candidates prepared to make every effort to respond to an urgent need of the Inuit population. This population, in turn, through the organizations that represent it, firmly supports the project. We have also described the organizational structures which lead us to believe that the project can be successful in the short term.

However, there remains the difficult question of financial support. In order to help administrators evaluate the costs involved in the project we have enumerated the human and material resources that

will be required. As precise cost figures as possible have been added, taking into account the indexation of the cost of living. We have also added a description of the kinds of tasks that will be necessary in the conception, adaptation and preparation of the course.

CONCLUSION

The upgrading course for three Inuit nurses is another step to be taken in the education of Inuit health workers. We look to the example of the Inuit Teacher Training Program of Kativik School Board which, under the auspices of McGill University, has trained many Inuit teachers in the North over the last ten years. Its approach has been a great inspiration to us.

The course 180-21 will be the first college-level course given north of the 55th parallel in Quebec. As we conceive of the course at the moment, other students who have already completed their Secondary V could join the program for non-nursing courses. We have reason to believe that there are several candidates who would be interested. This would provide us with a certain pool of students with the credits required for the nursing course (180-01). We hope to be able to organize this course in the near future.

Education in Nunavik is presently offered at the primary and secondary level. The nursing course would provide access to the college and eventually university levels. The possibility would offer a great deal of hope to young Inuit.

To: Mme Lucienne Robillard
Minister of Science and Higher Education
1033 de la Chevrotière
Québec
G1R F9K

Madam,

I am writing to inform you that, following the visit of the Minister of Health and Social Services, M. Marc-Yvan Côté to Kuujjuak, a project concerning the upgrading of the Inuit auxiliary nurses will soon be presented to him by the representatives of the Ungava Hospital. A request for authorization for the course 180-21 was made to Mme Claire Prévost-Fournier (head of of the Planning Section of your ministry) by John Abbott College this month. A meeting has also taken place with Mr Louis Gendreau, Director of Education Services, College Education Branch (DGEC), Ministry of Education, with the purpose of coordinating our efforts towards the success of this project.

Knowing your interest for the specific issue of education in northern regions, we trust that you will support the objectives of this program when it is presented to Cabinet.

Yours truly,

Minnie Grey

To: Mme Lucienne Robillard
Ministère de L'Enseignement Supérieur,et de la Science
1033 de la Chevrotière
Québec
G1R FK9

Madame,

La présente est pour vous aviser que, suite à la visite du Ministre de la Santé et des Services Sociaux, M. Marc-Yvan Côté à Kuujjuak, un dossier concernant le de recyclage des infirmières auxiliaires inuit lui sera présenté sous peu par les représentants de l'hôpital d'Ungava. Une demande d'autorisation pour le cours 180-21 a été faite à Mme Claire Prévost-Fournier (chef du service de la planification) par le CEGEP John Abbott, ce mois-ci. Une rencontre a aussi eu lieu avec M.Louis Gendreau, Directeur de la Direction des programmes aux Services Educatifs au DGEC, dans le but de coordonner nos efforts pour la réussite de ce projet.

Connaissant votre intérêt pour la problématique spécifique de l'éducation en régions nordiques, nous espérons que vous supporterez les objectifs de ce programme lorsqu'il sera présenté au Conseil des Ministres.

Bien à vous

Minnie Grey

cc P. Blankgff
cc. B
L. Gendreau DGEC Robillard

Gouvernement du Québec
Ministère de la Main-d'œuvre,
de la Sécurité du revenu
et de la Formation professionnelle

NOTE

A	:	Claire Lavoie	MMSRFP
		Yves Turcotte	CFP de Québec
		Chantal Leclerc	MESS
		Huguette Sauvageau	MSSS
		Colette Couture	Chargée de projet
		Darky Gagné	ARK
		Paul Katchadourian	CSK
		Jim Deslauriers	CSK
		Phyllis Blaukopf	Cégep John Abbott
		Minnie Grey	Hôpital de l'ungava
DE	:	François Paré	
DATE	:	Le 24 mars 1992	
OBJET	:	**Les infirmières inuit**	

Bonjour,

Par la présente vous recevez la dernière version de notre document de travail. En même temps qu'on peut constater des progrès, on peut se rendre compte aussi des écarts qui subsistent.

Je vous précise aussi que la Commission scolaire Kativik peut payer en partie ou en totalité les frais suivants: voyages, logements et activités étudiantes, lorsque les étudiantes sont à Montréal.

Sincères salutations.

FRANCOIS PARÉ

OFFRES RELATIVES À LA FORMATION D'INFIRMIÈRES INUIT

Postes budgétaires	Coûts trois années CÉGEP	Nouvelle estimation	MMSRFP	MESS	MSSS	Autres
Enseignants Général	176 600,00			105 000,00 (2.1 etc.)		
Nursing	135 100,00		60 592,00			
Alloc. nordique	4 200,00		27 471,00			
Voyages	50 400,00		15 600,00			
Mobility (Entreposage)	24 950,00		A.S.			
Nourriture	12 925,00		A.S.			
Housing	198 000,00	108 000,00				
Rec. Pedag. + Dev. de curriculum	97 900,00					45,000,00 (Challenge)
Voyage + Hôtel	9 325,00					
Stages à Montréal	103 500,00					34 500,00 (Kuujjuamiut)
Voyages	18 000,00					
Aide + Conseil pédagogique	69 000,00	10 000,00				
Voyage + Prime	30 000,00	~~0~~				
Secrétariat	36 000,00					
Ben. marginaux	147 500,00					

1992.03.19

[redacted]

OFFRES RELATIVES À LA FORMATION D'INFIRMIÈRES INUIT

Postes budgétaires	Coûts trois années				MSSS	Autres
	CÉGEP	Nouvelle estimation	MMSRFP	MESS		
Fournitures + matériels - Lab. clinique	3 900,00					
-Lab. biologique	3 000,00					
-Livres + matériels (étudiants)	7 800,00					
-Livres + matériels (académique)	2 400,00					
-Transp. de matériels	2 500,00		1 250,00			
-Mat. audio-visuel	2 400,00					
-Mat. de référence	10 500,00					
-Mat. périssable	8 900,00		9 544,00			
-Divers (Lab. nursing)	15 200,00					
-Équip. audio-visuel	18 000,00					18 000,00 CSK
Administration générale (frais d'encadrement)	75 000,00					
-Frais d'encadrement (Kuujjuaq)	4 500,00					4 500,00 CSK
-Frais scolaires d'inscription	3 000,00					3 000,00 CSK
-Stages hospitaliers (Montréal)	900,00					900,00 CSK

1992.03.19

OFFRES RELATIVES À LA FORMATION D'INFIRMIÈRES INUIT

Postes budgétaires	Coûts trois années				MSSS	Autres
	CÉGEP	Nouvelle estimation	MMSRFP	MESS		
Contingence	155 000,00					
Étudiants						
-Entreprosage (Stages hosp.)	12 000,00					
-Voyage	5 600,00					
-Logement	16 800,00					
-Act. étudiantes	16 000,00					
-Autres coûts (personnels)	-0-			60 000,00		
-Non-attribués	-0-				225 000,00	
GRAND TOTAL:	**1 447 900,00**	**1 329 900,00**	**114 457,00**	**165 000,00**	**225 000,00**	**105 900,00**
				610 357,00		

1992.03.19

NOTES

1) 105 000,00 -> Il s'agit du taux normal pour 30 élèves.

2) A.S.-> Il est possible de payer un certain nombre de coût relié au professeur de nursing.

3) 108 000,00-> Bachelor 36 000,00 / AN X 3 ANS, pour 2 professeurs.

4) 10 000,00-> Voir pour une personne à Kuujjuaq, ce qui diminuerait les coûts reliés au tuturat.

5) -0-> Si la personne ressource est déjà à Kuujjuaq, le coût serait nul.

6) 60 000,00-> Il s'agit d'un montant disponible au MESS sans affectation particulière.

7) 225 000,00-> Il s'agit d'un montant disponible au MESS sans affectation particulière.

8) 610 357,00-> Il s'agit de la somme actuellement disponible pour ce projet.

ANNEX 16

ANNEX 15

Kativik Regional Council of Health and Social Services

Report on Consultation Visit to the Community of Kuujjuarapik concerning the Possible Merging of the Cree and Inuit Nursings

Since the adoption of the resolution 34-86 by the Corporation of the Northern Village of Kuujjuarapik on September 8, 1986, discussions were held at political and administrative levels regarding the improvement of community Health and Social Services facilities for the Inuit community of Kuujjuarapik. The participants to the above-mentioned political and administrative discussions studied the possibility of merging the Cree and Inuit Nursing and Social Services installations.

Despite these numerous political and administrative meetings, no signification or concrete development took place on that important issue since the past four (4) years.

Confronted with a situation which had not evolved during all those years, and disappointed by the fact that they were never adequately and sufficiently consulted on the question, representatives from the Corporation of the Northern Village and the Local Health Committee from Kuujjuarapik as well as Inuulitsivik Hospital requested Kativik Regional Council of Health and Social Services assistance to proceed to a complete review of the file.

The Kativik Health Council accepted the mandate and in reason of the importance of the file hold extensive consultation on the issue with all Inuit parties involved. These consultation took place in Kuujjuarapik between August 30 and September 1, 1990. On that occasion, three representatives form Kativik Council met with the following groups or persons:

- Representatives from the Corporation of the Northern Village (Mayor and Municipal Councillor);
- Kativik Regional Councillor;
- The Local Health Committee;
- Community Social Services Workers;
- The Physician residing in Kuujjuarapik;
- Nursing Staff attached to the Inuit Nursing;
- Inuit Interpreters and Support Staff;
- The Patients Services.

All the persons met by the Kativik Health Council share the same concerns and foresee important difficulties if there would be a merging of Inuit and Cree Nursing and Social Services facilities:

- Difference of functioning between Cree and Inuit Health Boards;
- Equipment ownership and accessibility to population;
- Localization of a joint nursing (land issue);
- Identification of the population to its services.

All Inuit met during the consultation express the desire to continue to have a good neighboring relationship with the Cree but they fear that differences on approaches, objectives or evaluation of needs between the two groups could have a negative impact on such relationship and ultimately on the quality of services to the population.

It is obvious that all Inuit people met by the Kativik Health Council representatives feel uncomfortable with the idea of Cree and Inuit nursing being merged. All the parties involved expressed strong reservations and foresee more difficulties than they can foresee benefits from a merging of the services.

If such a merging would ever take place, the Inuit population would see it as being imposed on them and a great segment of the population would accept it reluctantly and would not identify themselves to such a Health and Social Service Centre.

Corporation of the Northern Village of Kuujjuaraapik

Resolution 91-10

Concerning possible merging of the Inuit and Cree Health and Social Services Facilities.

Whereas: in resolution 34-86, adopted on September 8, 1986, the Corporation of the Northern Village of Kuujjuaraapik, acting as spokesmen for the population of Kuujjuaraapik, clearly stated the need to obtain a new community Health and Social Services Centre for the Inuit of Kuujjuaraapik;

Whereas: as of today, the nursing, social services and patient services are still located in their same old federal trailer buildings erected in 1962 and for that reason the need to obtain a new community Health and Social Services Centre is becoming urgent;

Whereas: the existing foster homes for patients are no longer adequate to provide adequate services and that there is also an urgent need to obtain a transit house for patients similar to the one in Kuujjuaq;

Whereas: the above mentioned old installations are no longer adequate to provide quality services to the Inuit population of Kuujjuaraapik and more specifically:

a) the old nursing station built in 1962 experience at least two or three times a year flooding problems which damage medical supplies and equipment;

b) all facilities (nursing station, social services, patient services and foster homes for patients) are located far apart one from the other;

c) social services trailer is presently in such a bad condition that it cannot be used anymore for the daily operation of the service. The two community workers have to accomplish their tasks from their respective home. Under such circumstances quality of social services available for our community is greatly reduced;

d) the actual foster homes for patients are far apart from the nursing and are not able to provide adequately the services required by a high number of patients travelling every day from the North and from South;

Whereas: compared to the situation which prevails in almost all other Inuit communities, where new nursing buildings have been constructed since James Bay and Northern Quebec Agreement signature, the Kuujjuaraapik nursing services are still provided from the old building which has been transferred from Federal Government;

Whereas: compared to the situation which prevails in Kuujjuaq where they have a transit house facility for patients;

Whereas: since September 1986, the Corporation had the opportunity in numerous occasions to rediscuss about the opportunity of merging its Health and Social Services with the Cree community;

Whereas: since resolution no. 34-86 has been adopted in September 1986, and despite numerous political and administrative discussions on the matter, no significative and or concrete development took place on that important issue for the Inuit population of Kuujjuaraapik;

Whereas: because of the important differences in the functioning of the Cree Health Board, the Inuulitsivik and the Kativik Council of Health and Social Services there exists important worries among our population that Inuit needs would not be properly monitored and carried out if the Cree and Inuit Health and Social Services would be merged;

Whereas: the questions of the localization of a joint nursing and the ownership of equipments has never been clarified to the satisfaction of our community.

Therefore, be it resolved that;

1. That the preamble is an integral part of this resolution.
2. That the Corporation of the Northern Village of Kuujjuaraapik by the present amends its resolution 34-86 and requests from Inuulitsivik, the Kativik Council of Health and Social Services to take all necessary measures to obtain the construction of a separate Inuit Health and Social Services Centre and a transit house for patients which would service the Inuit community of Kuujjuaraapik instead of a joint Cree and Inuit Centre.
3. That said Inuit Health and Social Services Centre and the Transit House shall be located within Inuit Category I lands.
4. That Social Services shall be located in the same building as the nursing station in order to offer complete and integrated services to our population within the same facilities.
5. That the Transit House for patients shall be integrated to the Community Health and Social Services Centre or be built not far apart.
6. That this project be entirely funded by the Quebec government pursuant to its obligations under Section 15 of the James Bay and Northern Quebec Agreement.
7. That this resolution comes into effect immediately.

Proposed by: Willie Tookoo

Seconded by: Paulosie Papatsie

In favor: 3

Opposed: 0

Abstentions: 1

Absents: 3

Date of adoption: Feb 13/91

Mayor: [signature]

Secretary-Treasurer: [signature]

Gouvernement du Québec

Le ministre de la Santé et des Services sociaux

QUEBEC, October 15th, 1990

Mr. Jimmy Johannes
Chairman of the Board of Directors
Kativik Regional Board of Health
and Social Services
P.O. Box 9
Kuujjuaq (Québec)
JOM 1C0

Sir,

The relocation of part of the Kuujuuarapik-based Inuit population toward Umiujaq prompted our undertaking discussions as to how might be reorganized the administration and provision of health and social services for the Cree, Inuit and non-native populations of Poste-à-la-Baleine.

You will recall the commitment made by the gouvernement du Québec, in July 1982, concerning the services it was prepared to fund should the Inuit of Kuujjuarapik decide to relocate in the Golfe de Richmond area. In his letter dated September 24, 1982, addressed to the Mayor and the Municipal Councillors of the Northern village of Kuujjuarapik, the Premier of Québec indicated that the Conseil des ministres had decided that the Golfe de Richmond community (today Umiujaq) would be the only one to subsist after the vote, as recognized by the legislation following upon the James Bay and Northern Québec Agreement. However, such decision was in no way to deprive of access to services those who elected to remain in Kuujjuarapik.

You will appreciate that the aftermath of the 1982 decision renders impossible any thought of erecting two nursing stations. Consequently, I wish to advise you that the ministère de la Santé et des Services sociaux expects to authorize the construction of a new community clinic in Whapmagoostui, on Cree territory, as of April 1991, with administration of same entrusted to the Cree Regional Board of Health and Social Services of James Bay. Naturally, all the services dispensed to the Inuit and non-native populations will be exactly the same as those provided to the Crees.

.../2

1075, chemin Ste-Foy, 15e
Québec, QC G1S 2M1
(418) 643-3160

The authorities with my Department who are in charge of Native dossiers are at your disposal to establish all administrative mechanisms for identifying and meeting your community's needs.

Should you require additional information about this or any related question, please communicate with the Department's Coordinator for Native Affairs, Roger Richard, by telephoning (418) 643-4145.

I trust this meets with your approval.

Yours truly,

Marc-Yvan Côté
Minister

INNUULISIVIK
CENTRE HOSPITALIER DE LA BAIE D'HUDSON
HUDSON BAY HOSPITAL CENTRE
Povungnituk, Québec J0M 1P0
Tél.: (819) 988-2957

November 23, 1990

Mr. Marc-Yvan Côté
Ministere Sante Services Sociaux
Direction Generale Relation Travail
6161 Ste Denis Suite 402
Montreal, QC
H2S 2R5

Mr. Côté,

In view of the Minister's stated position concerning the Kuujjuarapik Nursing Station, as documented in Appendix 1, it is important that Inuulitsivik express its concerns and clearly state its position on the matter.

We must deplore first and foremost the lack of consultation that has characterized the Minister's approach: after 4 years of silence on the matter this sudden decision is difficult to comprehend and appears to leave very little room for concertation, conciliation or compromise.

To the best of our abilities we shall attempt to demonstrate why the Inuit of Kuujjuarapik should be provided with their own nursing station within the framework of the Inuulitsivik CLSC.

First and foremost must be considered the issue of culture and language where requirements for interpretation, documentation, signs and health promotional materials will remain quite distinctive and specific.

In the area of community health some programs are so specific that one must question whether they could effectively and efficently be provided by a Cree administration without a complex service agreement with the Inuulitsivik CLSC.

Example: - hearing and otitis program
- perinatal program

DEC 11 1990

The Hearing and Otitis Program was designed in view of a problem set quite peculiar to the Inuit population and its coordination is done jointly by Inuulitsivik and the McGill School for Human Communication Disorders. The core staff travels to the various communities and an integrated file system is maintained for the entire Kativik region. It is doubtful that the CLSC of the Cree Board of Health and Social Services would have the interest and the ability to carry on with this program of great importance for the Inuit.

The perinatal program is another good example of the specificity of services that could seriously suffer from the proposed merger. Our current system integrates the local follow up of pregnancy through the regional perinatal committee where care plans are outlined including place of delivery, use of diagnostic or other procedures, support, etc... the Inuulitsivik approach also focuses on allowing a greater involvement of Inuit in the birthing process through training programs for native midwives and maternity workers, prenatal classes in Inuttitut and a negociated agreement with Air Inuit for reduced Paternal fares (half price). Further expansion and decentralization of perinatal services is currently being envisioned.

Again here we are concerned that Inuit women in Kuujjuaraapik would suffer greatly from a transfer of their care to Cree Health Services.

Other example could be the preventive dental health program, social services, mental health programs, etc...

Kuujjuraapik is also a main transit point for our patients. The presence of one of our physicians there has always facilitated our procedures for reassuring patients during a med-evac or continuing care when weather conditions delay transfer any further, up or down. Kuujjuarapik is also the former "home base" for most people currently living in Umiujaq. Family ties, seasonal employment, schooling and other motivations create a movement back and forth between Inuit from these two communities. If patients were to switch from one health care system to another, many problems could arise in files mix-up, loss of files, lack of continuity of care, delays in transfer of significant medical information, etc... Finally, in relation again to the Umiujaq situation, patients from that community are often refered to Kuujjuarapik to see a medical specialist in transit, avoiding a more costly transfer to Povungnituk.

Loosing the ability to redirect our staff according to current needs and emergencies could impact on our day to day operations.

example: when staffing is tight at the hospital in Povungnituk, nurses in Kuujjuaraapik may be requested to take over med-evac allowing Povungnituk nurse to return sooner to base.

For these reasons it is our belief that a separate Inuit Nursing Station affiliated to the Inuulitsivik CLSC must be retained for Kuujjuraapik.

On the other hand, they may be room for further discussions and compromises on some issues such as:

- sharing a common building
- sharing expensive technical equipment like x-rays, ECG
- sharing an emergency room or on-call duties at night
- sharing specialized human resources
    - physician
    - dentist

We would like to propose a meeting between representatives from the MSSS, the Kativik Regional Council of Health and Social Services, the Cree Board of Health and Social Services and Inuulitsivik Board of Directors to discuss these issues once again in a spirit of cooperation.

Yours truly,

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Pauloosie Padlayat
President
Inuulitsivik Hospital
Povungnituk

Gouvernement du Québec

Le ministre de la Santé et des Services sociaux

Québec, January 30, 1991

Mr. Paulussie Padlayat, Chairman
Board of Directors
Hudson Bay Hospital Center
Povungnituk (Québec)
JOM 1P0

Sir,

I refer here to your letter of November 23, 1990, advising me of your preoccupations about the construction of a community clinic to serve the populations of Whapmagoostui and Kuujjuaq.

Please be assured that I intend to provide the native and non-native communities in those areas with a well built modern structure; moreover the cultural specificities of each user will be fully respected.

I shall discuss this project with you in greater detail when I next visit the Inuit territory, within the coming months.

I trust this is satisfactory.

Yours truly,

Marc-Yvan Côté
Minister

1015 chemin Ste-Foy, 15e
Québec, QC G1S 4N4
(418) 643-3160

LISTE: KO3.T810.S5O TABLEAU NO. O1
MINISTERE DE LA SANTE ET DES SERVICES SOCIAUX
REGISTRE DES AUTOCHTONES
LISTE OFFICIELLE DES BENEFICIAIRES SELON LES COMMUNAUTES D'AFFILIATION

SELON LE FICHIER EN DATE DU 1991 07 03

PEUPLE INUIT — AFFILIATION: KUUJJUARAAPIK

NOM	PRENOM(S)	ADM.	BENEF.	NUMERO DISQUE	DATE NAISSANCE	SEXE	STATUT	COMMUNAUTE DE RESIDENCE
AKPAROOK	TROY	13A	64835		1980/04/21	M	C	KUUJJUARAAPIK
AKPAROOK	WILLIAM	12A	60076	E9-4059	1971/04/21	M	C	KUUJJUARAAPIK
ANGATOOKALOOK	ALICE	13B	64600	E9-4678	1977/08/09	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	ALICIA ALICE	13A	64717	E9-4205	1981/08/24	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	ANNA LOUISA	12A	60106	E9-4124	1973/12/17	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	ANNIE	13A	65002	E9-4529	1976/02/23	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	CAROLINE	12A	60100	E9-102	1945/10/04	F	I	KUUJJUARAAPIK
ANGATOOKALOOK	CHARLIE QUMALUK	13A	65749	E9-5108	1977/12/04	M	C	KUUJJUARAAPIK
ANGATOOKALOOK	DAVID PAUL	13B	66254	E9-5173	1985/07/06	M	C	KUUJJUARAAPIK
ANGATOOKALOOK	EVA BRIGITTE	13A	67247		1989/08/18	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	JIMMY	12A	60088	E9-2829	1960/08/30	M	I	KUUJJUARAAPIK
ANGATOOKALOOK	JIMMY PAUL	12A	60103	E9-3560	1968/07/02	M	I	KUUJJUARAAPIK
ANGATOOKALOOK	JOE	12A	60099	E9-228	1942/09/08	M	I	KUUJJUARAAPIK
ANGATOOKALOOK	JOHNNY	12A	60101	E9-3283	1964/08/28	M	I	KUUJJUARAAPIK
ANGATOOKALOOK	LOUISA	12A	60096	E9-324	1940/06/16	F	I	KUUJJUARAAPIK
ANGATOOKALOOK	LUCASSIE	12A	60093	E9-3303	1965/03/26	M	I	KUUJJUARAAPIK
ANGATOOKALOOK	LUCY	12A	60091	E9-364	1938/05/07	F	I	KUUJJUARAAPIK
ANGATOOKALOOK	MARK	12A	60105	E9-4089	1972/09/20	M	C	KUUJJUARAAPIK
ANGATOOKALOOK	MARY	12A	60097	E9-3846	1970/10/24	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	MARY HANNAH	12A	60104	E9-3842	1970/10/11	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	PENINA CAROLINE	13A	67459	E9-5294	1991/01/15	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	PETER JOHN	12A	60094	E9-4056	1971/04/15	M	C	KUUJJUARAAPIK
ANGATOOKALOOK	RHODA	12A	60102	E9-3347	1966/04/21	F	I	KUUJJUARAAPIK
ANGATOOKALOOK	SAMANTHA WINNIE	13A	66671	E9-5186	1986/12/01	F	C	KUUJJUARAAPIK
ANGATOOKALOOK	SAMUEL	13B	65990	E9-5210	1983/11/07	M	C	KUUJJUARAAPIK
ANGATOOKALOOK	TOMMY JOHNATHAN MICHAEL	13A	67426	E9-5293	1990/04/12	M	C	HORS DU TERRITOIRE
ANGATOOKALOOK	WILLIE	12A	60095	E9-227	1938/10/26	M	I	KUUJJUARAAPIK
ANGATOOKALOOK (	JOHNNY	12A	60098	E9-4122	1974/12/23	M	C	KUUJJUARAAPIK
ANGIYOU	MARKUSI KIATAINAK	12A	61334	E9-2966	1962/12/15	M	M	POVUNGNITUK
ANGIYOU	SIMEONIE JASON	13A	66031		1983/04/04	M	C	KUUJJUARAAPIK
ANGIYOU (TUCKAT	HEATHER JEAN	12A	60581	E9-3057	1962/06/25	F	M	KUUJJUARAAPIK
ANGUTIGULUK	JOSEPH ANDREW	13A	67024	E9-5248	1988/12/30	M	C	KUUJJUARAAPIK
ARAGUTAK	AKULIAK	12A	60116	E9-1798	1948/07/27	M	I	KUUJJUARAAPIK
ARAGUTAK	ANDY	13A	66851		1987/09/26	M	C	UMIUJAQ
ARAGUTUK	JEANNIE	12A	60121	E9-3808	1969/01/09	F	C	UMIUJAQ
AUDLA	MARY JEAN	12B	64846		1969/02/14	F	C	HORS DU TERRITOIRE
AUDLA	NELLIE	12B	64847		1971/02/13	F	C	HORS DU TERRITOIRE
AUDLA	SIMON	13A	64848		1981/09/06	M	C	HORS DU TERRITOIRE
AUDLAROCK	FREDERICK	12A	60125	E9-4079	1972/02/07	M	C	KUUJJUARAAPIK
AUDLAROCK	JOHANASSIE	12A	60124	E9-38	1944/10/03	M	I	KUUJJUARAAPIK
AUDLAROCK	LAWRENCE NELSON	12A	60127	E9-4118	1973/11/04	M	C	KUUJJUARAAPIK
AUDLAROCK	MARIA ALICE LOUISA	13A	64620	E9-5120	1979/01/10	F	C	KUUJJUARAAPIK
AUDLAROCK	SHARON JEAN	12B	64778	E9-4116	1969/06/21	F	C	KUUJJUARAAPIK
AUDLAROCK	SHEILA LAUREEN	12A	60126	E9-4117	1973/11/04	F	C	KUUJJUARAAPIK
BENNET	JASON LEE	13A	64621	E9-5149	1979/12/24	M	C	KUUJJUARAAPIK

LISTE: KO3.T810.S50 TABLEAU NO. 01
MINISTERE DE LA SANTE ET DES SERVICES SOCIAUX
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SELON LE FICHIER EN DATE DU 1991 07 03

PEUPLE INUIT — AFFILIATION: KUUJJUARAAPIK

NOM	PRENOM(S)	ADM.	BENEF.	NUMERO DISQUE	DATE NAISSANCE	SEXE	STATUT	COMMUNAUTE DE RESIDENCE
BENNETT	GREGORY	13C	64779		1950/06/25	M	C	KUUJJUARAAPIK
BENNETT	KIMBERLY MINA	13A	65968	E9-4249	1983/06/04	F	C	KUUJJUARAAPIK
BOWN	JOHN	13C	64780		1956/12/04	M	M	HORS DU TERRITOIRE
BOWN	KELLY PATRICIA	13B	65945	E9-4250	1983/05/15	F	C	UMIUJAQ
BUTTRUM (NOVALI	MAGGIE MAE	13A	64816		1977/09/14	F	C	KUUJJUARAAPIK
COOKIE	ALICE	12A	60130	E9-309	1926/04/11	F	I	KUUJJUARAAPIK
COOKIE	ANDREW	12A	60133	E9-3841	1970/09/01	M	C	KUUJJUARAAPIK
COOKIE	ANDREW	12A	60137	E9-516	1951/08/09	M	I	KUUJJUARAAPIK
COOKIE	ANGNATUK	13A	65967	E9-5203	1983/09/29	F	C	HORS DU TERRITOIRE
COOKIE	ANNIE	12B	64788		1951/02/10	F	M	HORS DU TERRITOIRE
COOKIE	CAROLINE	12B	64821		1971/02/15	F	C	HORS DU TERRITOIRE
COOKIE	DANIEL	13A	64820		1980/03/31	M	C	HORS DU TERRITOIRE
COOKIE	DAVID	12A	60159	E9-3439	1967/04/13	M	I	KUUJJUARAAPIK
COOKIE	HANNAH	12A	60160	E9-3567	1968/08/16	F	I	KUUJJUARAAPIK
COOKIE	ISAAC	12A	60168	E9-3269	1964/03/23	M	I	HORS DU TERRITOIRE
COOKIE	JEANNIE	12A	60156	E9-297	1934/02/10	F	I	KUUJJUARAAPIK
COOKIE	JIMMY	12A	60166	E9-2889	1961/09/09	M	I	KUUJJUARAAPIK
COOKIE	JIMMY SAM	12A	60161	E9-3834	1970/03/20	M	C	KUUJJUARAAPIK
COOKIE	JOBIE	12A	60163	E9-236	1923/03/01	M	I	KUUJJUARAAPIK
COOKIE	JOE	12A	60141	E9-2474	1959/02/10	M	I	KUUJJUARAAPIK
COOKIE	JOHNNY	12A	62274	E9-2888	1961/12/31	M	I	KUUJJUARAAPIK
COOKIE	JOHNNY ANDREW	13B	65910	E9-4244	1983/06/10	M	C	KUUJJUARAAPIK
COOKIE	JOSIE	12A	60167	E9-3709	1963/04/01	M	I	HORS DU TERRITOIRE
COOKIE	LANA PARSA	13A	64819		1978/01/04	F	C	HORS DU TERRITOIRE
COOKIE	LOTTIE	12B	64787		1954/11/01	F	M	HORS DU TERRITOIRE
COOKIE	LUCASSIE	12A	60157	E9-2817	1960/04/03	M	I	KUUJJUARAAPIK
COOKIE	MARTHA	13A	64823		1979/09/09	F	C	HORS DU TERRITOIRE
COOKIE	MIGUEL TOOMA	13A	66290	E9-5179	1985/10/21	M	C	KUUJJUARAAPIK
COOKIE	MINA	12A	60134	E9-3084	1963/04/26	F	I	KUUJJUARAAPIK
COOKIE	PAUL	12A	60131	E9-2810	1960/02/09	M	I	KUUJJUARAAPIK
COOKIE	PAUL	12A	64822		1972/01/30	M	C	HORS DU TERRITOIRE
COOKIE	PETER PAUL	12A	60162	E9-4090	1972/09/20	M	C	KUUJJUARAAPIK
COOKIE	REBECCA	12A	65005	E9-4076	1972/02/14	F	C	KUUJJUARAAPIK
COOKIE	RHODA	12A	60171	E9-2305	1956/12/15	F	I	HORS DU TERRITOIRE
COOKIE	RUTH	12A	65004	E5-1018	1951/12/19	F	I	KUUJJUARAAPIK
COOKIE	SAMUEL	13A	64824		1982/04/08	M	C	HORS DU TERRITOIRE
COOKIE	SARAH	12A	60138	E9-387	1948/02/10	F	I	KUUJJUARAAPIK
COOKIE	SILAS	12A	60155	E9-237	1932/10/06	M	I	KUUJJUARAAPIK
COOKIE	SILAS	12A	60169	E9-3801	1968/10/15	M	I	KUUJJUARAAPIK
COOKIE	TOMMY	12A	60165	E9-2533	1958/12/03	M	I	KUUJJUARAAPIK
COOKIE	WINNIE	12A	60140	E9-239	1919/02/01	F	I	KUUJJUARAAPIK
COOKIE (HORNE)	JEANNIE	12A	60136	E9-241	1946/01/26	F	M	UMIUJAQ
COOKIE JR	MINA	13A	66148	E9-5159	1984/12/04	F	C	KUUJJUARAAPIK
COOKIE-SIMARD	CYNTHIA	13A	66676		1987/04/30	F	C	KUUJJUARAAPIK
COOKIE-SIMARD	NICHOLAS	13A	67117	E9-5255	1989/04/01	M	C	KUUJJUARAAPIK

LISTE: K03.T810.S50 TABLEAU NO. 01
MINISTERE DE LA SANTE ET DES SERVICES SOCIAUX
REGISTRE DES AUTOCHTONES
LISTE OFFICIELLE DES BENEFICIAIRES SELON LES COMMUNAUTES
D'AFFILIATION

SELON LE FICHIER EN DATE DU 1991 07 03
PEUPLE INUIT AFFILIATION: KUUJJUARAAPIK

NOM	PRENOM(S)	ADM.	NUMERO BENEF.	NUMERO DISQUE	DATE NAISSANCE	SEXE	STATUT	COMMUNAUTE DE RESIDENCE
COOKIE-SIMARD	RHODA	12A	60158	E9-3100	1963/09/07	F	M	KUUJJUARAAPIK
CROW	BESSIE	12B	64789		1940/08/24	F	M	HORS DU TERRITOIRE
CROW	BETSY	12A	60195	E9-260	1905/00/00	F	I	HORS DU TERRITOIRE
CROW	CHARLOTTE QIQLUAT	13B	67248		1989/04/03	F	C	HORS DU TERRITOIRE
CROW	DAVIDEE	12A	60178	E9-3419	1966/09/17	M	I	KUUJJUARAAPIK
CROW	FIONA	13A	67321	E9-5279	1990/02/23	F	C	KUUJJUARAAPIK
CROW	JOBIE	12A	60188	E9-263	1938/09/26	M	I	HORS DU TERRITOIRE
CROW	JOHN MARK	12A	60177	E9-3276	1964/05/30	M	I	KUUJJUARAAPIK
CROW	MARKOSSIE	12A	60179	E9-3828	1970/01/17	M	C	KUUJJUARAAPIK
CROW	MINA	12A	60191	E9-2854	1961/03/12	F	I	KUUJJUARAAPIK
CROW	MINA SERENE	13A	65975	E9-5201	1983/09/23	F	C	KUUJJUARAAPIK
CROW	NICHOLLE SARAH JANE F.	13A	66770	E9-5199	1987/08/10	F	C	KUUJJUARAAPIK
CROW	PHILIP	12A	60176	E9-3055	1962/05/17	M	M	KUUJJUARAAPIK
CROW (FARIES)	MARCELLA WANDA	13C	66084	E9-5194	1964/03/08	F	M	KUUJJUARAAPIK
DELMAIRE	BERNARD	13C	64793		1945/05/22	M	M	HORS DU TERRITOIRE
DELMAIRE	JASON ALEC	13A	66247		1985/02/08	M	C	HORS DU TERRITOIRE
DELMAIRE	ROBERT EDWARD	13A	67428	E9-5288	1987/12/17	M	C	HORS DU TERRITOIRE
DELMAIRE (KOKIA	DORA	12A	60297	E9-2544	1959/03/04	F	M	KUUJJUARAAPIK
ESPERON	ALICE	12A	60199	E9-3529	1967/09/23	F	I	KUUJJUARAAPIK
ESPERON	ANNIE	12A	60200	E9-4087	1972/09/02	F	C	KUUJJUARAAPIK
ESPERON	DANNY LOUIS	13A	67134	E9-5262	1989/05/29	M	C	KUUJJUARAAPIK
ESPERON	GINA	12A	60528	E9-2863	1961/07/02	F	M	HORS DU TERRITOIRE
ESPERON	JEFFREY	13A	66986		1988/08/31	M	C	KUUJJUARAAPIK
ESPERON	LYDIA	12A	60198	E9-3088	1963/05/03	F	I	KUUJJUARAAPIK
ESPERON	MAGGIE MAI	13A	67377	E9-5283	1990/05/03	F	C	KUUJJUARAAPIK
ESPERON	NATHALIE	13A	66669		1983/04/07	F	C	KUUJJUARAAPIK
ESPERON (INUKPU	MINA	12A	60197	E9-2849	1961/02/23	F	M	KUUJJUARAAPIK
FLEMING	ALEC	12A	60201	E9-279	1946/09/20	M	I	KUUJJUARAAPIK
FLEMING	ALICE	13A	65965	E9-5206	1983/09/15	F	C	KUUJJUARAAPIK
FLEMING	ALICE CINDY	13A	65009	E9-4526	1976/03/03	F	C	KUUJJUARAAPIK
FLEMING	ANDREW	12A	60239	E9-2505	1958/01/03	M	I	KUUJJUARAAPIK
FLEMING	ANNIE RITA	12A	60225	E9-4091	1972/10/05	F	C	KUUJJUARAAPIK
FLEMING	ANTHONY RUPERT	13A	64799	E9-4238	1982/02/21	M	C	KUUJJUARAAPIK
FLEMING	BETSY GINA	13A	64723	E9-5153	1981/06/03	F	C	KUUJJUARAAPIK
FLEMING	CAROLINE	12A	60244	E9-4072	1971/12/22	F	C	KUUJJUARAAPIK
FLEMING	CHARLIE	12A	60240	E9-2812	1960/02/25	M	M	KUUJJUARAAPIK
FLEMING	CHARLIE	13A	66925	E9-5240	1988/02/16	M	C	KUUJJUARAAPIK
FLEMING	CHERYL JOCELYN	13A	67397		1978/01/22	F	C	KUUJJUARAAPIK
FLEMING	CORA LOUISE	13A	64593	E9-5136	1980/01/15	F	C	KUUJJUARAAPIK
FLEMING	DAISY LOUISA	12A	60243	E9-3850	1971/01/08	F	C	KUUJJUARAAPIK
FLEMING	DAVID	12A	60210	E9-3322	1965/09/11	M	M	KUUJJUARAAPIK
FLEMING	DAVID THOMASSIE	13A	66235	E9-5170	1985/04/11	M	C	KUUJJUARAAPIK
FLEMING	DAVIDEE	12A	60232	E9-3559	1968/06/20	M	I	KUUJJUARAAPIK
FLEMING	DINAH	13A	67402	E9-5285	1990/06/28	F	C	KUUJJUARAAPIK
FLEMING	EMILY	12A	60202	E9-278	1926/04/17	F	I	KUUJJUARAAPIK

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FLEMING	ERNEST JOHN	13A	64595	E9-4246	1980/06/08	M	C	KUUJJUARAAPIK
FLEMING	EVA	12A	60211	E9-3564	1968/08/01	F	I	KUUJJUARAAPIK
FLEMING	GEORGE	13A	64596	E9-5122	1978/09/13	M	C	KUUJJUARAAPIK
FLEMING	HARRY	12A	60226	E9-4120	1973/11/15	M	C	KUUJJUARAAPIK
FLEMING	IDLOUT CHESTER	13A	64631	E9-5139	1980/06/09	M	C	KUUJJUARAAPIK
FLEMING	ISAAC	12A	60224	E9-4058	1971/05/08	M	C	KUUJJUARAAPIK
FLEMING	JEANNIE	12A	60212	E9-4119	1973/11/12	F	C	KUUJJUARAAPIK
FLEMING	JEANNIE	12A	60216	E9-2865	1960/07/26	F	I	KUUJJUARAAPIK
FLEMING	JEANNIE	13A	67027	E9-5247	1988/12/05	F	C	KUUJJUARAAPIK
FLEMING	JIMMY	12A	60206	E9-269	1936/08/16	M	M	KUUJJUARAAPIK
FLEMING	JIMMY ANDREW	13A	67025	E9-5249	1988/12/06	M	C	KUUJJUARAAPIK
FLEMING	JOANA JOHN	13B	65946	E9-4241	1983/05/05	M	C	KUUJJUARAAPIK
FLEMING	JOHNNY	12A	60214	E9-274	1920/12/01	M	I	KUUJJUARAAPIK
FLEMING	JULLIET CLARA MARY	13A	66236	E9-5169	1984/05/21	F	C	KUUJJUARAAPIK
FLEMING	LAZARUSI AUPALUK	13A	66668	E9-5189	1987/02/07	M	C	KUUJJUARAAPIK
FLEMING	LEROY PAUL	13A	66027	E9-5221	1984/02/28	M	C	KUUJJUARAAPIK
FLEMING	LEVI	12A	60233	E9-528	1952/07/26	M	I	KUUJJUARAAPIK
FLEMING	LIZZIE	12A	60203	E9-3825	1969/09/03	F	C	KUUJJUARAAPIK
FLEMING	LOUISA	12A	60173	E9-206	1935/06/25	F	M	KUUJJUARAAPIK
FLEMING	LOUISA	12A	60215	E9-275	1926/09/01	F	I	KUUJJUARAAPIK
FLEMING	LUCY	12A	60229	E9-71	1936/08/20	F	I	KUUJJUARAAPIK
FLEMING	MAGGIE	12A	60217	E9-3428	1967/01/07	F	I	KUUJJUARAAPIK
FLEMING	MARGARET	13A	67454		1990/02/07	F	C	KUUJJUARAAPIK
FLEMING	MARTHA MARIE	13A	66852	E9-5200	1987/11/16	F	C	KUUJJUARAAPIK
FLEMING	MARY	12A	60223	E9-1844	1949/04/26	F	I	KUUJJUARAAPIK
FLEMING	MARY	12A	60237	E9-306	1935/01/10	F	I	KUUJJUARAAPIK
FLEMING	MOSES	13A	65008	E9-4150	1975/08/19	M	C	KUUJJUARAAPIK
FLEMING	NELLIE AGNES	13A	66667	E9-5185	1986/11/07	F	C	KUUJJUARAAPIK
FLEMING	PAUL	12A	60241	E9-2887	1961/12/25	M	I	KUUJJUARAAPIK
FLEMING	PETER	13B	66019	E9-5209	1983/10/25	M	C	KUUJJUARAAPIK
FLEMING	RICHARD	12A	60209	E9-2828	1960/08/25	M	I	KUUJJUARAAPIK
FLEMING	RICHARD	12A	60228	E9-272	1936/08/15	M	I	KUUJJUARAAPIK
FLEMING	ROBERT	12A	60222	E9-390	1949/11/29	M	I	KUUJJUARAAPIK
FLEMING	ROBERT	13A	66987	E9-5244	1988/10/20	M	C	KUUJJUARAAPIK
FLEMING	SAPPA	12A	60238	E9-2478	1956/08/10	M	M	KUUJJUARAAPIK
FLEMING	TIMOTHY	12A	60205	E9-527	1953/01/28	M	M	KUUJJUARAAPIK
FLEMING	TIMOTHY REX	13A	66757	E9-5197	1987/05/02	M	C	KUUJJUARAAPIK
FLEMING	WILLIE	12A	60218	E9-3839	1970/07/25	M	C	KUUJJUARAAPIK
FLEMING	WILLIE	12A	60236	E9-268	1931/05/19	M	I	KUUJJUARAAPIK
FLEMING (COOKIE	EDNA ANN	12A	60142	E9-2856	1961/03/31	F	M	KUUJJUARAAPIK
FLEMING (WEETAL	MARTHA	12A	60622	E9-3295	1965/01/09	F	M	KUUJJUARAAPIK
FLEMING-TOOKALO	ZEBEDEE	13A	67438	E9-5292	1990/09/23	M	C	KUUJJUARAAPIK
GARNEAU ANGATOO	KIM	13A	66753		1987/04/01	F	C	KUUJJUARAAPIK
GEVRIT	EUGENE	13C	64777		1942/11/02	M	M	KUUJJUARAAPIK
GORDON	RITA	12A	60536	E9-455	1955/03/26	F	I	KUUJJUARAAPIK

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GRIFFIN	BRENT	12A	60338	E9-4139	1974/05/14	M	C	KUUJJUARAAPIK
INUKPUK	ALEC	13A	64800	E9-4220	1982/03/31	M	C	KUUJJUARAAPIK
INUKPUK	ANDREW PAUYUNGIE	13A	66929	E9-5238	1988/03/31	M	C	KUUJJUARAAPIK
INUKPUK	JACK SONNY	13A	64609	E9-4674	1977/08/03	M	C	KUUJJUARAAPIK
INUKPUK	JENNY MADELEINE	13A	67447	E9-5296	1991/01/22	F	C	KUUJJUARAAPIK
INUKPUK	LOUISA LOUISA	13A	64624	E9-5121	1979/02/02	F	C	KUUJJUARAAPIK
INUKPUK	LUCASSIE	12A	60250	E9-196	1951/06/10	M	M	KUUJJUARAAPIK
INUKPUK	LUCY	12A	64406	E9-184	1950/08/08	F	M	UMIUJAQ
INUKPUK	SARAH	13A	65966	E9-5204	1983/09/19	F	C	KUUJJUARAAPIK
ISABELLE	JOSEPH SAMWILLIE	13A	64837		1979/11/08	M	C	HORS DU TERRITOIRE
ISABELLE	ROBERT	13C	64794		1946/12/09	M	M	HORS DU TERRITOIRE
ISABELLE	WILLIAM DAVIDEE	13A	64836		1982/08/28	M	C	HORS DU TERRITOIRE
ITTOSHAT	ALICE CINDY	13A	67235	E9-5269	1989/09/12	F	C	KUUJJUARAAPIK
ITTOSHAT	ANTHONY	12A	60274	E9-3054	1962/03/17	M	M	KUUJJUARAAPIK
ITTOSHAT	BETSY MINNIE	13B	67457	E9-5302	1991/03/01	F	C	KUUJJUARAAPIK
ITTOSHAT	CHARLIE	12A	60275	E9-2465	1956/02/02	M	I	KUUJJUARAAPIK
ITTOSHAT	ELI SAM	12A	60269	E9-4077	1972/02/27	M	C	KUUJJUARAAPIK
ITTOSHAT	GEORGE	12A	60267	E9-441	1944/03/27	M	I	KUUJJUARAAPIK
ITTOSHAT	ISAAC	12A	60273	E9-2542	1959/02/24	M	I	KUUJJUARAAPIK
ITTOSHAT	JOANNE	13A	66020	E9-5218	1983/04/19	F	C	KUUJJUARAAPIK
ITTOSHAT	JOE	12A	60270	E9-504	1950/02/04	M	M	KUUJJUARAAPIK
ITTOSHAT	JOHN GEORGE	13A	67034	E9-5237	1987/12/14	M	C	KUUJJUARAAPIK
ITTOSHAT	LEVI FLEMING	13A	64632	E9-5146	1980/10/09	M	C	KUUJJUARAAPIK
ITTOSHAT	LOUISA	13A	65580	E9-4661	1976/10/19	F	C	KUUJJUARAAPIK
ITTOSHAT	MALAYA	12A	60272	E9-411	1917/01/01	F	I	KUUJJUARAAPIK
ITTOSHAT	MARY	12A	60268	E9-310	1937/03/17	F	I	KUUJJUARAAPIK
ITTOSHAT	MINNIE	12A	60263	E9-273	1939/03/10	F	I	KUUJJUARAAPIK
ITTOSHAT	NOAH	12A	60265	E9-3339	1966/01/24	F	I	KUUJJUARAAPIK
ITTOSHAT	RHODA LIZZIE	13B	64802	E9-4658	1976/06/16	F	C	KUUJJUARAAPIK
ITTOSHAT	RICHARD NINGIUK	13B	66028	E9-5213	1983/12/09	M	C	KUUJJUARAAPIK
ITTOSHAT	SAVANA ANITA	13A	66192	E9-3054	1985/01/04	F	C	KUUJJUARAAPIK
ITTOSHAT	TIMOTHY QUMAK JR.	13B	65911	E9-4245	1983/06/04	M	C	KUUJJUARAAPIK
ITTOSHAT (SHAUK	MALAYA	12A	60508	E9-2842	1961/01/12	F	M	KUUJJUARAAPIK
KAVIK	ANNIE	12A	60283	E9-65	1944/08/19	F	I	HORS DU TERRITOIRE
KAVIK	ELIJAH	12A	60282	E9-153	1947/04/04	M	I	HORS DU TERRITOIRE
KAVIK	IDA	13A	65012	E9-4443	1976/01/07	F	C	HORS DU TERRITOIRE
KITISHIMIK	JOSEPH	12A	60286	E9-588	1955/05/13	M	I	KUUJJUARAAPIK
KOKIAPIC	ALICE	13A	65014	E9-4515	1976/02/20	F	C	KUUJJUARAAPIK
KOKIAPIC	LAZARUSSIE	12A	60302	E9-3833	1970/03/11	M	C	KUUJJUARAAPIK
KOKIAPIC	MINA	12A	60300	E9-291	1932/03/14	F	I	KUUJJUARAAPIK
KOKIAPIC-DELMAI	ROGER JOHN	13A	64692	E9-5148	1980/12/22	M	C	KUUJJUARAAPIK
KOWCHARLIE	CHARLIE	12A	60431	E9-2477	1956/09/09	M	I	KUUJJUARAAPIK
KOWCHARLIE	DAISY	12A	60307	E9-3812	1961/03/15	F	I	HORS DU TERRITOIRE
KOWCHARLIE	DAVIDEE	12A	60305	E9-3040	1963/03/01	M	I	HORS DU TERRITOIRE
KOWCHARLIE	ISAAC	12A	60432	E9-2821	1960/05/04	M	I	KUUJJUARAAPIK

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KOWCHARLIE	JEANNIE	12A	60306	E9-3302	1965/03/23	F	I	HORS DU TERRITOIRE
KOWCHARLIE	LOUISA	12A	60304	E9-64	1941/01/15	F	I	HORS DU TERRITOIRE
KOWCHARLIE	SOLOMONIE	12A	60308	E9-3832	1970/02/28	M	C	HORS DU TERRITOIRE
KOWCHARLIE	THOMASSIE	12A	60303	E9-1729	1928/05/25	M	I	HORS DU TERRITOIRE
KUDLORJUK	THOMASSIE	12A	60315	E9-1972	1951/10/14	M	I	HORS DU TERRITOIRE
KUDLU	GEORGE	12A	60310	E9-1083	1944/03/03	M	I	KUUJJUARAAPIK
KUDLU	GEORGE TOMMY	12A	60313	E9-3837	1970/06/15	M	C	KUUJJUARAAPIK
KUDLU	HARRY ITTUAPIK	13A	67446	E9-5295	1991/01/20	M	C	KUUJJUARAAPIK
KUDLU	JEANNIE	12A	60312	E9-3809	1969/01/30	F	C	KUUJJUARAAPIK
KUDLU	LOUISA	12A	60311	E9-436	1945/11/15	F	I	KUUJJUARAAPIK
KUDLU	LUCAS	13B	65994	E9-5212	1983/11/27	M	C	KUUJJUARAAPIK
KUDLU	NOAH	13A	65015		1975/04/24	M	C	KUUJJUARAAPIK
KULULA	CHANTAL QULLIK	13A	67316		1989/06/16	F	C	KUUJJUARAAPIK
KULULA	ELISAPEE LEVINA	12A	62789	E8-1447	1968/04/21	F	I	KUUJJUARAAPIK
KUMARLUK	DAVIDEE	12A	60319	E9-2216	1952/11/30	M	I	KUUJJUARAAPIK
KUMARLUK	JEREMIAH EDDY	12A	60327	E9-3091	1963/06/13	M	I	KUUJJUARAAPIK
KUMARLUK	MINNIE	12A	60317	E9-2893	1962/02/12	F	I	HORS DU TERRITOIRE
KUMARLUK	PETER	12A	60336	E9-2454	1956/02/15	M	I	KUUJJUARAAPIK
KUMARLUK	TOMMY	12A	60322	E9-2496	1956/09/01	M	I	KUUJJUARAAPIK
KUMARLUK-KRISTE	KEVIN	13A	67253		1989/02/24	M	C	IVUJIVIK
KUMARLUK-WEETAL	VICTOR SAM	13A	66972		1988/06/16	M	C	KUUJJUARAAPIK
LOUTTIT	LILYBELLE EDITH	13C	67415		1959/10/05	F	M	KUUJJUARAAPIK
MACDONALD	CHRISTOPHER LAWSON ALEC	13A	60335		1976/03/14	M	C	KUUJJUARAAPIK
MACDONALD	LOUISA (TUCKATUCK)	12A	60332	E9-505	1950/05/04	F	I	KUUJJUARAAPIK
MACDONALD	MINA TERRI MAGGIE	13A	66246	E9-5172	1985/07/08	F	C	KUUJJUARAAPIK
MACDONALD	NATASHA ITA	12A	60334		1974/03/01	F	C	KUUJJUARAAPIK
MACDONALD	PETER JR.	13A	64838		1977/07/10	M	C	HORS DU TERRITOIRE
MACDONALD	RAY PETER LAWSON	13C	65016		1945/04/22	M	I	KUUJJUARAAPIK
MACDONALD	ROSE ANNE	12A	60333	E9-3348	1971/08/15	F	C	KUUJJUARAAPIK
MATTE	LIZZIE AMIAKO	12A	65595		1941/10/07	F	S	KUUJJUARAAPIK
MEEKO	AGNES	12A	60337	E9-2480	1956/01/17	F	I	KUUJJUARAAPIK
MEEKO	ALICE	12A	60344	E9-2306	1956/01/27	F	I	KUUJJUARAAPIK
MEEKO	ALICE	12A	65668	E9-4094	1954/02/11	F	C	KUUJJUARAAPIK
MEEKO	BILLY	12A	60345	E9-4094	1972/10/14	M	C	KUUJJUARAAPIK
MEEKO	ERIC	13A	64782		1976/10/16	M	C	KUUJJUARAAPIK
MEEKO	JOHNNY	12A	60342	E9-2868	1961/02/09	M	I	KUUJJUARAAPIK
MEEKO	LOUISA	12A	60343	E9-3553	1968/04/24	F	I	KUUJJUARAAPIK
MEEKO	LUCY	12A	60340	E9-319	1929/08/11	F	I	KUUJJUARAAPIK
MEEKO	LUCY ANN	13A	66006	E9-5215	1984/01/05	F	C	KUUJJUARAAPIK
MEEKO	MARKOSSIE	12A	60341	E9-2499	1957/08/17	M	I	KUUJJUARAAPIK
MEEKO	MARY ATTITUQ	13A	65756	E9-4680	1977/12/03	F	C	KUUJJUARAAPIK
MEEKO	NOAH	12A	60339	E9-318	1928/01/15	M	I	KUUJJUARAAPIK
MEEKO	RAY	13A	65017	E9-4638	1976/05/14	M	C	KUUJJUARAAPIK
MENARICK	ARNACTUK (BRIDGET)	13A	66147	E9-5158	1984/10/10	F	C	KUUJJUARAAPIK
MENARICK	BILLY BOBY	12A	60034	E9-652	1958/09/18	M	M	KUUJJUARAAPIK

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MENARICK	ERIC	13A	64804		1981/12/12	M	C	KUUJJUARAAPIK
MENARICK	JEFFREY DAVID	12A	60061	E9-4519	1972/07/29	M	C	KUUJJUARAAPIK
MENARICK	JIMMY PETER	12A	60036	E9-2872	1961/10/19	M	I	KUUJJUARAAPIK
MENARICK	MOSES	12A	60028	E9-612	1917/01/01	M	I	KUUJJUARAAPIK
MENARICK	NELLIE AGNES	12A	60038	E9-2884	1963/12/15	F	I	KUUJJUARAAPIK
MENARICK	PAUL DANIEL	13B	64605		1978/04/19	M	C	KUUJJUARAAPIK
MENARICK (FLEMI	LIZA MINA	12A	60033	E9-645	1954/04/10	F	M	KUUJJUARAAPIK
MICKEYOOK	CAROLINE	13A	64828		1981/08/06	F	C	HORS DU TERRITOIRE
MICKEYOOK	DANIEL	12A	60346	E9-552	1955/03/29	M	I	KUUJJUARAAPIK
MICKEYOOK	DORA EVA	12A	60353	E9-3840	1970/08/28	F	C	KUUJJUARAAPIK
MICKEYOOK	JIMMY	13A	64827		1980/08/02	M	C	HORS DU TERRITOIRE
MICKEYOOK	JOHNNY	12A	60352	E9-3331	1965/11/27	M	I	KUUJJUARAAPIK
MICKEYOOK	MARY	12A	60235	E9-553	1955/06/14	F	I	KUUJJUARAAPIK
MICKEYOOK	MARY	13A	64825		1975/04/15	F	C	HORS DU TERRITOIRE
MICKEYOOK	MINA	12A	60349	E9-325	1932/09/26	F	I	KUUJJUARAAPIK
MICKEYOOK	MOSES CHARLIE	13A	64826		1977/11/07	M	C	HORS DU TERRITOIRE
MICKEYOOK	PETER	12A	60350	E9-2523	1958/07/10	M	I	KUUJJUARAAPIK
MICKEYOOK	QUENTIN LEVI	13A	65581	E9-4666	1977/03/11	M	C	KUUJJUARAAPIK
MICKEYOOK	SAM	12A	60348	E9-305	1930/04/03	M	I	KUUJJUARAAPIK
MICKEYOOK	SARAH	12B	64790		1952/12/23	F	M	HORS DU TERRITOIRE
MICKEYOOK	SARAH MIMI	13A	64616	E9-5118	1978/09/27	F	C	KUUJJUARAAPIK
MICKEYOOK	WINNIE	12A	60351	E9-3267	1964/03/15	F	I	KUUJJUARAAPIK
MIKPEGAK	EMILY	12A	60354	E9-554	1955/06/20	F	I	KUUJJUARAAPIK
MIKPEGAK	JOHNNY	12A	60361	E9-3446	1967/07/17	M	I	KUUJJUARAAPIK
MIKPEGAK	LOUISA	12A	60360	E9-2818	1960/04/10	F	I	KUUJJUARAAPIK
MIKPEGAK	PAULOSSIE	12A	60359	E9-2519	1958/05/01	M	I	KUUJJUARAAPIK
MIKPEGAK	RAYMOND GEORGE	13A	64610	E9-4673	1977/08/02	M	C	KUUJJUARAAPIK
MIKPEGAK	SAMWILLIE	12A	60357	E9-312	1922/05/22	M	I	KUUJJUARAAPIK
MULUCTO	CHARLIE	12A	60364	E9-2807	1959/09/29	M	M	KUUJJUARAAPIK
MULUCTO	JACOB ANDREW	12A	60368	E9-3843	1970/10/15	M	C	KUUJJUARAAPIK
MULUCTO	JEANNIE	12A	60363	E9-224	1929/02/14	F	I	KUUJJUARAAPIK
MULUCTO	JOSEPH JOE LOUIS	13A	67448	E9-5301	1990/11/01	M	C	KUUJJUARAAPIK
MULUCTO	LOUISA	12A	60367	E9-3562	1968/07/23	F	I	KUUJJUARAAPIK
MULUCTO	MALAYA	12A	60366	E9-3290	1964/12/14	F	I	KUUJJUARAAPIK
MULUCTO	SAM	13B	64862		1982/11/01	M	C	KUUJJUARAAPIK
MULUCTO	SARAH	12A	60365	E9-3072	1963/02/06	F	I	KUUJJUARAAPIK
NAPARTUK	ALEC	12A	60378	E9-2548	1959/04/08	M	M	KUUJJUARAAPIK
NAPARTUK	ALEC	13A	66680		1984/08/09	M	C	KUUJJUARAAPIK
NAPARTUK	ANNIE	12A	60382	E9-3835	1970/04/06	F	C	KUUJJUARAAPIK
NAPARTUK	CAROLINE	12A	60377	E9-287	1935/01/01	F	I	KUUJJUARAAPIK
NAPARTUK	DINAH SAMANTHA	13A	66661	E9-5182	1986/08/12	F	C	KUUJJUARAAPIK
NAPARTUK	ESTHER LUCY	13B	66353	E9-6052	1986/01/11	F	C	KUUJJUARAAPIK
NAPARTUK	JOHNASSIE	12A	60383	E9-4078	1972/03/19	M	C	KUUJJUARAAPIK
NAPARTUK	MAGGIE	12A	60381	E9-3330	1965/11/25	F	I	KUUJJUARAAPIK
NAPARTUK	MARY	12A	60926	E9-2690	1963/06/07	F	I	KUUJJUARAAPIK

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NAPARTUK	PAULOSSIE	12A	60376	E9-1651	1928/01/10	M	I	KUUJJUARAAPIK
NAPARTUK	TOMMY	13A	64725	E9-4212	1982/01/17	M	C	KUUJJUARAAPIK
NAPARTUK (FLEMI	DINAH	12A	60230	E9-2538	1959/01/10	F	M	KUUJJUARAAPIK
NARLIK	ALEXANDRA LIZZIE	13A	65018	E9-4517	1976/03/10	F	C	HORS DU TERRITOIRE
NARLIK	ALICE MARY	13A	64805	E9-4219	1982/07/03	F	C	HORS DU TERRITOIRE
NARLIK	ANNIE	13A	65582	E9-4670	1977/04/24	F	C	HORS DU TERRITOIRE
NARLIK	DANIEL SAPPA	13A	66021	E9-5216	1984/02/04	M	C	HORS DU TERRITOIRE
NARLIK	LUCY	12A	60388	E9-2206	1952/10/01	F	I	HORS DU TERRITOIRE
NARLIK	SARAH	12A	60389	E9-4086	1972/08/14	F	C	HORS DU TERRITOIRE
NIVIAXIE	ALICE	13A	66675	E9-5191	1987/04/21	F	C	KUUJJUARAAPIK
NIVIAXIE	ANNIE	12A	60393	E9-2219	1952/11/02	F	I	KUUJJUARAAPIK
NIVIAXIE	ANNIE	12A	60405	E9-3345	1966/03/18	F	I	HORS DU TERRITOIRE
NIVIAXIE	CAROLINE	12A	60410	E9-579	1952/11/05	F	I	KUUJJUARAAPIK
NIVIAXIE	CHARLES DARCY	13A	65019		1975/11/28	M	C	KUUJJUARAAPIK
NIVIAXIE	CORNELIUS	12A	60391	E9-2823	1960/05/19	M	M	KUUJJUARAAPIK
NIVIAXIE	JACKO QUARAK	13A	64591		1980/10/05	M	C	KUUJJUARAAPIK
NIVIAXIE	JACKOSIE	12A	60394	E9-3844	1970/10/21	M	C	KUUJJUARAAPIK
NIVIAXIE	JEANNIE	12A	60404	E9-435	1945/05/31	F	I	HORS DU TERRITOIRE
NIVIAXIE	JEREMIAH	12A	60403	E9-1545	1947/07/24	M	I	HORS DU TERRITOIRE
NIVIAXIE	JEREMY	13A	66672	E9-5180	1985/12/10	M	C	KUUJJUARAAPIK
NIVIAXIE	MARKOSSIE	13A	66144	E9-5155	1984/11/15	M	C	KUUJJUARAAPIK
NIVIAXIE	MYVA	12A	60409	E9-1903	1950/09/06	M	I	KUUJJUARAAPIK
NIVIAXIE	PAULOSSIE	13A	66749	E9-5188	1986/11/10	M	C	KUUJJUARAAPIK
NIVIAXIE	PETER	12A	60392	E9-3431	1967/01/16	M	I	KUUJJUARAAPIK
NIVIAXIE	RAINA	13A	66046		1984/05/30	F	C	KUUJJUARAAPIK
NIVIAXIE	SILAS	13A	64806		1982/09/06	M	C	KUUJJUARAAPIK
NIVIAXIE	SILASSIE	12A	60411	E9-732	1930/08/27	M	I	KUUJJUARAAPIK
NIVIAXIE	ZACHARIAS	12A	60395	E9-2461	1956/02/06	M	M	KUUJJUARAAPIK
NIVIAXIE (ANGAT	DORA	12A	60089	E9-2848	1961/02/11	F	M	KUUJJUARAAPIK
NIVIAXIE (NUKTI	NELLIE	12A	60444	E9-3301	1965/03/17	F	M	KUUJJUARAAPIK
NOVALINGA	CAROLINE	13A	65584		1977/03/03	F	C	KUUJJUARAAPIK
NOVALINGA	LOUISA	13A	64833		1981/05/27	F	C	HORS DU TERRITOIRE
NOVALINGA	MARY	12A	60413	E9-62	1911/01/01	F	I	KUUJJUARAAPIK
NOVALINGA	SARAH EMILY	13A	64832		1979/05/28	F	C	HORS DU TERRITOIRE
NOVALINGA (PALL	MARY	13B	64863		1982/10/31	F	C	HORS DU TERRITOIRE
NOWRA	ABELIE	12A	60420	E9-892	1936/05/28	M	I	KUUJJUARAAPIK
NOWRA	JOHNNY	12A	61000	E9-2128	1954/08/02	M	I	INUKJUAK
NOWRA	JOHNNY	13A	64807		1982/01/23	M	C	INUKJUAK
NOWRA	JOSEPH	12A	60423	E9-3804	1968/12/01	M	I	KUUJJUARAAPIK
NOWRA	SARAH	12A	60421	E9-1736	1938/04/02	F	I	KUUJJUARAAPIK
NUKTIE	CHARLIE	12A	60438	E9-534	1954/03/10	M	M	CHISASIBI I
NUKTIE	DANIEL	12A	60073	E9-3069	1962/12/19	M	I	UMIUJAQ
NUNGA	MAGGIE QUMALU	12A	61524	E9-2052	1955/02/25	F	I	POVUNGNITUK
PALLISER	JESSICA ALICE	13A	66251	E9-5176	1985/08/23	F	C	INUKJUAK
PALLISER	LEAH	13A	64781		1981/03/18	F	C	INUKJUAK

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PALLISER	LOUISA	12A	61453	E9-2661	1961/09/23	F	I	INUKJUAK
PAPYARLUK	LOUIS ALEC	13B	66930	E9-5241	1988/04/23	M	C	KUUJJUARAAPIK
PAPYARLUK	TILLIE	12A	60452	E9-1302	1952/10/30	F	I	KUUJJUARAAPIK
QAKQUTUK (FLEMI	MINA NIRIJJA	12A	61599	E9-2572	1958/11/20	F	M	KUUJJUARAAPIK
QUARAK	ALEC	12A	60454	E9-3312	1965/06/24	M	M	KUUJJUARAAPIK
QUARAK	ANITA MARY	13A	66670	E9-5184	1986/09/23	F	C	KUUJJUARAAPIK
QUARAK	ANNIE	12A	60453	E9-92	1932/05/15	F	I	KUUJJUARAAPIK
QUARAK	ANNIE LUCY SAVANNA	13A	67320		1990/02/08	F	C	KUUJJUARAAPIK
QUARAK	ANNIE MARY ANN	13A	67033	E9-5251	1989/01/13	F	C	KUUJJUARAAPIK
QUARAK	CAROLINE	12A	60463	E9-4074	1972/01/17	F	M	KUUJJUARAAPIK
QUARAK	CHARLIE	12A	60457	E9-3432	1967/01/20	M	I	KUUJJUARAAPIK
QUARAK	CHARLIE	12A	60458	E9-53	1936/01/07	M	I	KUUJJUARAAPIK
QUARAK	ELIZABETH	12A	60465	E9-428	1932/06/06	F	I	KUUJJUARAAPIK
QUARAK	ERIK JOE	13B	66143	E9-5224	1984/07/01	M	C	KUUJJUARAAPIK
QUARAK	IMA	13B	66142	E9-5223	1984/07/02	F	C	KUUJJUARAAPIK
QUARAK	JIMMY	12A	60456	E9-3097	1963/08/26	M	M	KUUJJUARAAPIK
QUARAK	LUCY	12A	60461	E9-3292	1964/12/30	F	I	KUUJJUARAAPIK
QUARAK	MARY	12A	60459	E9-1050	1943/07/02	F	I	KUUJJUARAAPIK
QUARAK	MIVA	12A	60460	E9-3255	1963/11/17	M	I	KUUJJUARAAPIK
QUARAK	PETER CROW	13A	64694	E9-5114	1978/08/06	M	C	KUUJJUARAAPIK
QUARAK	SAMWILLIE	12A	60464	E9-96	1942/02/15	M	I	KUUJJUARAAPIK
RAYSON	KYLE RICHARD	13A	67246		1989/01/10	M	C	HORS DU TERRITOIRE
RIBAIRO	MANUEL	13C	64817		1957/03/23	M	M	HORS DU TERRITOIRE
ROUSSEL	JULIAN CHARLIE	13B	67123	E9-5254	1989/04/10	M	C	KUUJJUARAAPIK
ROUSSEL	PIERRE	13C	66190		1956/05/09	M	M	KUUJJUARAAPIK
ROUSSEL	VICKY	13A	66250	E9-5177	1985/10/04	F	C	KUUJJUARAAPIK
ROUSSEL (FLEMIN	MARY	12A	60208	E9-2508	1958/03/16	F	M	KUUJJUARAAPIK
ROUSSEL (WEETAL	MINA	13B	66191	E9-5250	1985/04/08	F	C	KUUJJUARAAPIK
SALA	ALICE	12A	60471	E9-4092	1972/10/10	F	C	HORS DU TERRITOIRE
SALA	ANNIE IRQUASIAQ	13A	64611	E9-5101	1977/12/23	F	C	KUUJJUARAAPIK
SALA	CHARLIE	12A	60483	E9-4109	1973/06/17	M	C	KUUJJUARAAPIK
SALA	ELIJA SIMON	13A	64831		1982/09/01	M	C	HORS DU TERRITOIRE
SALA	HARRY	12A	60469	E9-1417	1946/10/06	M	I	HORS DU TERRITOIRE
SALA	ISAAC	12A	60481	E9-3824	1969/08/30	M	C	KUUJJUARAAPIK
SALA	JEREMIAH	12A	60473	E9-1722	1938/12/29	M	I	KUUJJUARAAPIK
SALA	JOANASSIE	13A	65021	E9-4144	1975/04/15	M	C	KUUJJUARAAPIK
SALA	MAGGIE	12A	60470	E9-229	1945/02/20	F	I	HORS DU TERRITOIRE
SALA	MARKOSSIE	12A	60477	E9-1691	1944/04/10	M	I	KUUJJUARAAPIK
SALA	MARKOSSIE	13A	65587	E9-4644	1976/11/08	M	C	HORS DU TERRITOIRE
SALA	MARY	12A	60472	E9-4121	1973/12/12	F	C	HORS DU TERRITOIRE
SALA	MARY CAROLINE	13A	64829		1980/04/22	F	C	HORS DU TERRITOIRE
SALA	PETER	13A	64830	E9-5127	1979/01/27	M	C	HORS DU TERRITOIRE
SALA	RHODA	12A	60478	E9-205	1943/11/18	F	I	KUUJJUARAAPIK
SALA	SAMWILLIE	12A	60479	E9-3413	1966/08/09	M	I	KUUJJUARAAPIK
SALA	SARAH	12A	60480	E9-3565	1968/08/09	F	I	KUUJJUARAAPIK

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SALA	SARASSIE	12A	60482	E9-4065	1971/09/25	F	C	KUUJJUARAAPIK
SAPPA	DAVIDEE	12A	60502	E9-325	1930/06/17	M	I	KUUJJUARAAPIK
SAPPA	ELIZABETH	12A	60504	E9-4060	1971/06/03	F	C	KUUJJUARAAPIK
SAPPA	WILLIE	12A	60301	E9-2531	1959/10/15	M	I	KUUJJUARAAPIK
SHAUK	LEVI	13A	66682	E9-5146	1980/10/09	M	C	KUUJJUARAAPIK
SHAUK	MINNIE	12A	60507	E9-2479	1956/09/15	F	I	KUUJJUARAAPIK
SHAUK	PAULOSSIE	12A	60506	E9-328	1918/12/20	M	I	KUUJJUARAAPIK
SHIELDS (WEETAL	KAREN MADONNA	12B	64860		1974/01/29	F	C	HORS DU TERRITOIRE
SHIELDS (WEETAL	KEITH RUPERT	12B	64880		1971/03/21	M	C	KUUJJUARAAPIK
SHIELDS (WEETAL	MICHAEL PIERRE	12B	64881		1962/10/16	M	C	HORS DU TERRITOIRE
SHIELDS (WEETAL	WANDA	12B	64882		1967/01/28	F	C	HORS DU TERRITOIRE
SHIELDS TUKKIAP	SANDRA	13A	66973		1988/01/14	F	C	KUUJJUARAAPIK
SIMARD	MIGUEL	13C	66977		1962/12/05	M	M	KUUJJUARAAPIK
SREPEL	DANIEL	13A	64601	E9-5145	1980/07/24	M	C	KUUJJUARAAPIK
SREPEL	MARY	12A	65773	E9-2502	1957/09/29	F	I	KUUJJUARAAPIK
SREPEL	PAUL	13A	65775	E9-5143	1976/12/28	M	C	KUUJJUARAAPIK
SREPEL	RICHARD CHARLES	13C	65774		1955/10/30	M	I	KUUJJUARAAPIK
SREPEL	SUSAN	13A	65776	E9-5144	1978/07/09	F	C	KUUJJUARAAPIK
STONE (FLEMING)	ANNIE	12A	60231	E9-3332	1966/10/29	F	M	KUUJJUARAAPIK
SURUSILA	MINA PULUMAQ	13A	66927	E9-5236	1988/04/17	F	C	KUUJJUARAAPIK
SURUSILA	TAMUSI JOHN GLENN	12A	61812	E9-2949	1962/02/20	M	I	KUUJJUARAAPIK
SURUSILAK	WILLIE	13A	66404	E9-6058	1986/06/02	M	C	KUUJJUARAAPIK
SURUSILAK (FLEM	AGNES	12A	60242	E9-3329	1965/10/24	F	I	KUUJJUARAAPIK
SURUSILAK (FLEM	HARRY DANIEL	13A	66252	E9-5175	1984/03/31	M	C	KUUJJUARAAPIK
SURUSILLA	RICHARD	13A	67405	E9-5287	1990/06/21	M	C	KUUJJUARAAPIK
TOOKALOOK	ADAMIE CHARLIE	13A	67393		1985/10/07	M	C	KUUJJUARAAPIK
TOOKALOOK	ALIVA	13A	66024	E9-5219	1984/02/20	M	C	UMIUJAQ
TOOKALOOK	EMILY	12A	60523	E9-2475	1956/09/01	F	M	UMIUJAQ
TOOKALOOK	ERNEST CHARLES	13A	64628	E9-5125	1979/05/25	M	C	UMIUJAQ
TOOKALOOK	EVELYN LILLIAN	13C	67398		1955/10/20	F	M	KUUJJUARAAPIK
TOOKALOOK	JACOB	12A	60524	E9-532	1954/02/22	M	I	KUUJJUARAAPIK
TOOKALOOK	JACOB ROBBIE GEORGE	13A	67396		1988/08/25	M	C	KUUJJUARAAPIK
TOOKALOOK	JUDY	13A	66751	E9-5196	1986/10/21	F	C	UMIUJAQ
TOOKALOOK	LINDA	12A	60527	E9-460	1958/08/21	F	I	KUUJJUARAAPIK
TOOKALOOK	MARY ANN	12A	60546	E9-2809	1960/01/14	F	I	KUUJJUARAAPIK
TOOKALOOK	NATHALIE WENDY AMANDA	13A	67395		1986/12/12	F	C	KUUJJUARAAPIK
TOOKALOOK	RHODA	12A	60521	E9-2517	1958/04/04	F	I	KUUJJUARAAPIK
TOOKALOOK	RICHARD ISAAC	13A	67394		1984/03/10	M	C	KUUJJUARAAPIK
TOOKTOO	AKINIK SR.	12B	64791		1929/01/24	F	M	HORS DU TERRITOIRE
TOOKTOO	BERNICE J.D.	13A	65918	E9-4239	1983/03/23	F	C	KUUJJUARAAPIK
TOOKTOO	CHARLIE	12A	60552	E9-361	1926/04/01	M	I	KUUJJUARAAPIK
TOOKTOO	CHARLIE	12A	60567	E9-2456	1955/09/05	M	M	UMIUJAQ
TOOKTOO	CHRISTOPHER CHARLES	13A	66999		1988/10/30	M	C	KUUJJUARAAPIK
TOOKTOO	DAPHNE CAROL	13B	64721	E9-5130	1979/10/07	F	C	KUUJJUARAAPIK
TOOKTOO	EDDY DARWIN	13A	66674	E9-5192	1987/02/14	M	C	KUUJJUARAAPIK

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TOOKTOO	GEORGE	13A	64693	E9-4647	1977/08/12	M	C	KUUJJUARAAPIK
TOOKTOO	ISAAC JOSHUA	13A	66289	E9-5178	1985/10/06	M	C	UMIUJAQ
TOOKTOO	JOHN DAVID	12A	60557	E9-3806	1969/01/08	M	C	KUUJJUARAAPIK
TOOKTOO	LIZZIE	12A	60574	E9-3085	1963/05/01	F	I	KUUJJUARAAPIK
TOOKTOO	MAGGIE	12A	60554	E9-2528	1958/09/23	F	I	KUUJJUARAAPIK
TOOKTOO	MARY	12A	60555	E9-3056	1962/06/11	F	I	KUUJJUARAAPIK
TOOKTOO	MICHAEL CLINT	13A	65025	E9-4543	1976/05/24	M	C	KUUJJUARAAPIK
TOOKTOO	MICHEL ANDREWS	13A	66752	E9-5195	1987/05/01	M	C	KUUJJUARAAPIK
TOOKTOO	MINA	12A	60572	E9-317	1937/10/18	F	I	KUUJJUARAAPIK
TOOKTOO	MOSES	12A	60573	E9-2546	1959/04/02	M	M	KUUJJUARAAPIK
TOOKTOO	MOSES	12A	65722	E9-2214	1952/12/29	M	I	KUUJJUARAAPIK
TOOKTOO	NELLIE RHODA	12A	60556	E9-3323	1965/09/12	F	I	KUUJJUARAAPIK
TOOKTOO	PATRICIA JEANNIE	13A	67319	E9-5280	1990/03/17	F	C	KUUJJUARAAPIK
TOOKTOO	PETER	12A	60570	E9-397	1949/06/04	M	I	KUUJJUARAAPIK
TOOKTOO	PETER	12A	60577	E9-4095	1972/11/17	M	C	KUUJJUARAAPIK
TOOKTOO	SAMSON	13A	65757	E9-5116	1978/07/26	M	C	KUUJJUARAAPIK
TOOKTOO	SCOTT ANDRE DONALD	13A	66673		1986/10/29	M	C	KUUJJUARAAPIK
TOOKTOO	SUVAKI NORIKO	13A	65964	E9-5205	1983/10/10	F	C	UMIUJAQ
TOOKTOO	VINCENT BENJAMIN MARK	13A	64718	E9-4204	1981/08/23	M	C	KUUJJUARAAPIK
TOOKTOO	WILLIE	12A	60571	E9-362	1933/04/02	M	I	KUUJJUARAAPIK
TOOKTOO (NUKTIE	ALICE	12A	60441	E9-2527	1958/09/18	F	M	UMIUJAQ
TOOKTOO (SAM)	DEBORAH MARTHA	13C	67416		1960/01/31	F	M	KUUJJUARAAPIK
TOOKTOO-STONE	ERIC PETER	13A	66164	E9-5162	1985/01/13	M	C	KUUJJUARAAPIK
TUCKATUCK	ALEC	12A	60584	E9-505	1948/05/25	M	I	KUUJJUARAAPIK
TUCKATUCK	BETTY BRENDA	13B	64602	E9-4643	1976/10/01	F	C	KUUJJUARAAPIK
TUCKATUCK	EDDY	12A	60582	E9-3317	1965/07/14	M	I	KUUJJUARAAPIK
TUCKATUCK	LEVI	13A	65026	E9-4546	1976/06/06	M	C	KUUJJUARAAPIK
TUCKATUCK	LUCY DINAH	13A	67000		1988/11/13	F	C	KUUJJUARAAPIK
TUCKATUCK	MAGGIE	12A	60585	E9-615	1947/02/09	F	I	KUUJJUARAAPIK
TUCKATUCK	MARILYN SUE	12A	60586	E9-4071	1971/12/12	F	C	KUUJJUARAAPIK
TUCKATUCK	MARY	12A	60583	E9-4054	1972/01/11	F	C	KUUJJUARAAPIK
TUCKATUCK	MINA	12A	60580	E9-2822	1960/05/04	F	I	KUUJJUARAAPIK
TUCKATUCK	SAPPA	12A	60589	E9-3447	1967/09/16	M	M	KUUJJUARAAPIK
TUCKATUCK	SARAH RHODA	13A	67439	E9-5293	1990/12/03	F	C	KUUJJUARAAPIK
TUCKATUCK	SAURUK PETER	13B	66912	E9-5235	1988/04/16	M	C	KUUJJUARAAPIK
TUCKATUCK	SIMEONIE	12B	64785		1955/07/01	M	C	KUUJJUARAAPIK
TUCKATUCK (AMIT	ANNIE	12A	60579	E9-357	1930/03/04	F	M	KUUJJUARAAPIK
TUCKATUCK(BENNE	SARAH	12A	60588	E9-2521	1958/06/08	F	M	KUUJJUARAAPIK
UPPIK	DAVIDEE	12A	60599	E9-193	1951/06/19	M	I	HORS DU TERRITOIRE
UPPIK	JOHNASSIE	12A	60602	E9-3557	1968/05/28	M	I	HORS DU TERRITOIRE
UPPIK	LUCY	12A	60600	E9-215	1935/09/10	F	I	HORS DU TERRITOIRE
UPPIK	SIMON	13A	65027	E9-4516	1976/02/02	M	C	HORS DU TERRITOIRE
UPPIK (VINCENT)	ALICIE	12A	60601	E9-2506	1958/02/04	F	M	KUUJJUARAAPIK
VINCENT	JOEL	13C	64786		1958/11/23	M	M	HORS DU TERRITOIRE
VINCENT	MARK	13A	64739	E9-4211	1981/01/02	M	C	KUUJJUARAAPIK

LISTE: KO3.T810.S50 TABLEAU NO. 01
MINISTERE DE LA SANTE ET DES SERVICES SOCIAUX
REGISTRE DES AUTOCHTONES
LISTE OFFICIELLE DES BENEFICIAIRES SELON LES COMMUNAUTES D'AFFILIATION

SELON LE FICHIER EN DATE DU 1991 07 03

PEUPLE INUIT — AFFILIATION: KUUJJUARAAPIK

NOM	PRENOM(S)	ADM.	NUMERO BENEF.	NUMERO DISQUE	DATE NAISSANCE	SEXE	STATUT	COMMUNAUTE DE RESIDENCE
VINCENT	SUSIE LUCY	13A	64603	E9-5138	1980/01/28	F	C	KUUJJUARAAPIK
VISITOR	MARTY JOHN	13A	66022		1982/07/25	M	C	KUUJJUARAAPIK
WEETALTUIK	SAPPA RODERICK	13A	67427	E9-5290	1990/09/05	M	C	KUUJJUARAAPIK
WEETALTUK	ABELIE	13A	67244		1989/09/06	M	C	KUUJJUARAAPIK
WEETALTUK	ALEC RUPERT	13A	67048	E9-5253	1989/03/13	M	C	KUUJJUARAAPIK
WEETALTUK	ALICE	12A	60621	E9-234	1945/02/02	F	I	KUUJJUARAAPIK
WEETALTUK	ANNIE	12A	60606	E9-3810	1969/02/19	F	I	KUUJJUARAAPIK
WEETALTUK	ANNIE	12A	60610	E9-343	1938/04/08	F	I	KUUJJUARAAPIK
WEETALTUK	BILLY	12A	60053	E9-443	1933/04/20	M	I	KUUJJUARAAPIK
WEETALTUK	BILLY	12A	60603	E9-402	1921/08/04	M	I	KUUJJUARAAPIK
WEETALTUK	CAROLINE	12A	60605	E9-2890	1962/01/17	F	I	KUUJJUARAAPIK
WEETALTUK	CAROLINE	13A	66403	E9-6057	1986/07/06	F	C	KUUJJUARAAPIK
WEETALTUK	CHARLIE	12A	60614	E9-450	1949/11/12	M	I	KUUJJUARAAPIK
WEETALTUK	CLAYTON	13A	67245	E9-5271	1989/10/01	M	C	KUUJJUARAAPIK
WEETALTUK	DANIEL JOHNNY	13A	65919	E9-4240	1983/05/14	M	C	KUUJJUARAAPIK
WEETALTUK	DAVID	12A	60609	E9-408	1929/12/25	M	I	KUUJJUARAAPIK
WEETALTUK	DINAH	13A	65028	E9-4513	1976/01/12	F	C	KUUJJUARAAPIK
WEETALTUK	DORA JEAN	12A	60625	E9-3816	1969/04/30	F	C	KUUJJUARAAPIK
WEETALTUK	EDDY	12A	60607	E9-422	1932/03/19	M	I	UMIUJAQ
WEETALTUK	GEORGE	12A	60612	E9-3275	1964/06/05	M	I	KUUJJUARAAPIK
WEETALTUK	GILBERT	12A	60623	E9-3424	1966/11/30	M	I	KUUJJUARAAPIK
WEETALTUK	IRENE SHARON	12A	60057	E9-3438	1968/03/23	F	I	KUUJJUARAAPIK
WEETALTUK	JAMES	12A	60626	E9-4063	1971/07/14	M	C	KUUJJUARAAPIK
WEETALTUK	JEANNIE ALICE	13A	65588	E9-4671	1977/04/26	F	C	KUUJJUARAAPIK
WEETALTUK	JOHNNY	12A	60630	E9-3272	1964/05/13	M	M	KUUJJUARAAPIK
WEETALTUK	JOHNNY WILLIE	13A	64633	E9-5137	1980/04/07	M	C	KUUJJUARAAPIK
WEETALTUK	LINDY WALTER	12A	60060	E9-4521	1974/04/04	M	C	KUUJJUARAAPIK
WEETALTUK	LIZZIE	12A	60616	E9-1046	1935/11/12	F	I	KUUJJUARAAPIK
WEETALTUK	LOUISA	13A	67458	E9-5298	1991/02/08	F	C	KUUJJUARAAPIK
WEETALTUK	MAGGIE	13A	64811	E9-4207	1981/10/17	F	C	KUUJJUARAAPIK
WEETALTUK	MALAYA	12A	60617	E9-420	1916/06/02	F	I	KUUJJUARAAPIK
WEETALTUK	MARK	12A	60618	E9-437	1947/01/23	M	I	KUUJJUARAAPIK
WEETALTUK	MARY	12A	60624	E9-3538	1968/01/07	F	I	KUUJJUARAAPIK
WEETALTUK	MARY (BOBBISH)	12A	60054	E9-3825	1940/08/31	F	I	KUUJJUARAAPIK
WEETALTUK	MAURICE DWIGHT	13A	65971		1967/01/22	M	C	KUUJJUARAAPIK
WEETALTUK	MINA	12A	60604	E9-414	1919/07/03	F	I	KUUJJUARAAPIK
WEETALTUK	MINA	12A	60629	E9-442	1946/12/22	F	I	KUUJJUARAAPIK
WEETALTUK	MINNIE	13A	64630	E9-5124	1979/02/28	F	C	KUUJJUARAAPIK
WEETALTUK	REDFERN FREDDY	12A	60055	E9-3266	1964/02/27	M	I	KUUJJUARAAPIK
WEETALTUK	RICHARD ROBERT	12A	60059	E9-3265	1972/08/25	M	C	KUUJJUARAAPIK
WEETALTUK	RICKY THOMAS	13A	66779	E9-5198	1987/04/05	M	C	KUUJJUARAAPIK
WEETALTUK	RUPERT	12A	60620	E9-434	1939/09/09	M	I	KUUJJUARAAPIK
WEETALTUK	SANDRA LYNN	12A	60058	E9-3561	1969/11/13	F	M	KUUJJUARAAPIK
WEETALTUK	SERENA KATHY	13A	66219	E9-5248	1985/03/23	F	C	KUUJJUARAAPIK
WEETALTUK	THOMAS	12A	60613	E9-3333	1965/11/29	M	I	KUUJJUARAAPIK

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NOM	PRENOM(S)	ADM.	NUMERO BENEF.	DISQUE	DATE NAISSANCE	SEXE	STATUT	COMMUNAUTE DE RESIDENCE
WEETALTUK	THOMASSIE	12A	60628	E9-429	1933/03/10	M	I	KUUJJUARAAPIK
WEETALTUK	TINA ROSE	13A	65001	E9-4524	1975/05/20	F	C	KUUJJUARAAPIK
WEETALTUK	TOMMY RUDOLF	12A	60611	E9-2891	1962/01/30	M	I	KUUJJUARAAPIK
WEETALTUK	WINNIE LISA	13A	67049	E9-5252	1989/03/11	F	C	KUUJJUARAAPIK
WHITESIDE	BRIAN	13C	64861		1953/06/04	M	M	HORS DU TERRITOIRE

TOTAL DE L'AFFILIATION KUUJJUARAAPIK 545

ANNEX 17

Gouvernement du Québec
Ministère de la Santé et des Services sociaux
Direction générale de la prévention et des services communautaires

+ document

ANNEX 16

UNOFFICIAL ENGLISH TRANSLATION OF A LETTER DATED DECEMBER 20, 1990, ADDRESSED BY MONSIEUR MAURICE BOISVERT, SOUS-MINISTRE ADJOINT, TO MRS. LIZZIE EPOO-YORK, GENERAL MANAGER, KATIVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES, P.O. BOX 9, KUUJJUAQ (QC) J0M 1C0

RE: Non-insured services

Madam,

Subsequent to the discussions that have taken place between the representatives of the ministère de la Santé et des Services sociaux, the hospital centers in the Kativik region (10-A) and your organization, I am sending you certain documents concerning the provision of non-insured services to be furnished free of charge to the Inuit who are beneficiaries of the James Bay and Northern Québec Agreement. Those documents - although of a temporary nature - will help institute the program in its entirety.

In order to harmonize the financing and administration of such services, we have consulted with the Department of National Health and Welfare Canada. Further, the ministère de la Santé et des Services sociaux has decided to entrust the administration of such services to the Régie de l'assurance-maladie du Québec.

We are counting on your organization and the regional establishments to carry out the work this dossier involves.

Thank you for your collaboration.

JAN 18 1991

Unofficial Translation from French into English
March 11, 1991

PROGRAM FOR UNINSURED HEALTH SERVICES

GENERAL INFORMATION

Ministère de la Santé et des Services sociaux

Service de liaison avec les régions nordiques
et les communautés autochtones

Quebec City

December 1990

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GENERAL INFORMATION

1. Target populations

This temporary framework concerns the Cree, Inuit and Naskapi beneficiaries of the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement who are registered on the list of beneficiaries permanently residing in the designated regions.

Those beneficiaries temporarily residing outside of these regions in order to study, to participate in training programs or upgrading courses, or to work for a native organization having its corporate seat outside the regions are also eligible.

(Section 3 of the James Bay and Northern Québec Agreement).

2. Objectives

The objective of this document is to provide information regarding the health services to which the beneficiaries are entitled.

3. General considerations regarding existing programs

All Quebec residents are eligible for health services covered under the Quebec health insurance and hospitalization insurance plans, including the Cree, Naskapi and Inuit.

Access to these services is guaranteed through the health insurance card (carte-soleil) issued by the Régie de l'assurance-maladie du Québec (RAMQ-Quebec health insurance board); it is important to safeguard this card.

4. Responsibilities of the ministère de la Santé et des Services sociaux

When these two agreements were signed, the Government of Quebec committed itself to providing the native people in the regions contemplated with the insured and uninsured services that were previously dispensed by National Health and Welfare Canada.

5. Administration of services according to populations

The following regional structure allows all the residents contemplated by the health and social services programs to be reached.

5.1 Cree

The James Bay Regional Council of Health and Social Services has its corporate seat in Chisasibi and is responsible for the following villages:

Whapmagoostui
Chisasibi
Wemindji
Eastmain
Ouje-Bougoumou
Mistassini
Waswanipi
Nemaska
Waswaganish

5.2 Inuit

The Kativik Regional Council of Health and Social Services, whose corporate seat is located in Kuujjuaq, plans the health and social services for the region, which is divided into two:

a) Inuulitsivik, Povungnituk, Hudson Bay, which provides services to the following villages:

Kuujjuarapik
Umiujaq
Inukjuak
Salluit
Povungnituk
Akulivik
Ivujivik

b) Ungava Hospital, Kuujjuaq, which serves the following communities:

Kangiqsujuaq
Quaqtaq
Kangirsuk
Aupaluk
Tasiujaq
Kuujjuaq
Kangiqsualujjuaq

c) Naskapi

The Kawawachikamach nursing station falls under the administrative jurisdiction of the Fermont CLSC, which is responsible for paying and administering the health and social services provided to Quebec's Naskapi.

6. Definition of uninsured services

A limited number of goods and services that are not already provided to the beneficiaries of the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement by other organizations or programs.

The main services currently not insured are:

a) medication and other supplies;
b) transportation for health reasons, escorts, interpreters, lodging;
c) prescription eyeglasses;
d) dental care;
e) hearing aids.

7. Uncovered services

The following services are not covered:

a) a private or semi-private room requested by the patient;
b) surgery and other care for purely esthetic reasons;
c) pharmaceutical, dietetic or cosmetic products (not included in the drug policy);
d) treatment outside the country unless approved by the Régie;
e) artificial insemination, in vitro insemination, honoraria for abortion.

8. Conclusion

In order to have access to health services, the patient must:

a) have in his/her possession a health insurance card (carte-soleil);

b) have his/her status as a beneficiary under the James Bay and Northern Québec Agreement or the Northeastern Québec Agreement clearly established.

MEDICATION

Policy regarding the dispensing of medication,
pharmaceutical services and materials
required for administering medication

1. OBJECT

The object of the services described below is to assist beneficiaries in obtaining drugs prescribed by a physician, dentist or according to local treatment protocols, as well as pharmaceutical services and the materials necessary for administering these drugs for the treatment or prevention of an illness.

CATEGORY OF INSURED DRUG:

2.0 SERVICES

2.1 Drugs sold on prescription

Drugs which the provincial law stipulates must be obtained through prescription and which are considered medically necessary by the treating physician or dentist.

Drugs which may not necessarily require a prescription according to provincial law, but which are normally given through prescription, for example, insulin.

2.2 Drugs available to the public

The categories of drugs available to the public at large and with a drug identification number and a therapeutic or diagnostic purpose:

a) analgesics and antipyretics
b) antacids and antiflatulents
c) antidiarrhoeals and antiemetics
d) antihistamines and decongestants
e) antiparasitics
f) antitussives and expectorants
g) local antibiotics

h) vitamins in therapeutic doses to treat specific pathologies: pregnant women, nursing babies
i) fluoride for children
j) laxatives
k) dermatological preparations (including topical anaesthetics)
l) preparations for hemorroids
m) preparations for the maintenance of electrolytes
n) drugs ready to be injected
o) enzyme preparations (lactase only)
p) products for blood and urine analysis (section 36.00 of the RAMQ list)

2.3 Pharmaceutical specialties

The products listed below and carrying a general product number:

a) sunscreen protection products with a protection of 15 or more
b) antifungal preparations
c) preparations for psoriasis
d) preparations containing acetaminophen
e) contraceptive preparations (vaginal)
f) calamine lotion

2.4 Magistral prescriptions

2.5 Drugs for metabolic illnesses (dietary supplements)

2.6 Materials for administering drugs (disposable)

Automatic pump injector
Disposable syringe with needle
. 1/2 ml
. 1 ml
. 2 ml
Disposal syringe without needle
. 3 ml
Materials for injection pump
Needles (disposable)
Magnifying glasses for syringes
Disposable materials for respiratory therapy

2.7 Products excluded

These are some of the products not covered by this policy and whose costs are not reimbursable:

a) Drugs sold by prescription

- anorexiants
- megavitamins
- preparations of tretinoic acid
- topical minoxidil lotion
- pentazocine hydrochloride

b) Drugs available to the public at large

The categories with drug identification numbers not appearing in section 2.2.

c) Pharmaceutical specialties

The products not appearing in section 2.3.

N.B. THE TRANSPORTATION COSTS FOR THE DRUGS SHOULD BE RECORDED SEPARATELY.

CRITERIA FOR FINANCIAL ASSISTANCE

3. The establishment will help to pay all or part or the services described in section 2.0 by virtue of the principles of the Program for Uninsured Services and paragraphs 1 to 7, according to the conditions below:

4. Administrative practices:

The administrative practices involve two aspects:
1. dispensing drugs within the region
2. dispensing drugs outside the region.

4.1 Within the region (services provided through the establishment's pharmacy)

Pharmacists working in the regions designated in the two agreements are remunerated on a salary basis; dispensing drugs as part of uninsured services does not include the section on fees for their professional services. Drugs thus provided are recorded separately from those provided to hospitalized patients.

4.2 Outside the region

The dispensing of drugs, pharmaceutical services and materials used for administering drugs is controlled by the following administrative practices:

4.2.1 The pharmacist providing drugs according to a prescription issued to a beneficiary of the James Bay and Northern Québec Agreement or the Northeastern Québec Agreement will send the establishment a request for payment.

4.2.2 The fee schedule enclosed and the rules of application and interpretation are those negotiated between the Association québécoise des pharmaciens propriétaires (AQPP-Quebec association of proprietary pharmacists) and the Government of Quebec.

These payments may be retroactive when the agreement, which has been expired since 1989, is replaced with a new one.

HEALTH INSURANCE AGREEMENT

BETWEEN

THE MINISTERE DE LA SANTÉ ET DES SERVICES SOCIAUX

AND

THE ASSOCIATION QUÉBÉCOISE DES PHARMACIENS PROPRIÉTAIRES
(AQPP)

ADMINISTRATIVE NOTICE:

See section 2.1.2.4E - drafting of request for payment.

999920 Special remuneration
Special remuneration may be applicable to insured services:
a) when carried out under extraordinary circumstances;
b) when not mentioned in the fee schedule; or
c) in order to determine the cost payable according to section 16 of the rules of application and interpretation of fees.

The pharmacist must then provide the Régie with the necessary information.

ADMINISTRATIVE NOTICE:

See section 2.3.3 - drafting of request for payment.

Supply of disposable syringes-needles	1.76	1.83

Manufacture of Placebo capsules.
AQPP standards

1 to 30 capsules	8.14
31 to 60 capsules	11.68
61 to 100 capsules	15.57

ADMINISTRATIVE NOTICE:

The manufacture of Placebo capsules is a result of an accredited evaluation by the AQPP, and is therefore not negotiated in this agreement.

APPENDIX II

RULES OF APPLICATION AND INTERPRETATION OF FEES

RULE 1
For remuneration purposes, the cost of services and drugs provided by the pharmacist is only payable if the drugs and services were provided in conformance with the *Health Insurance Act*, its regulations and the provisions of the agreement; these drugs and services must be related to filling a valid prescription within the meaning of the *Pharmacy Act*, its regulations and all regulations governing the dispensing of certain drugs covered under the *Food and Drugs Act* and the *Narcotic Control Act*.

RULE 2
The Régie pays the pharmacist the cost of the services personally provided to the beneficiary or given by another person authorized under the *Pharmacy Act*, as well as the cost of drugs or dietary supplements established by the law. However, only the following service is applicable to dietary supplements:

- provision by prescription or on renewal of a prescription of a dietary supplement.

However, regarding any person contemplated in section 1.02 of the agreement, the cost of services is payable by the Régie only if these services were provided by a pharmacist in his/her employment.

The cost of services includes in particular the delivery fees, if applicable.

RULE 3
The cost of services provided for in the fees is payable for each drug or dietary supplement supplied according to a prescription given to a patient.

RULE 4
The cost of services is payable for the renewal of a prescription when the renewal is duly prescribed on the prescription.

However, in the case of drugs used on a continual basis for the treatment of a chronic or long-term illness, such as:

1. Pernicious anemia
2. Agammaglobulinemia
3. Diabetes insipidus
4. Diabetes mellitus
5. Myxedema
6. Addison's disease
7. Parathyreoprival tetany
8. Sprue
9. Myasthenia gravis
10. Gout
11. Epilepsy
12. Parkinson's disease
13. Tuberculosis
14. Asthma and chronic bronchitis
15. Chronic heart failure
16. Chronic coronary insufficiency
17. Rheumatic fever
18. Rheumatoid arthritis
19. Glaucoma
20. Multiple sclerosis
21. Cystic fibrosis

identifiable or brought to the pharmacist's attention, as well as for birth control and hormonal replacement therapy for menopause, a prescription not indicating the frequency or number of renewals may, exceptionally, be renewed for a maximum period of 30 days.

If this renewal occurs in less than 30 days from the end of the treatment period indicated in the original prescription, it is considered to be an insured service and treated as such when the pharmacist, in filling the original prescription, informs the beneficiary, through a label, that at the end of the treatment, the prescription cannot be renewed.

RULE 5

A verbal prescription must always be recorded in the register of prescriptions.

For remuneration purposes, the recording of such a prescription must specify:

- the name of the prescriber
- the operating licence number of the prescriber
- the date of the prescription
- the identification of the patient
- the name, type, content and quantity of drug
- the dose
- the number of authorized renewals, if applicable
- the signature of the pharmacist receiving the prescription.

RULE 6
Should a pharmacist refuse to fill a prescription, the Régie will pay the pharmacist the cost of services stipulated in the fee schedule providing that:

a) a copy or facsimile of the prescription is added in the pharmacist's register;

b) the name of the drug as well as a statement of the motives for the refusal are produced with the payment request;

c) as much as possible, the pharmacist stamps the refused prescription with the following statement: "Prescription refused by (pharmacist's name and registration number) on ____."

RULE 7
When the refusal to fill a prescription is accompanied by a pharmaceutical opinion, only the opinion is payable.

RULE 8
The prescription already refused by a pharmacist cannot be eligible for any other payment for services rendered.

RULE 9
No payment will be made for refusal to fill a prescription because of a lack of drugs or dietary supplements.

RULE 10
A pharmaceutical opinion is a notice justified by a pharmacist; this opinion is prepared under the pharmacist's authority, and deals with the pharmaceutical and therapeutic history of a patient, or with the therapeutic value of one or a series of treatments ordered by prescription. This opinion is given in writing to the prescriber, and a copy may be given to the patient if the pharmacist deems

necessary. However, the pharmacist must give a copy to the patient if so requested by the patient.

In order to be payable, the opinion must deal with drugs, at least one of which is prescribed and insured under the program; the opinion must also involve a recommendation specifically for the patient concerned that aims at modifying or interrupting the treatment prescribed.

RULE 11
A pharmaceutical opinion is given upon the request of the prescriber or on the pharmacist's initiative.

RULE 12
A pharmaceutical opinion deals particularly with:

a) the interaction between drugs;

b) incompatibilities;

c) counterindications;

d) inaccuracy of treatment;

e) under or over-consumption;

f) the concomitant use of several drugs prescribed by more than one prescriber.

RULE 13
The payment request for a pharmaceutical opinion is accompanied by a copy of this opinion.

RULE 14
The Régie pays the pharmacist the cost of services and magistral drugs prescribed when the drugs meet the following conditions:

a) the pharmacist uses laboratory instruments; and

b) an extemporaneous mixture of products (appearing on the list of drugs provided by the law) in associations and proportions other than those existing in manufactured products; or

c) the extemporaneous addition of products (appearing on the list of drugs provided by the law) to a simple or composed preparation, already

manufactured, appearing on the list of drugs, insofar as this mixture does not reproduce a drug already manufactured and excluded from the list.

However, the simple reconstitution of a product that is already manufactured by adding a solvent or through suspension is not considered a magistral drug.

Notwithstanding the preceding provisions, the following magistral preparations are not payable:

i) those supposed to have the same therapeutic indications as drugs belonging to a pharmacotherapeutic category or sub-category not included on the list of drugs prepared under section 4 of the *Health Insurance Act*;

ii) those whose therapeutic value, according to the Conseil consultatif de pharmacologie (pharmacological advisory council), is not proven. In this case, the Régie will pay the cost of services and magistral drugs if this preparation was dispensed prior to the date of the notice issued by the Régie to the pharmacist informing him/her to stop honouring any request concerning this preparation.

Paragraph ii) is preceded by a notice from the pharmacological advisory council to the Association which may then make representations within 30 days of receiving this notice.

RULE 15
The cost of services and magistral drugs is payable even if the pharmacist uses a solvent or pharmaceutical adjuvant to prepare this drug.

RULE 16
The cost of the magistral drug corresponds to the total of the costs of each product on the list of drugs, as well as each adjuvant or vehicle (appearing on the list of adjuvants and vehicles published by the Régie) incorporated into the magistral drug. However, when only part of the conditioning of a product on the list is used to prepare a magistral drug, the cost of the product will be considered a special remuneration.

RULE 17
The cost of drugs payable by the Régie for a prescription corresponds to the quantity of drugs prescribed on the prescription or, if such quantity is not specified, to the quantity required for the duration of the treatment prescribed on the prescription.

However, when the quantity prescribed exceeds that required for a thirty-day period and the pharmacist has reason to believe that the patient is over-consuming the drugs or using them carelessly, the pharmacist may exceptionally provide the drugs in quantities less than those stipulated on the prescription. Also, the pharmacist may exceptionally provide the drugs in quantities less than stipulated on the prescription when the quantity prescribed is contrary to a rational practice of prescribing drugs.

In all the cases mentioned in the previous paragraph, the quantities dispensed must be equal to those required for a treatment of thirty days, except the last renewal, whose quantity may be less or more than 30 days if this quantity corresponds to the quantity required to complete the treatment.

RULE 18
The cost of dietary supplements payable by the Régie for a prescription is the quantity prescribed and supplied.

RULE 19
A complementary document must accompany the payment request in the following cases:

a) special remuneration;

b) refusing to fill or renew a prescription;

c) filling a magistral prescription involving more than two ingredients.

RULE 20
The cost of services provided for supplying disposable syringes-needles as well as the cost of the disposable syringes-needles are payable when:

a) the service was given to a beneficiary with a prescription for insulin;

b) the service was given during the filling or renewal of this prescription;

c) the quantity of disposable syringes-needles supplied corresponds to the dosage of the prescription.

RULE 21

The fees will be reduced after a specified annual number of prescriptions are paid to a pharmacy under this agreement. The number is 20,000 prescriptions per twelve-month period, beginning on August 1 of each year, and calculated according to the date of providing the services; this number includes each filling and renewal of a prescription for a drug, dietary supplement or magistral drug.

The term "pharmacy" is understood to mean any premise in which pharmacy within the meaning of the *Pharmacy Act* (R.S., c. P-10) is practised, and this, independently of its owner(s).

PATIENT TRANSPORTATION

Patient transportation policy - beneficiaries of the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement.

Circular 1982-108 describes the policy for transporting and transferring all residents of the health and social services network in Quebec.

However, for the residents of region 10-A and 10-B and the Naskapi of Kawawachikamach, beneficiaries of the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement, certain provisions have been added in order to respect these two agreements.

1. Escorts

1.1 Medical: a medical escort is ordered by the attending physician or nurse depending on the patient's condition.

1.2 Family: a member of the immediate family or a person designated by the immediate family must be recommended.

1.3 0-18 years old: must have a family escort.

1.4 65 years old or more: must have a family escort.

1.5 18-65 years old: an escort is authorized by the nursing or medical personnel according to the patient's physical and/or psychological condition.

1.6 A woman in labour sent outside her normal place of residence to give birth may be accompanied (return airfare and accommodation expenses) by a person of her choice who will attend the birth.

1.7 For humanitarian reasons, a member of the family is authorized to visit a hospitalized patient upon the written request of the attending physician.

1.8 A monthly family visit of a total of five (5) days is authorized in the case of an extended stay (for example, waiting for a kidney transplant).

Patient services

In different places, infrastructures are in place for reception, lodging and interpretation services.

OPTICAL SERVICES
(eyeglasses and contact lenses)

1. SUBJECT

This program aims at assisting beneficiaries receive optometric and ophthalmological goods and services.

1.1 SERVICES

1. Eyeglasses (frames and lenses).
2. Contact lenses when required for a medical reason.
3. Repair of eyeglasses.
4. Professional fees related to filling the prescription for eyeglasses and contact lenses.

1.2 SERVICES EXCLUDED

1. Contact lenses for esthetic reasons and related costs.
2. Protective glasses used for sports.
3. Tinted or "varygray" glasses.
4. Safety glasses.

1.3 FINANCIAL ASSISTANCE

The establishment will pay all or part of the costs of the uninsured optometric services described in section 1.1, depending on the case, in conformance with the principles of the uninsured service program and according to the following conditions:

a) the rules, conditions and fees are established by the ministère de la Santé et des Services sociaux (MSSS) according to fees in effect;

b) taking into account the allocated budget, the Regional Council of Health and Social Services is responsible for hiring professionals and for providing them with the materials required for them to practise.

New eyeglasses

The establishment will help the beneficiary obtain new eyeglasses (lenses or frames), according to the conditions and fees established by the MSSS, in

cases with changes of 0.5 diopter or more. This change must be justified by an authorized physician.

Replacement of eyeglasses

The establishment will help the beneficiary obtain other eyeglasses, according to the conditions and fees established by the MSSS, in the following situations:

a) the beneficiary is at least 18 years old, and 24 months have elapsed since the last prescription;

b) the beneficiary is less than 18 years old, and 12 months have elapsed since the last prescription.

Repair of eyeglasses

The establishment will help the beneficiary repair the eyeglasses, according to the conditions and fees established by the MSSS, and in conformance with the criteria established above in the section entitled "Replacement of eyeglasses" when:

a) the total cost invoiced to the establishment does not exceed the replacement cost of the eyeglasses;

b) the repairs will make the eyeglasses functional.

New contact lenses

The establishment will help the beneficiary obtain new contact lenses, according to the conditions and fees established, when:

a) these contact lenses are required for a medical reason;

b) the required correction for good eyesight cannot be obtained with eyeglasses.

Replacement of contact lenses

The establishment will help the beneficiary obtain other contact lenses, according to the same conditions established for the replacement of eyeglasses.

GUIDELINES FOR OPTOMETRISTS

FRAME

The amount allowed for frames is $44.

PAYMENT

The establishment agrees to pay the optometrist on the basis of the invoice or statement of account. If the beneficiary does not pick up the eyeglasses or contact lenses, the optometrist will send them to the establishment within the sixty (60) days following their payment, and will indicate the beneficiary's name.

OTHER CONSIDERATIONS

The optometrist who is unaware of the beneficiary status may contact the person responsible for the beneficiary register of the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement at (418) 643-7703.

When the beneficiary picks up the eyeglasses or contact lenses, he/she must sign an attestation that is written on the optometrist's invoice as follows:

"Attestation of beneficiary: _____"

FEE SCHEDULE

EYEGLASSES

Until 91/03/31

Mineral, single vision
Spherical or sphero-cylindrical power

.1.0	0.50	to	4.00	2 lenses	$44.00
.1.1	0.12	to	3.00	2 lenses	$52.00
.1.2	3.25	to	6.00	2 lenses	$70.00
.2.0	4.25	to	10.00	2 lenses	$62.00
.2.1	0.12	to	3.00	2 lenses	$74.00
.2.2	3.25	to	6.00	2 lenses	$94.00
.3.0	10.25	to	20.00	2 lenses	$78.00
.3.1	0.12	to	3.00	2 lenses	$98.00
.3.2	3.25	to	6.00	2 lenses	$115.00

Mineral, bifocal
Spherical or sphero-cylindrical power

.1.0	0.50	to	4.00	2 lenses	$70.00
.1.1	0.12	to	3.00	2 lenses	$82.00
.1.2	3.25	to	6.00	2 lenses	$98.00
.2.0	4.25	to	10.00	2 lenses	$90.00
.2.1	0.12	to	3.00	2 lenses	$102.00
.2.2	3.25	to	6.00	2 lenses	$122.00
.3.0	10.25	to	20.00	2 lenses	$104.00
.3.1	0.12	to	3.00	2 lenses	$118.00
.3.2	3.25	to	6.00	2 lenses	$132.00

Supplements:

- Prism 1.00 to 7.00 diopters	2 lenses	$44.00
- Prism 7.25 to 10.00 diopters	2 lenses	$56.00
- Compensatory prism	2 lenses	$84.00
- Spherical above 20.00 diopters	2 lenses	$56.00
- Cylindrical above 6.00 diopters	2 lenses	$44.00
- Addition above 4.00 diopters	2 lenses	$44.00
- Special-sized lenses	2 lenses	$26.00
- Fresnel lenses	2 lenses	$44.00

- Mineral-safety lenses	2 lenses	$14.00
- Mineral-flint lenses (for correction of at least 8 diopters)	2 lenses	$44.00
- Frame (allowance)		$42.00

PLASTIC LENSES (APHAKIC)

Lenticular single vision (per lens)

- Power .3.0	$78.00
- Power .3.1	$98.00
- Power .3.2	$99.00

Lenticular bifocal (per lens)

- Power .3.0	$118.00
- Power .3.1	$130.00
- Power .3.2	$130.00

Contact lenses (per lens)

- Spherical single vision	$115.00
- Toric	$196.00
- Bifocal	$196.00

TEMPORARY MEASURES FOR THE REIMBURSEMENT OF COSTS FOR DENTAL SERVICES GIVEN TO NATIVE PEOPLE AND CONSIDERED AS FREE UNDER THE AGREEMENT

Firstly, it should be noted that Mr. Maurice Boisvert, Assistant Deputy Minister, sent a letter dated September 19, 1989, advising the general managers of the Ungava Hospital and Hudson Bay Hospital Centre of the fee schedule to be applied by a dentist with a private practice or a denturologist (within or outside the community) providing services regarding cast metal partial dentures; these special rates for these services proved necessary because they had not been negotiated within the scope of the *Health Insurance Act* (see copy enclosed).

Recent meetings in Kuujjuaq and Povungnituk have allowed the MSSS to specify that it plans on providing a framework particularly for dental services considered free under the Agreement. This framework will specifically include the establishment of a more adequate method of remuneration, or of fees, depending on the case, as well as mechanisms for obtaining pre-approval for certain services. Implementing this policy will first require discussions with various parties, such as the Association des chirurgiens dentistes du Québec (Quebec association of dental surgeons), and users, dispensers and payers of services must be informed of this policy.

As you know, the MSSS has already begun consultations to establish its administrative policy; until that policy becomes effective, the following guidelines should be applied:

- generally continue to ensure access to dental services, including specialized services outside of the community when these are considered essential according to the dentist in the community; if possible, use as support the working documents enclosed, which establish fees similar to those proposed by the federal government, and which include the pre-approvals considered necessary as well as standards regarding orthodontics;

- do not request any payment from the native person being treated in the community; if any laboratory fees related to the services provided by the dentist on site are incurred, they must be paid by the establishment from the budget for uninsured services;

- with the exception of oral surgery services (except the removal of a tooth) given in a hospital centre, non-native persons must reimburse the establishment for dental services dispensed;

- the denturologist whose services are used in the region must be informed that, for the time being, he/she will continue to be remunerated for services dispensed according to the fee schedule in the dentists' agreement if it is a question of a service that was negotiated, or at 90% of the fee schedule proposed by the Association des chirurgiens dentistes du Québec if it is a question of a non-negotiated service; a prescription from the dentist in the community is required for making a denture;

- the establishment will continue to pay the costs of dental services given outside of the community providing that these costs respect the honoraria normally requested by dentists or denturologists, or that the costs take into account agreements between the dentist in the community and the dentist or denturologist outside of the community, based on the working document enclosed.

DENTAL SERVICES

I. ACCESSIBLE SERVICES

DIAGNOSTIC

1. Complete examination

   Limited to once per 36-month period.

2. Periodic or recall examination

   Limited to two per 12-month period.

3. Emergency or special examination

   Limited to once for a specific sextant and for the problem in question.

4. Examination by a specialist

   Pre-approval required.

BIOPSIES

As required.

PREVENTIVE SERVICES

1. Scaling and preventive dentistry

   Limited to two (maximum) per 12-month period.

   The honoraria will be completely reimbursed if the patient has more than 16 teeth. Half of the honoraria will be reimbursed if the patient has less than 16 teeth in the two dental arches.

2. Fluoridization

Limited to two times per 12-month period for children under 18 years old.

3. Cavity and fissures sealant

Limited to children under 14 years old for new permanent molars whose occlusal surface has not been restored.

4. Interproximal grinding of teeth (pre-approval required)

Limited to two units per patient per 12-month period.

5. Fixed appliance (pre-approval required)

Limited to one per quadrant.

RESTORATIONS

1. Amalgam restorations: according to fee schedule

If during the same appointment, distinct amalgam restorations are done on the same tooth for conservation reasons, the total number of surfaces restored must be counted to determine the fee. The maximum remuneration for the amalgam is five surfaces per tooth.

For primary dentition, the rates should not exceed the cost of a stainless steel or polycarbonate crown.

2. Retention pin

Limited to a maximum of three per tooth.

3. Restorations of esthetic materials: according to the fee schedule

The remuneration for restoring a permanent molar with esthetic materials must not exceed the cost of an equivalent amalgam restoration.

N.B. Putting in a pre-made or composite facet is not considered an admissible service.

REMOVABLE PROSTHESES

1. Complete, partial, immediate dentures (pre-approval required)

   Limited to one denture per arch per 60-month period.

   The remuneration for complete, partial or immediate dentures includes adjustments and modifications for a 3-month period after insertion.

2. Adjustment

   More than 3 months after insertion.

3. Repair and addition

   Limited to one time per denture per 12-month period.

4. Rebasing or refitting with/without tissue conditioning

   Limited to one of these services per denture per 24-month period.

5. Immediate denture

   Because the immediate denture includes adjustments for a 3-month period after insertion, no other treatment such as tissue conditioning or refitting will be reimbursed to the attending dentist during this period.

FIXED PROSTHESES (pre-approval required)

If the prothetic requirements are satisfied for a given arch, the establishment will contribute an amount equivalent to the cost of a partial denture (including the equivalent laboratory cost for such a partial), once per arch per 60-month period.

ORTHODONTICS (pre-approval required)

Orthodontic treatment will be limited to patients under 18 years old. The case will be submitted to a committee that will evaluate and determine the validity of the request for financial assistance to cover the cost of the treatment.

ORAL SURGERY

Only the following services and the prior examination done as an emergency may be given at all times by a dentist with a private practice:

- removal of the tooth or root;
- opening of the pulp cavity;
- incision or drainage of an abscess;
- alveolitis;
- hemorrhage control;
- repair of a tear in soft tissue;
- reduction of an alveolar fracture;
- immobilization of a tooth loosened by traumatism;
- reimplanting of a tooth completely exfoliated.

All other surgical services must be pre-approved, with the exception of those dispensed in a hospital centre.

COMPLEMENTARY SERVICES

1. General anesthesia / conscious sedation / neuroleptanalgesia / parenteral injection / intravenous injection or intramuscular injection.
2. Emergency services, according to the fee schedule.
3. Professional visits (visits to the hospital and visits outside of regular office hours).
4. Laboratory fees.

II. NON-ADMISSIBLE SERVICES

Putting in pre-made facets or composites are restorations that are not admissible. Implants are also not admissible.

B. Administrative practices

a) Access to services

1.0 In the community

1.1 Each regional centre has the resources to dispense regular dental care to all beneficiaries in the community. In addition, dentists and denturologists travel to the various nursing stations at regular intervals.

1.2 The community's dentists must decide on the necessity of having the services of a specialist dentist or denturologist.

1.3 The denturologist must claim his/her honoraria from the establishment; reimbursement will be paid according to the fee schedule periodically decreed by the ministère de la Santé et des Services sociaux.

1.4 The beneficiary who must reside for a certain time outside the region must visit the dentist in the community and must have the work required as well as any preventive treatment done before leaving the region.

2.0 Outside the community

2.1 Pre-approval

This authorization corresponds either to a request by a dentist working in a native community or to an authorization issued by a dentist working in a community after reviewing the forms and documents deemed necessary.

All requests for the reimbursement of services provided without pre-approval and noted as essential may be deemed inadmissible.

See appendix for particular conditions concerning orthodontic services.

2.2 Invoicing and payment

The dentists (generalists and specialists) as well as denturologists must invoice the establishment for the services provided by enclosing a copy of the pre-approval, if applicable.

Payments will be made according to the fees established by the ministère de la Santé et des Services sociaux, or according to the frequency already provided for in the *Health Insurance Act's* implementing regulation.

ORTHODONTIC CARE

All orthodontic treatments must be pre-approved and the establishment will under no circumstances be held responsible for reimbursing treatment done by the community's dentist without authorization.

Applications will be considered according to the following conditions:

1. The patient must have been examined by a general practitioner.

2. Major cases must be submitted by a certified orthodontist. The following information must accompany the submission:

2.1 an examination report describing the diagnostic of the orthodontic condition along with a summary of the general condition of the teeth;

2.2 the complete treatment plan, including the type of appliance(s) to be used during the treatment phase;

2.3 the duration and cost of treatment (cost spreading if applicable), including retention;

2.4 the provision of intraoral and extraoral photographs (Polaroid type) is greatly appreciated.

3. Minor cases (see note below) may be submitted by a general practitioner or an orthodontist. The following information must accompany the submission:

3.1 an examination report describing the diagnostic of the orthodontic condition along with a summary of the general condition of the teeth;

3.2 the complete treatment plan, including the type of appliance(s) to be used during the treatment phase;

3.3 the duration and cost of treatment (cost spreading if applicable);

NOTE: Minor cases are those which correspond to the orthodontic codes as they appear in the fee schedule (chapter XI) of the Association des chirurgiens dentistes du Québec, with the exception of the following codes: 84,100 - 84,200 - 84,300 - 85,100 - 85,200 - 85,300.

Government of Quebec
Ministère de la Santé et des Services sociaux
Direction générale de la prévention et des services communautaires

Quebec City, September 19, 1989

Ms. Aani Palisser-Tulugak
General Manager
Hudson Bay Hospital Centre
Povungnituk (Quebec)
J0M 1P0

SUBJECT: Dental prosthesis services not covered under the *Health Insurance Act*

Sir:

The ministère de la Santé et des Services sociaux is currently developing a policy regarding health services not covered under the *Health Insurance Act* but guaranteed free for native people contemplated in the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement.

Because this process is quite long, please find enclosed a temporary framework for dental prosthesis services.

Free access to these services for native people is an indisputable principle, and registration in the register of beneficiaries of the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement is a condition for obtaining services free of charge.

In the case of dental prostheses, it is understood that when these services are given by a dentist working in the community and remunerated on a salary or session basis by the Régie de l'assurance-maladie (Quebec health insurance board), the eligible native person does not have to pay for these dental prostheses, either because he/she is eligible for one of the dental programs contemplated in the *Health Insurance Act* or because he/she has the right to free services as stipulated in one of the above-mentioned agreements.

When these services for complete or partial acrylic dental prostheses are exceptionally given outside the region by a dentist with a private practice or a denturologist (within or outside the community), the fees to be applied are those negotiated within the scope of health insurance (see Appendix 1). For partial prostheses in cast metal, whose fees have not been negotiated because these services are not covered, the applicable fee schedule is 90% of that proposed by the Association des chirurgiens dentistes du Québec (Quebec association of dental surgeons) (see Appendix II).

Furthermore, as provided by the *Denturologists Act*, the patient must have an oral health certificate when a prosthesis is done by a denturologist.

Taking into account your establishment's financial situation, the ministère de la Santé et des Services sociaux is aware that such provisions add to your costs. Necessary steps have been taken with the authorities concerned to obtain additional budgets to cover these costs. We urge you to keep very accurate accounting records so that costs related to these services may be clearly identified.

Yours truly,

original signed by

Maurice Boisvert

Assistant Deputy Minister

c.c. Ms. Lizzie Epoo-York
Mr. Jacques Dufour

HEARING AIDS

The *Health Insurance Act*, through its implementation regulation, governs the methods of dispensing hearing aids for a specific population of Quebecers (section XIX, schedule C).

The beneficiaries of the James Bay and Northern Québec Agreement and the Northeastern Québec Agreement who are not insured under this coverage receive the same benefits, according to the same conditions and fees negotiated with the association of audio-prosthesists.

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Kativik Regional Board of Health and Social Services
Conseil régional Kativik de la Santé et des Services Sociaux
P.O. Box 9 KUUJJUAQ (QUÉBEC) CANADA J0M 1C0

April 4, 1991

Mr. Johnny Naktialuk
Acting General Manager
Inuulitsivik
Povungnituk (Québec)
J0M 1C0

Sir,

Pursuant to the letter dated December 3, 1990 addressed to Mrs. Huguette Sauvageau (see appendix 1), please find in appendix 2 the English translation of a letter dated December 20, 1990 sent by Mr. Maurice Boisvert and the document providing guidelines concerning the non-covered/non-insured health services.

Please make sure that all your Department Heads and the seven CLSC points of services be informed of that document.

For your information,

1. The date to start applying these temporary provisions is January 1, 1991

2. The date of the retroactivity to proceed to reimbursement in applying these temporary measures is January 1, 1990.

3. The payments of non-insured services to be furnished free of charge to Inuit who are James Bay and Northern Quebec Agreement's beneficiaries are to be taken in your specific budget allowed for that program which is of 292 800$.

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Kativik Regional Board of Health and Social Services
Conseil régional Kativik de la Santé et des Services Sociaux
P.O. Box 9 KUUJJUAQ (QUÉBEC) CANADA J0M 1C0

April 4, 1991

Mr. Jocelyn Bernier
Acting General Manager
Ungava Hospital
P.O. Box I49
Kuujjuaq (Québec)
J0M 1C0

Sir,

Pursuant to the letter dated December 3, 1990 addressed to Mrs. Huguette Sauvageau (see appendix 1), please find in appendix 2 the English translation of a letter dated December 20, 1990 sent by Mr. Maurice Boisvert and the document providing guidelines concerning the non-covered/non-insured health services.

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For your information,

1. The date to start applying these temporary provisions is January 1, 1991

2. The date of the retroactivity to proceed to reimbursement in applying these temporary measures is January 1, 1990.

3. The payments of non-insured services to be furnished free of charge to Inuit who are James Bay and Northern Quebec Agreement's beneficiaries are to be taken in your specific budget allowed for that program which is of 287 700$.

We would really appreciate receiving your comments about these temporary provisions; it will greatly help our Council, the Ministère de la Santé et des Services sociaux, and the Quebec Health Board to develop a specific provincial policy and program for the James Bay and Northern Quebec Agreement beneficiaries.

Please forward your comments to Mrs. Francine Tremblay, Planning and Programming Director.

Sincerely,

Lizzie Epoo-York
General Manager

LEY/lc

c.c.: Mr. Jacques Tremblay, Administrative Services Director, Ungava Hospital
Mrs. Nancy Anderson, Coordinator, Module du Nord québécois, DSC-MGH
Mr. Antonio Masone, Administrative Services Director, Inuulitsivik
Mr. Roger Richard, Chef du Service de Liaison avec les régions nordiques, MSSS
Mr. Emile Valcourt, Administrative Services Director, CRSSS Kativik
Mrs. Francine Tremblay, Planning and Programming Director, CRSSS Kativik
Local Health Committee Presidents
Mrs. Josée Vilandré, Lawyer, Makivik Corporation
Mr. Charlie Watt, President, Makivik Corporation
Mrs. Annie Popert, General Manager, Kativik School Board
Mr. Claude Grenier, Manager, Kativik Regional Government
Mr. Robert Gibeault, Transit House, Lachine
Mrs. Mary Stone, Transit House, Dorval
Dr. Pierre Gagnon, Dentist, Projet Nord, DSC-CHUL
Dr. André Corriveau, Community Health Adviser, CRSSS Kativik

We would really appreciate receiving your comments about these temporary provisions; it will greatly help our Council, the Ministère de la Santé et des Services sociaux, and the Quebec Health Board to develop a specific provincial policy and program for the James Bay and Northern Quebec Agreement beneficiaries.

Please forward your comments to Mrs. Francine Tremblay, Planning and Programming Director.

Sincerely,

Lizzie Epoo-York
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Kativik Regional Board of Health and Social Services
Conseil régional Kativik de la Santé et des Services Sociaux
P.O. Box 9 KUUJJUAQ (QUÉBEC) CANADA J0M 1C0

December 3, 1990

Mrs. Huguette Sauvageau
Ministère de la Santé et
des Services sociaux
1075, chemin Ste-Foy
Québec (Québec)
G1S 2M1

Subject: Covered and non-covered services - Follow-up of the consultation meetings held in Kuujjuaq and Povungnituk (November 19-21, 1990)

Madam,

First, I would like to tell you that all participants were waiting for a long time for a such consultation and they all appreciated your team involvement.

By the present I wish to resume what we agreed upon:

1. That you will be coordinating the file at the ministry level and that I will coordinate the file in the Kativik region;

2. That our Director General, the Director of our two (2) establishments and the Director of Module du Nord québecois will be receiving a letter from your department with a document which will indicates the temporary measures to be followed by all parties. The deadline is the first week of December 1990;

3. That at the same time you start working with the Ministry (Mrs. Cliche) and the Quebec Health Board for the production of an identification card for the JBNQA Beneficiaries (which will be equivalent to the "carte soleil").

4. That at the end of March a first working document related to the policy and guidelines for covered and non-covered services for the Beneficiaries of the James Bay Northern Quebec Agreement should be submitted to Kativik Health Council by your department;

5. That the Kativik Health Council will consult the establishments and the Module du Nord québecois;

6. That the Kativik Council will provided the Ministère de la Santé et des Services sociaux (MSSS) with a summary report of the comments, recommendations and/or proposals for modifications.

/2...

Hope the present reflects the content of our discussions.

Sincerely,

Francine Tremblay

Francine Tremblay
Director of Planning and Programming

c.c.: Mrs. Lizzie Epoo-York, Director General, Kativik CRSSS
Mr. Gilles Plante, Director General, Ungava Hospital
Mr. Johnny Naktialuk, Director General by Interim, Inuulitsivik
Mrs. Nancy Anderson, Module du Nord québecois
Mr. Roger Richard, Northern liaisons, MSSS

P.S. I also enclosed the minutes of the meeting held in Povungnituk made by Mrs. Louise Côté, Secretary of Inuulitsivik. Could you forward your corrections to her attention if necessary. Thank you.

ANNEX 18

ANNEX 17

INNUULISIVIK
CENTRE HOSPITALIER DE LA BAIE D'HUDSON
HUDSON BAY HOSPITAL CENTRE
Povungnituk, Québec J0M 1P0
Tél.: (819) 988-2957

To Francine

Please give me this project. Are you aware about it? The building would be the same as Kuujjuaq Group home (SHQ). I wait for your comments

M. Létourneau
90-12-18

90-11-08

Mrs. Lizzie Epoo-York
Genral Manager
Kativik CRSSS
P.O. Box 9
Kuujjuaq (Québec)
J0M 1C0

SUBJECT : GROUP HOME FOR YOUNG OFFENDERS

Hello,

Enclosed is the resolution to request the Group Home for young people along you will find the information that was given to and approved by the population of Inukjuak. The resolution from the Municipal Council for the site of the Group Home is also enclosed. The minor changes mentioned could very well be done after the building is completed, therefore it is advisable that they be disregarded in the official request.

I hope this is to your understanding.

Yours truly.

Johnny Naktialuk
Acting General Manager
Inuulitsivik H. & S.S.C.
Povungnituk (Québec)[
J0M 1P0

JN/lc

Encl.

NOV 21 1990

88-45 14. **PRESENTATION OF THE GROUP HOME PROJECT**

Upon a proposal presented by Simon Makimak and seconded by Jennifer Stonier it is resolved that the Board of Directors agrees that the request for a Group Home is valid and desirable, however, the Board is concerned that the plans for the building might not sufficiently meet the real needs of such a project...to this effect, the Board requests the Director General to work with the director of Social Services, and the Director of Youth Protection to set up a working committee composed of people from the community involved, the social services and the administration of the hospital.

It is further resolved that Inukjuak is chosen as the location where the Group Home will be built but that this decision is to be confirmed after the Health Committee of Inukjuak consults with the population.

In favor : 10
Absent : 1

90-08-03

INUKJUAK GROUP HOME

Meetings with the Health Committee and Social Services are held to further plan the Group Home for young people.

- The structure of the building will be the same as the Group Home in Kuujjuaq with very minor changes such as one room and one stairway.

- Tentative list of required staff:
  - One manager
  - Two families to alternate for care of the clients and the home.
  - One Social Worker.
  - One night watchman.
  - Four seasonal workers for camping and other activities - two men and two women.

- The Community Council of Inukjuak initially suggested that the home be for teenagers with different problems, but they wanted to meet with the population before taking a final decision.

- The Department of Youth Protection of and the Department of Social Services of Inukjuak suggested that the Group Home be used for substance abusers, but they also wanted to know how the community felt about the two suggestions.

- Through a FM radio phone-in, for suggestions about the Group Home, the population was informed of the plans and was asked who, they thought, would benefit the most from the home; and how they saw the community as a whole, or groups and individuals supporting the Group Home.

- Their suggestions were as follows :
  - support to keep Inuit language and traditions strong on individual basis and with groups.
  - the staff be helped out by white professionals at the beginning and the Inuit staff would take over slowly after on-the-job training.
  - some wanted to hear from other communities first, before taking a decision, but other felt that it would be better for the population of Inukjuak to decide since they are the ones involved and would not want to end up with something they cannot handle.
  - most suggestions were that the home be used for problem teens of all kinds and some wanted it be used exclusively for substance abusers but the majority wanted "general use".
  - It was also suggested that clients from Inukjuak be sent to Kuujjuaq and clients from Kuujjuaq to Inukjuak to avoid conflicts with family members.

It is also planned to meet with different organizations such as : Education, Recreation, Youth, Alcohol and Drug, Hunters' Support Committee to plan activities for the clients within a year.

A resolution from the Land Holding Corporation will be obtained in the near future for the location of the Group Home.

The Municipal Corporation,
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Inukjuak, Québec.
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J0M 1M0

Resolution #90-59

Re: Site for Rehabilitation Centre.

Whereas : The rehabilitation centre was approved to be in Inukjuak in 1989 but the location has not been resolved yet,

Therefore : On a municipal council meeting held on August 7, 1990, it is resolved that the centre be located at the site as per annexed.

Moved by : Daniel Nulukie

Seconded by : Markoosie Patsauq

Approved by : 5

Apposed by : 0

Abstentions : 0

Absent : 0

Date of Adoption : August 7, 1990.

Date of Publication : August 15, 1990.

Mayor : [signature]

Seccretary Treasurer : [signature]

THE REPORT ON

A symposium given under the

auspices of

the Kativik Regional Council of

Health and Social Services

Effective Social Services

for

Inuit Communities

Preparing the Symposium

Report of the Symposium on Social Services held by Kativik Regional Council of Health and Social Services, March 5th - 7th 1991 at Inukjuak.

This symposium was held at Inukjuak in conjunction with the Annual Meeting of Kativik Regional Council of Health and Social Services.

The symposium was attended by about 100 people including mayors and representatives from most of the Inuit Communities, administrators and staff of Ungava Social Services and Hudson Bay Social Services, representatives from Health and Educational Services, together with staff from Kativik Regional Council of Health and Social Services who were responsible for running the conference.

The programme of the symposium consisted of General sessions at the beginning and end of each day with five workshop groups in between. The workshop groups were:

A. Power-Leadership-Balance
a workshop for management

Chairperson	-	Eva Lapage
Resource Person	-	Betty Kalmanasch
Recorder	-	Joy R. Smith

Attended by administrators, supervisors, planners mayors and board members.

B. Social Assistants, Community Workers and Community Needs - in three sections

BI.	Chairperson	-	Martha Craig
	Resource persons	-	Liesel Urtnowsky
		-	Caroline Oblin
	Recorder	-	Malee Saunders
BII.	Chairperson	-	Louisa May
	Resource person -	-	Maryanne Pentick
	Recorder	-	Maggie A. Berthe
BIII.	Chairperson	-	Eva Deer
	Resource person	-	Liesel Urtnowsky
	Recorder	-	Pasha Berthe

These workshops were attended by Social assistants, Community workers and community representatives.

C. Substitute Care - For all substitute care givers

Chairperson	-	Jeannie Sala
Resource person	-	Pierre Portelance
Recorder	-	Kaudjak Padlayat

This workshop was attended by care givers and community representatives.

Recordings and conclusions were received from all groups except BI.

Recommendations were made by the concluding General Assembly.

CONCLUSIONS OF WORKSHOP "A"

1: Inuit need to develop their own style of leadership and management of organizations Methods used down south are often not appropriate here and using them leads only to confusion. Inuit management need to consider their employees personally if they want them to develop effective methods of works

2 Inuit must take a much larger part in hiring committees when people are being selected for jobs from the south only people who can share attitudes and goals of Inuit society can make a useful contribution. Inuit can judge whether people are appropriate from this point of view.

3: Inuit must develop their own trained people in certain areas of special skills. Some of this can be accomplished by "on the job" training as at the Hudsons Bay Hospital. Other skills require more academic work but it is difficult for Inuit students to stay down south for extended periods of time and still keep in touch with their communities - travel is very expensive. Some kinds of courses need to be given up North.

4: There should be regular opportunities for Inuit who are in management and leadership positions to get together to share experiences, learn fro each other and support each other in developing new Inuit methods of organization.

5 Why are there two social services under th management of the two hospitals? Would it not be better to have one social services network and one medical network? (this question was raised but never answered at the workshop) Answer- - it was part of the James Bay Agreement (See General Session's Recommendation #11).

CONCLUSIONS

Community Workers and Community Needs B.II

1: We can see from this symposium that we have not been supporting and helping our community workers and social assistants enough. When we go back home we should start to talk to our workers more, be more open with each other and thank them once in a while because they are doing a very difficult job.

2: There needs to be more help available in each community, Social Assistants should be able to get help from elders and natural helpers when they need it. They should not be used for arranging things for patients. There are enough family problems to keep them busy.

3: Good space and equipment should be available for social services.

4: There should be police of some kind in each community so that the social assistant does not have to do police work.

5: Supervisors should visit more often and be available to consult with the community.

6: Drugs, "Sniffing" and child neglect are community problems and must be solved with community participation, Social Services cannot do it alone.

7: The extended family problems before they go for specialized, outside help - police for violent people - social services for marital conflicts, patient-child conflicts, child neglect abuse. the extended family should discuss their problems with social assistants and help them to solve the problems. In changing times they need to cooperate very closely together.

8: Foster families are not a good idea because children do not know who is their family-foster or natural parents, if children need temporary care (for instance, if mother is sick) they should be told they will go back to their natural family as soon as possible. It would be even better if someone could go into their home to care for the children if it is for a period of weeks or months. When a mother is unable to care for her children for along time she should allow them to be adopted.

9: Suicide prevention must be a community concern as well as a family one. Churches, schools, recreation programs can all help to make children grow up as happy and useful community members. Too often children in trouble drop out of everything and no one tries to find out what the problem is.

CONCLUSIONS from workshop B III

1: If problems in the community are to be solved the whole community has to care and get involved.

2 Something must come out of this symposium about drinking problems. Especially the leadership must stop they are role models for the young.

3: Incest - everyone is shy about this subject. Not enough is said people must become more open about it. Social workers can have special training to deal with it. But unless the community and relatives are going to talk about out it very little can be done.

4: In family violence and sexual abuse cases it should not be the victim who has to leave home. The police should remove the violent person instead. This needs close co-operation between the community and the police to do effectively.

5 Suicide prevention is important. It needs to be discussed in all kinds of groups. Criticizing youth and putting them down does not help. Just referring family problems to the social assistants can't solve them unless the family helps as well. Priests, church groups, and natural helpers should also support and help people in the community.

6 People need to talk to people they trust - not necessarily specialists.

7: Police should send children home at 10.P.M. This would help parents with their responsibilities. There are not enough police in communities.

8 Communities need to understand that sicknesses like S.T.D. should be tested and treated right away. This would help people to do it and keep disease from spreading.

CONCLUSIONS of Substitute Care Group

1: There is a need for training in all areas of substitute care - group home parents, home care etc... Group homes cannot function without Inuit staff..

2 An annual budget for Home care for medical reasons in all communities is needed.

RECOMMENDATIONS

1. Unify Inuit philosophy and policy in life and services
2. Hiring and selection must be under Inuit control.
3. The general public must be actively involved in problem solving.
4. Work on your self esteem and confidence.
5. Local leaders must show commitments and actively support care givers and people in difficulties.
6. Bring back extended family network.
7. Parents, leaders and care givers must set up an example.
8. Parents must show interest in their children every day life with tender loving care.
9. Create a working network among all organizations at all levels within Nunavik.
10. Negotiate for a CEGEP campus for Nunavik.
11. Unify the administration of Health and Social Services.
12. Support the develop,ment of Municipal police.
13. Relocate Rehabilitation Centre to Nunavik for Youth.
14. Develop and establish at treatment centre for Alcohol, Drug and substance abuse.
15. Ensure continuation of accredited community workers programs and include specific courses offered in the territory.
16. Insist T.N.I. to enforce regulations related to personal affairs and abuse of local F.M. station.
17. Social Assistants must be more actively involved in information and education, education prevention in Social Services.

How recommendations can be implemented.

1. Discussion of Inuit philosophy and policy need to take place at Board meeting, Town meetings certain church meetings planned for this purpose, between amongst staff of Kativik Regional Council of Health and Social Services, Social Services and hospital services. Check in one year to see where this is being done.

2. At the end of each year all hiring committees should be reviewed to ensure that more and more Inuit are represented on them . Where this has not occurred personnel depts must be requested to increase the Inuit on hiring committees.

3. At the end of a year each community should be asked how they have increased their participation in solving social problems - what problems they have tried to deal with and how they have tried to deal with them e.g.: making new programmes, new by-laws, increasing co-operation amongst community groups, getting more citizens to volunteer to help etc...

4. Only people can know whether they are implementing this recommendation!

5. At the end of a year contact community workers in each community to see how local leaders have increased their support for care givers in the community.

6.7.8. Cannot be measured - but it would be interesting to see if people think they are being put into practice.

9. By March 1992 there should be some means of increased communication between organizations within Nunavik which will lead to a working network - what are the indications of this?

10. Begin negotiations for CEGEP level courses with Department of Education. Enter into negotiations with Champlain Regional College to see if they could help with setting up some courses up North as a beginning since they have a multi-campus charter (Quebec, Sherbrooke and St-Lambert) and are an English language C.E.G.E.P. Would the school Board back this move? It would b important to try to get some technology courses started.

11. This will need considerable negotiations to accomplish but should be started in some form.

12. Follow up to see what developments have taken place in regards to the municipal police.

13.14. What steps can be taken locally towards the development of these institutions?

15. Contact social services to see what is being done in this area. Push McGill or Quebec Department of Education according to need.

16. Follow up with T.N.I. to see what they are doing to control abuse of radio stations.

17. Meet with Social Services to see how they have increased their information and prevention services.

ANNEX 19

ANNEX 18

CONSULTACTION
RÉSEAU

CONSULTATION REPORT

KUUJJUAQ GROUP HOME

C.S.S. UNGAVA

SERVICE DE READAPTATION

May 13-17, 1991

Robert Vyncke, Consultant
Consultaction Réseau
Montréal

THE CONSULTATION

CONSULTATION MANDATE

Since its re-opening in April 1990, the Kuujjuaq Group Home has been facing chronic staffing shortages and noted lack of input from the community. The feeling has been very strong that this essential resource for native youth between the age of 12-18 may have to close its doors again!

To prevent this from happening, C.S.S. Ungava Director of Professional Services & Readaptation, Jean Gratton, undertook to call for new expertise and start a process of consultation which would facilitate the C.S.S. and the community to have a better reading and an enhanced understanding of the problems emerging from the present organizational, program, and community set-up of the group home. In other words, ***CONSULTACTION RÉSEAU*** was asked to examine the external and internal factors which may effect the service delivery in the group home.

The consultation mandate incorporates the following steps:

A. PROBLEM STATEMENT:

- This problem definition stage involved the wider community. Views and impressions of key community people in Kuujjuaq, Kangirsuk and Quaqtaq are being included. Information is being obtained regarding the place of the group home in the community, i.e. what are the community's expectations of the group home; how does the group home fit in the native context; how well has this program been able to meet the needs of the native population in dealing with its troubled youth; how well is the group home linked to the communities and its other services; how does the community understand the role of the group home staff; how would they best be able to support the group home.

- Group home staff input: the problem definition stage provides an opportunity for staff to give their viewpoint on program, organizational and staffing issues, as well as how they look at the place of the group home in the global system of service delivery for native youth in Kuujjuaq and other settlements.

B. Fact Finding - Data Collection:

The initial input thus includes clarification of group home mandate, admissions criteria, statistics on number of clients served, and program description.

This exercise will also attempt at reconstituting the group home's short history.

C. Problem Analysis and Feedback

This phase in the consultation focuses on the synthesis and analysis of the findings in order to produce a base for problem-solving. All findings are first discussed with the Director.

D. Problem - Solutions & Action Plan

A set of avenues which should lead to a better functioning of the group home in Kuujjuaq will be proposed. Those suggested solutions will be shared and discussed with all groups who had input during the initial phase of the consultation.

CONSULTATION CONTEXT

A. SOCIO-CULTURAL AND DEMOGRAPHIC ENVIRONMENT [1] (Summary)

The population of the Kativik territory north of the 55th parallel totals approximately 7000 people, of which 90% are Inuit, unevenly spread amongst 14 settlements located along the coast of Hudson Bay, Detroit of Hudson and Ungava Bay. Fifty percent of the population is younger than 18 and more than 20% is between 10 and 18 years of age.

Other relevant data are the incredibly high number of adoptions. In 1987, the adoption rate reached 38%. Neglect and physical and sexual abuse appear to be increasing, and at Secondary III level the drop-out rate reaches more than 40%. Inuit society is confronted with a dramatically high rate of suicide among youth between 15 and 24. Between 1987-1990, 16 suicides took place in the Kativik region. The reality of rapid social change creates an environment with "*constant state of transition and turbulence in roles and social norms. With a growing gap between generations, youth have no recognizable role models able to provide direction and bolster their identity as natives empowering them to face southern non-native influences.*"

The lack of appropriately developed recreational and leisure time facilities or programs for youth brings about a great sense of boredom and powerlessness. This creates an environment where vandalism, drug and alcohol abuse are seen as ready alternatives.

Youth is furthermore confronted with high levels of family violence, separation and drug-related criminal activities within their small communities.

This summarizes in great lines what most interveners reported.

B. INSTITUTIONAL AND NON-INSTITUTIONAL ENVIRONMENT

The group home is part of the C.S.S. Ungava and thus the Ungava Hospital service stream. As such it is a M.H.S.S. resource which was originally started with the help of the C.A. L'Étape from Val d'Or. A service contract was negotiated between the C.A. and the hospital with regards to hiring human resources on loan from l'Etape. At present, the hospital and C.S.S. carry total responsibility for this rehabilitation program.

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1 Data source: Conseil Régional Kativik. "*Pour la santé et le bien-être dans la région Kativik - Défis et objectifs prioritaires*". Mars 1991.

The group home has a major linkage to the Director of Youth Protection as almost all referrals are the result of decisions taken under the Youth Protection Act or Young Offenders Act.

In some situations, the local Police Department (Sûreté du Québec) makes use of the group home for emergency back-up services when a young person has been apprehended under the Young Offenders Act.

Most children from the group home attend the Kuujjuaq High School Jaanamarik. The group home has no formal liaison with the school authorities.

As to the other community organizations, i.e. Health Committee, Youth Committee, Elders and Women's Group, they have as of yet not established any specific links or support to the group home.

C. THE KRCHSS (KATIVIK REGIONAL COUNCIL OF HEALTH AND SOCIAL SERVICES)

The KRCHSS has the mandate of ensuring the establishment of health and social programs for the Ungava Bay and Hudson Bay areas and to guarantee that these programs meet the needs of the population.

The KRCHSS is presently working on a Regional plan of Services for "*Youth with Difficulties*" (March 1991) and in the process of validating the objectives set in the plan.

The present group home consultation intends to be complementary to the KRCHSS process. Although it is primarily focussing on the better functioning of the group home, all information and conclusions should serve to enhance the KRCHSS process. The group home adheres to the overall goals and objectives of the KRCHSS.

THE CONSULTATION PROCESS

Great attention was given to communicating with a wide base of interlocutors which would enable us to present a better view on the magnitude of the problem the group home is facing within the community. In this section of the report, we provide a summary of all meetings.

SUMMARY OF MEETINGS:

MEETING WITH JEAN G. GRATTON AND DOROTHY MESHER, D.P.R.S. AND GROUP HOME COORDINATOR (MAY 13TH, 1991)

- First an overview of the overall group home situation and its linkage to the community in Kuujjuaq and other settlements was provided. It was felt that the group home program was very misunderstood by the community. (Place for bad kids, one hears some people talk about "The Crazy House"). The actual general lack of active support from the community gave a feeling of isolation.

- Underlined dramatic staffing shortage; the great difficulty in finding and hiring houseparents led us to a definite feeling of discouragement, in that it was seen as a major obstacle to give a future to the group home. The "good" people in the community had already jobs. Finding male partner/houseparent seemed even harder, as one of the job requirements is to be a model in the community.

- Lack in training.

- Reviewed history of the group home.

  First opened June 1988 to close shortly after in September 1988.

  After Jean Gratton's arrival, the group home re-opened in April 1990 and has been providing care for 44 young people between 01.04.90 and 31.03.1991.

  It needs to be underlined that a relatively high staff turnover rate has plagued the group home. Since its re-opening: 3 psycho-éducateurs, 18 "houseparents"-staff, both regular and relief. These numbers do not take into account the times social service staff had to supplement the group home staffing when nobody was available to work at the group home.

- It was further highlighted that the group home coordinator has some contact with school authorities related to handling specific situations and informal contacts with municipal leaders.

- Annexe 3: Group home data sheet.

MEETING WITH KATIVIK REGIONAL COUNCIL OF HEALTH AND SOCIAL SERVICES (KRCHSS)

(Lizzy Epoo-York, Director General;
Francine Tremblay, Director of Program;
Two consultants: Pierre Portelance and Jeannie Sala)

- Identified problems with the way the group home was started in 1987. Although public consultation seemed to have been planned, it was never done. Regional Council had no say in budget and in the contract MHSS set up with L'Etape. Regional Council had neither any involvement in the referral process. The Council felt "*services had been forcefed*" to the Inuit community.

- Aware of the problem in recruiting houseparents.

- It was felt present group home team has done a lot for community.

- Underlined need to explore what community can now do for the group home.

  Regional Council would gladly assist in any broad consultation process to see how community can become part of the group home efforts.

  In this context, it was seen as particularly important to look into the Volunteer aspect. It would seem to be good to work from a volunteer framework, provided it would incorporate a phase of teaching volunteers how to be a volunteer in such a specific context as the group home and the Inuit community. Focus should be on self-help groups.

- Regional Council underlined it suffers from a definite lack of resources to develop the area of community organizing, which essentially affects the group home too.

- Regional Council appeared to have relatively good insight in the group home program and the type of admissions which could be handled by the group home vs. the residential facility in Val d'Or.

- There is no specific formal regional admissions process which prioritizes admissions into institutional resources. L'Etape and the group home had formed the admissions committee.

- As to the native issues relevant to running a group home based on a "white man's" concept, it was felt the families should take care of the children and that the group home was to be seen as a very temporary solution to a problem the family could not resolve alone. The "native way" does not incorporate a group home concept; however, as the native society is in permanent evolution, the group home was seen as a necessity to provide a sense of continuity in support to the families. The Regional Council felt maybe the group home should be regarded more as an "extended" foster family if it is to be run more according to a native way of doing things. It was felt the institutional components of the program should be looked at, and group home should reflect more the idea of a program based in the community.

- As to the community involvement, since the municipal authorities had originally been involved, it was felt this link should be re-established as they could be helpful in

facilitating recruitment of houseparents. The Council felt also that the group home should reach out to the overall community by first telling them (educating them) about the problems the group home is facing, enhanced with information on what the program is all about. This broader process could be done jointly with KRCHSS.

It was felt the community had to go back to basic principles of a traditional healing process. They saw the group home as fulfilling a leadership function in this respect.

- The difficulty of implicating other coastal settlements was highlighted. It was felt Hudson Bay should have its own resources as distance made work with families extremely difficult.

- Training Inuit staff was seen as vital to any program survival. However, it was underlined that no sufficient budgets were being allocated and that neither were training programs adapted to the learning process of the native group.

- The KRCHSS introduced their own consultation process within the framework of the elaboration of a "*Regional Plan of Services for Youth with Difficulties*" (March 1991). They further situated this regional plan in the context of the "*Politique de Santé et de Bien-Etre dans la Région Kativik 10A*" produced in March 1991 for MHSS.

  It was discussed and understood that the group home consultation process could best be done complementary to KRCHSS process and that mutual support would be lent.

MEETING WITH THE KUUJJUAQ LOCAL HEALTH COMMITTEE

(Shirley Dupuis, Elizabeth Peters, Madge Pomerleau, Maggie Johannes)

- All members attending the consultation session were new to the Local Health Committee. The mandate of L.H.C. was clarified.

- It was explained the group home and L.H.C. had no linkage, neither formal nor informal.

- The L.H.C. members appeared to have only a rather scattered view of the group home program and the problems the children were facing.

- The L.H.C. explained people in the community never approached them on issues pertaining to difficulties with their children other than related to health service delivery. They had never been asked how to obtain services from the group home. They felt people would go directly to social services.

- As to the native context issues, a lot of ambivalence was expressed. It was felt youth in trouble and young people in general had no place to go to receive help in the Inuit culture. It was felt elders were too remote, inaccessible and did not deal well with tumultuous changes in Inuit environments.

  There was a real sense that people in the communities are going their own ways and that traditional supports are eroded. They felt people are working too much and that the custom of "visiting each other" had changed dramatically.

They felt they could not quite well indicate how the group home program could adapt to native ways other than through re-establishing contact with nature, e.g. going camping, going out in the land, getting fresh air, getting a sense of "good freedom", no worries, getting happy again!

- The L.H.C. suggested very strongly that volunteers should help the group home. They offered to assist the group home on whatever way it was seen as useful.

- The L.H.C. would like to receive more information in what the group home is all about.

MEETING WITH MUNICIPAL COUNCIL AND HEALTH COMMITTEE IN QUAQTAQ (MAY 14TH, 1991)

(Eva Deer, Mayoress; Bob Deer, Etua Tukkiapik, Charlie Tukkiapik, Eva Tukkiapik for the Municipal Council; and Lizzie Oovaut, Maggie Okpik, Christina Aloupa, Annie Kakkinik, David Okpik for the Health Committee).

- Both groups felt ill-informed about the group home. They had some vague notion of the types of children that were being placed. They saw it mostly as a "step-over" place for young people who are not having serious enough problems to be placed in Val d'Or. It was also seen as a place where one is "waiting for time to pass".

- There was some awareness of the staff-recruiting problems.

- There was some exchange on the question of why there was no group home in Quaqtaq and people's difficulty in seeing most services being located "south", i.e. Kuujjuaq. Through this discussion, it became apparent that some members had mixed feelings about the very existence of a group home in the Inuit context, even to the extent of suggesting it was possibly a waste of money.

- There was further some exchange on individual experiences which had something to do with the group home, which highlighted confusion on what the group home can provide.

- As there appeared to be a great lack of information, some members made excellent suggestions on how to involve their communities, which should include: written communication to leaders, briefings on purpose and objective of the group home, providing FM with succinct information to transmit on the air, making press releases, producing TV program information, organizing workshops amongst children, getting posters, making better use of the youth committees.

- On the issue of native components of the program, the groups felt with native staff being hired this provides for a sufficient level of "nativeness". They felt the group home should enable youth to function in both cultures.

- The group resumed the meeting by asking how they could help and they would organize a group to give us feedback on the consultation document.

MEETING WITH MUNICIPAL COUNCIL AND HEALTH COMMITTEE OF KANGIRSUK (MAY 14TH, 1991)

(Elijah Grey, Mayor; Annie Eetoak, Tommy Kauki, Tomishaw Augairk, Council members; Eyetsiak Simigaq, President, Health Committee; Sarah Grey, Secretary, Health Committee; Lizzie Eetook, Maggie Auglak, social assistant, and Betsy Annahatak, Health Committee Members.)

- It was rather striking that in this community nobody seemed to know anything about the group home. Members of both groups insisted on the fact that they preferred the native way of resolving problems of children in Kangirsuk.

  A high-geared discussion took place amongst the group members relating how parents used not to be scared of providing discipline for their children; before, children did not have to leave, now others interfere. The group felt they are facing new problems and end up with even more complex problems as they were unsure about which methods to use to solve those problems

- Some members felt that maybe the group home could provide a useful avenue to learn how to deal with problems when they go south..

- In this group, a lot more importance seemed to be given to the elders, even to the extent that some felt the elders should be group home employees and then they would feel better about the group home.

- Both groups felt, as they had had problems with youth between the ages of 12 and 18, that some of those youth could be sent away from the community. Police, the group home and the community could probably cooperate, take action together.

- Both groups felt very strongly that the future will be bringing more situations which may require group home intervention. Although they would rather see things more in the traditional Inuit way, they felt they had probably to accept the reality and support the group home as a service to their community.

- They felt the social assistants should serve as a "transmission" between the group home and the community. The social assistants could disseminate information and help people understand better what group home services are about.

- They felt L.H.C. could help in this process and organize, if desired; a public meeting. It was stressed that anything new takes time and that once people knew, more collaboration would be given.

- There was a very strong feeling about the job posting for group home parents to be limited to Kuujjuaq. They insisted the hospital and KRCHSS should review this practice and advertise in all communities.

- Both groups felt that native programs should be part of overall group home activities program. Teach hunting and survival skills. They offered to help if such a need was felt. Presently, the municipality is already involved in a work program for youth who have run into problems with the law.

- Both groups offered their support to the group home staff.

MEETING WITH STAFF OF SOCIAL SERVICE (MAY 15TH, 1991)

(Louisa May, D.Y.P. , Annie N. Snowball, Joanne Mesher, Lizzie K. Gordon, Kitty Johannes, Jean G. Gratton, Dorothy Mesher)

- Perception, knowledge social service workers have about the group home mandate and program appear to be limited to a general understanding, in that they seem to know which youth can be admitted but do not seem to have much information on what is being done in the group home and what types of programs the group home provides.

- D.Y.P. appears to have very good understanding of the original goals the community had put forward in wanting a group home program: helping parents who feel unable to control the behaviour of their children; having another alternative to placement in Val d'Or.

- The group expressed great concern about the lack of communication with parents once youth placed. Rarely are goal-setting meetings held with staff and parents when the youth has been admitted. Social service workers seem to struggle with knowing how to create liaison with the group home and provide for continuity in service delivery. It appears social service workers often stop their interventions with placed youth once admitted in the group home. Sporadic communication is what remains.

  Group home staff, if they do not insist on worker contact, have to operate on their own. Social service workers claim the group home is not "open" enough and "nobody is making a move". A wait and see approach became very much a central dynamic between both groups.

- Social service workers' perceptions of how community "reads" the group home is to consider it as "a crazy house", a place for bad kids, a place where kids are not disciplined but spoiled, a "jail", a place to send them to be punished; it is often called "children jail"; people also ask why the children are free in the group home; people do not understand why they are receiving help, why kids are being taken away from their family.

- Social service workers feel "parents feel failure" and therefore are reluctant to receive help, which colours their view of the group home. They feel they should get parents more involved.

- Some social service workers feel they just now start to better understand the intervention process and, therefore, want to keep the communication more open in the group home as they just now seem to "grasp better the notion that their job is not finished once the youth is placed".

- As for the native character of the program, they insist on "bush programs" with volunteers.

- As for involving community, it is felt that meetings with different committees is probably the best approach.

MEETING WITH KUUJJUAQ POLICE DEPARTMENT, SURETÉ DU QUÉBEC (MAY 15TH, 1991) *(Robert Challfoux)*

- It appears the Sûreté du Québec has an understanding of the group home program which focussed on their use of the service, i.e. transit, back-up, use of "secure room" when a youth in the community is picked-up for drunken behavior or vandalism. The S.Q. does not use the group home for arrested young offenders and intervene primarily in acting-out situations that have a violent character.

  They do not have a perception "that everybody can be dumped there" either.

- When the S.Q. uses "back-up" room, they seem to follow a clear procedure of admission understood by both parties.

- The real vocation of the group home does not appear to be very well known, other than that the group home takes care of youth with problems. They seem to have no idea on what kind of program is provided, neither on what the youth has to do to stay in the program.

- The S.Q. seems aware of the group home staff-recruiting problem and the group home high intake numbers.

- The S.Q. felt they could help the group home program by organizing prevention programs (i.e. drug, sexual assault, etc.) and sometimes help providing support in acting-out situations.

- The S.Q. is very open to have permanent formal liaison established.

- It was suggested the group home should take more of its place in the community. Reach out. It was felt occasionally that the group home did not want contacts.

MEETING WITH THE COUNCIL OF KUUJJUAQ (MAY 15TH, 1991)

(Mayor Johnny Watt & Councillors)

- It appeared the Council of Kuujjuaq knew very little about the group home as they have had no information about the program itself. There was some awareness of the staff-hiring problems as the mayor himself had tried to help resolve this problem in the past on an informal basis.

- They felt the group home was not a problem in the municipality. The group understood that since they were not being contacted, then it meant the group home did not need any help.

- The Mayor underlined clearly that they needed to know what the group home wants from the municipality and that the council was very open for exchange and assistance where and when possible.

- The council wants to be made aware of the goals of the group home, including their approach to cultivate the native aspect, as they feel this should not die down. Hiring Inuit staff is therefore vital. They suggested that maybe group home kids could join the Hunting and Trapping Program with school, and thus work with what already exists. It was also suggested the Education Committee should be approached with regards to have the Old Chimo Summer Camp be made available. The councillors felt this way the group home would not be kept apart but "integrated with society".

- The group underlined the issue of providing housing if staff came from other communities. The housing problem seems to be a hindrance which needs to be examined.

MEETING WITH SCHOOL TEACHERS, JAANAMARIK SCHOOL (MAY 15TH, 1991)

(School Director, Margaret Koplec with some 12 teachers)

- A quick "tour de table" brought to light that even the school teachers knew very little about the Kuujjuaq group home. Thoughts varied between "prison", place for young offenders only. Their notion seemed to emerge from having had some of the group home children in their classroom and being confronted with unannounced arrivals and leaves.

- Generally, teachers understood the group home to be a place for troubled children whose home environment was inadequate.

- Teachers related their class experiences with group home kids and highlighted difficulties for both themselves and the other pupils to deal with the "coming and going" of the group home kids at the Kuujjuaaq school. Some school children seem to demonstrate difficulty in accepting the kids from the group home, who are seen as kids with problems.

- Lengthy exchanges took place, which primarily addressed the lack of school resources for those children. School teachers stated school is not well equiped to face increasing numbers of children with behavior and learning problems.

- Teachers expressed great concern with the fact that the group home children stayed for very short periods of time in school as their stay in the group was often interrupted by going home or going to Val d'Or. Teachers wanted to know more about the length of stay and the reasons for termination.

- Teachers felt that children living at the group home were receiving good support and made good progress. They failed to see why then suddenly kids would be pulled out of school, the more that group home kids tended to appear happier than a lot of the other children. A teacher explained this by suggesting the consistent structure and motivation provided through the group home program helped those children to perform better at school level.

- Teachers wanted more information to be given to school as to each child's behavioral, academic and socialization objectives. They did not want to have a full background but rather information which would allow them to work in a

complementary fashion toward the same objectives as social service and the group home.

- The guidance counsellor suggested the group home and her service could be tied in to provide some counselling.

- Teachers urged for support in their classrooms and thought child care workers and teachers teams should be looked at. Make group home education part of the program in school was another suggestion.

- All teachers felt a formal link needed to be established. Communication could be enhanced by providing a better liaison structure to process general group home/school issues as well as case per case relevant issues.

The meeting with this group was carried over to May 17th, 1991 and some teachers who had not been able to attend on May 15th, 1991 joined.

This time, the group focussed more on concrete avenues for collaboration, looked at some particular problem areas and made suggestions to resolve them. Most agreed upon collaborative initiatives needed to be picked-up before the new school year or early fall.

- The Adult Education Coordinator underlined the role the group home should play in bringing back the valuable elements of the "native way". She felt that "how to care for other people" is being lost and that older people have a lot to contribute. However, the elders have lost their predominant place and are no longer looked upon as people having a lot of resources within them.

  She was very eloquent on the issue of building up pride and responsibility with young people. One way to realize such a goal was to provide lifeskills education programs/workshops. Lifeskills is seen as the first goal; schooling is the secondary goal.

  The elder and other adults from the different communities should play a role but "people do not seem to know how to deliver knowledge". The volunteers should be "taught how to deliver". It was felt we tend to look at education, teaching, learning with a focus on group, rather than look at youth as individuals. It was felt "we needed to ask each of the group home youth what they like and then develop from there". It was underlined we needed to start at the level children are at.

- It was suggested the group home should reach out to volunteers who could provide a lifeskill learning environment and set up sports, hunting and survival programs; group home children could provide for babysitting resources; create a cleaning-up crew. The community could give them a better chance if they offered their services as this community is more open to a lifeskills approach. Group home youth should be taught on how to play a more significant social role.

- A variety of communication-related issues between school and group home were addressed:

  . need to received background information on each child's academic, medical, behavior profile and suggested approaches to consequences;

  . daily feedback to and from the group is possible;

  . binders for housework sheets was seen useful;

THE MEETING SUMMARIES CONTAIN THE FOLLOWING MAJOR KEY ELEMENTS AND MESSAGES TO BE ACTED UPON.

A. Necessity to maintain/enhance the group home as a basic service for troubled youth.

B. All community groups are prepared to provide all necessary support if requested to do so.

C. Key groups such as school, police, social services wish to entertain a formal liaison with group home personnel to facilitate the planned, structured intervention.

D. All community groups requested the group home to inform all communities about their program within the earliest possible timeframe.

E. All relevant bodies would do everything within their powers to facilitate the recruitment of group home parents and staff. The Quaqtaq and Kangirsuk communities requested that a special effort be made to open job opportunities to their communities and change the restrictive hiring criteria applying only to residents of Kuujjuaq. It was strongly recommended that the hospital changes its policy in that regard, hereby facilitating hiring from those communities.

F. Group home is seen as having to fulfill a leadership function with regards to the enhancement of the cultural dimension within the Inuit community. Community organizing and educating volunteers how to help are key ingredients in this process. The group home should provide for culturally-adapted programs centered around a lifeskill approach which integrates the Inuit way of life.

G. All groups underlined the need to provide for more training adapted to the native mode of learning.

H. All groups saw a great need to involve the families to a much higher degree.

THE GROUP HOME /COMMUNITY RELATIONSHIP: A DESIRE FOR CLOSER COLLABORATION

PROBLEM ANALYSIS

A brief analysis of the situation as depicted by almost all groups encountered in the different communities shows the group home suffers from isolation because it never was properly introduced to the community.

Historically, not even the KRCHSS or the municipal authorities in Kuujjuaq had been part of the initial inception process. A feeling of *déjà vu* was shared by all. The government authorities had failed to hold a proper consultation.

Therefore, the present effort to "do things over" was seen as positive and essential to the survival of the group home.

It was clearly demonstrated that the group home's most important task now is to reach out, to inform, to do the education of the communities. These have been recurring themes all along this consultation journey.

All groups wanted to hear how they could be of any help.

STRENGTHS & WEAKNESSES

In light of their desire to participate in the group home's development, the **community groups' strongest points** appear to be:

- a great desire to do something to maintain and enhance the group home program;
- a virtually unanimous vote of confidence in the group home staff and their efforts;
- a clear-cut vision that the group home has a significant leadership role to fulfill in contributing to the revival of the traditional Inuit norms, values and beliefs, by teaching the Inuit way of life;
- a very strong commitment to an education and learning process which reflects an understanding of Inuit people, e.g. autonomy of the individual,

belief in his capacities to change. It is believed that it is only in this manner that "taking charge" by the Inuit for the Inuit will be possible.

On the downside, we must recognize <u>some weaknesses</u>:

- few people understand or have sufficient knowledge about the group home and its objectives;
- past unhappy experiences with other projects may influence their level of commitment to follow through as skepticism may surface;
- hardly anybody has a sense on *what kind of support* and *how it should be provided* to the group home program;
- past experiences to involve communities have failed because of lack of knowledge on how to develop community participation and interest;
- a lot of the groups consulted highlighted how much the Inuit society is going through dramatic and rapid changes which affect their identity. This is weakening the role given to significant role models such as the elders and they are left feeling confused on how much to follow the "lead of south".

PARTICULAR ROLE EACH GROUP COULD PLAY TO LEND SUPPORT TO THE GROUP HOME AT PRESENT TIME

MUNICIPAL AUTHORITIES:

- <u>Kuujjuaq</u>:
  - provide change to housing policy as to facilitate hiring from other communities;
  - facilitate job training programs for older group home youth;
  - participate in group home outreach to volunteers;
  - support specific community basic group home programs.

- Quaqtaq & Kangirsuk:

  - motivate the community to learn more about the group home and eventually help to solicit interest with adequate possible candidates to work in the group home;
  - take leadership in diffusion of information about the group home;
  - be of help to families who have a child placed in the group home, to keep contact with their child;
  - help organize volunteers.

POLICE DEPARTMENT:

- provide for liaison person;
- provide for specific prevention programs;
- maintain their support in cases of acting-out.

LOCAL HEALTH COMMITTEE:

- help organize health counselling with group home residents;
- help organize volunteers.

SCHOOL BODY:

- structure liaison with the group home to facilitate communication;
- set up group home/school committee to follow through on discussions started during the present consultation, focussing on mutual supports and possible adaptations to some facets of school programs for group home youth;
- open up hunting & trapping program to older youth in the group home;
- study possibility of having a group home educator at the school.

E. CREATION OF TWO FULL-TIME POSITIONS OF COMMUNITY ORGANIZERS.

To staff those many committees, ensure follow-up and to organize community support and volunteer group, it is vital to have people who are trained or who are very knowledgeable on the principles of community organizing and understand service delivery in the nordic context.

These positions would guarantee ongoing communication with all community groups involved as well as the necessary coaching and orientation to allow for Inuit staff to take these functions into their own hands within the earliest possible timeframe. These two staff would work under the direct authority of the DPSR and work in close collaboration with the group home coordinator, DYP and KRCHSS (Annex 2: Summary job description for community organizers).

F. THE ESTABLISHMENT OF A GROUP HOME INFORMATION NETWORK: REACHING OUT

Because of its dramatic staffing and program problems, the group home has been unable to ensure an organized form of reaching out to the communities.

As all groups indicated a great need to learn more about the group home program and activities, it is highly recommended to implement on a priority basis an information initiative which should reflect the suggestions made by some of the groups consulted:

- USING the proposed group home support committee as a launching board for the creation of a three-monthly group home NEWSLETTER;
- A SIGNIFICANT EFFORT should be made to provide all groups in all communities with simplified written explanation on what the group home program is all about. This information could equally be used for radio FM;
- It was suggested to use TV channel (CBC North) to explain the group home program to the wider Inuit population;
- It was suggested to use the youth committee and the school system to reach youth in providing them with contact opportunities with the group home;
- Visual aids should be used, such as video, posters;
- Above all, give priority to personalized meetings to allow from exchange with local groups.

In order to promote better communication with a vast range of interlocutors, the group home should provide *clarification* on the following key areas:

- MISSION STATEMENT and group home philosophy;
- Group home program objectives;
- Group home admissions criteria;
- Group home program needs both as to the internal functioning and as to the external relationships;

- Group home liaison lines with DYP, Social Service and KRCHSS;
- Group home organigramme.

It is highly recommended to provide the group home with a *NAME* reflecting Inuit history.

This could come about through a community participation process, soliciting adult input for the name creation, and promoting a drawing contest in all schools of the Ungava area.

This activity could culminate in a open house celebration where special guests could be asked to attend with all members of the communities. Create a real community day.

It is recommended that a small "GROUP HOME NAME COMMITTEE" be created with community participation. The newly hired community organizers could see this as one of their priority activities.

This outreach initiative is essential but can only be carried out if the necessary staffing is provided. (See our comments with regard to over-resourcing on page 26).

Many concepts from the South are totally alien to Inuit culture and learning. Inuktituk is a language based on images and metaphors. Coaching should take this into account. Our process should be adapted to the way Inuit think and look at the world.

It appears unacceptable to think that one should carry on by having the Inuit community *copy* the "white ways".

The Inuit people are extremely capable people. However, the government has imposed organizational structures and management approaches which are foreign to the Inuit way.

True "autochtonization" can only happen if we allow the Inuit people the time to first understand and integrate the approaches of "the South", which they in turn can adapt to how they see things to be according to their way of life. The models of "the South" should only be transmitted as "points of reference" or "points of information". It is up to the Inuit to work with those models to the extent they see fit. Without proper training and coaching, which focuses on adapting southern concepts to native culture, "autochtonization" will fail and loose its real meaning, i.e. the empowerment of the Inuit people within the wider Quebec society.

The Department of Rehabilitation Services seems determined to demonstrate the need to function according to the above-mentioned principles, and therefore to commit itself to advocate for the necessary training resources to support this undertaking, i.e. continuing education in a general curriculum leading toward a D.E.C. in Special Education; regular training sessions in the form of seminars and field placements, and finally on-the-job training/coaching.

The Department of Rehabilitation Services believes that empowerment of the Inuit staff is essential to the empowerment of the youth placed in the group home.

NOTE ON THE CONCEPT OF "OVER-RESOURCING"

It seems essential to underline that when undertaking the implementation of a new program, especially into an environment where such concept as a group home is foreign, we must pay extra attention to the need of putting in more resources than would normally be required under ideal conditions. Learning and training requirements are time, energy and staffing intensive.

The budget made available for the group home should reflect this. Staffing and equipment budgets should be higher in the beginning phases and gradually be re-adjusted as time progresses.

Essentially, the group home needs immediately extra staff to enhance the program in the following way:

- provide professional support to organize the Admissions Committee, stage and lead case discussions, and ensure each youth has a workable treatment plan;

- provide training on-the-job, primarily the houseparents, so they could gain better understanding of their duties and responsibilities on the floor.

Although this may appear to look like over-staffing, it is crucial to re-enforce the organizational structure to create stability in the program. Those functions could best be carried out by a consultant to the coordinator. Furthermore, other organizational/staffing adjustments are required (see Part II of the present report which focuses on internal issues).

This approach would support true "autochtonization" and allows to focus on and appropriate coaching process.

NOTE ON INTEGRATING THE SETTLEMENTS

Settlements such as Quaqtaq and Kangirsuk suffer from the impact of distance from where decisions are taken.

In order to facilitate the integration into the group home program, one should find ways to pay extra attention in providing those further away communities with contact possibilities, e.g. bring in a community representative twice per year to the group home and ask them to report back to their communities on what happens in the group home. This would tie in with the Inuit model of visiting as they are "travelling people" at ease with going from one community to the next.

NOTE ON SERVICE DELIVERY TO HUDSON BAY

The great transport hindrances make it virtually impossible to adequately satisfy the needs of the Hudson Bay settlements.

It is felt this group should have its own resources within the Hudson Bay area.

It is suggested to repeat the present consultation initiative for the establishment of Hudson Bay group home resources. This could be led by the KRCHSS as a complementary action parallel to the "*Regional Plan of Services for Youth with Difficulties*". This process should be carried out jointly with the Local Social Service Center.

THE GROUP HOME'S INTERNAL FUNCTIONING

The consultation process included, in part, reviewing how the group home's organizational functioning was evolving.

The group home had been plagued by repetitious high turnover of insufficient trained staff which led to closure. Vacant positions have become the norm. Building a stable team has been the group home management's biggest challenge.

STAFF COMPOSITION

The group home is managed by a **COORDINATOR** who is directly responsible to the Director of Professional Services and Rehabilitation.

Two sets of HOUSEPARENTS, thus four adults, are alternately responsible for the daily, 24-hour, basic child care and development of the residents. **Two SUBSTITUTE HOUSEPARENTS** provide relief during holidays and other absences.

One EDUCATOR, who's main responsibility is to update the educational and re-education plans of the youth in the group home and assist the group home parents in daily routines and the completion of their job responsibilities. This function assures that group home activities are well organized, coordinated and animated.

One PSYCHO-EDUCATOR, responsible to the Coordinator, sees to the clinical aspect of group home programs and interventions, ensures treatment plans meet clinical standards, are congruent with reasons for placement and are followed.

At the present time, 3 positions have been vacant for a while, i.e. a houseparent set, the substitute houseparents, and the psycho-educator, which in effect means 5 people.

JOB DESIGN AND ROLE CLARIFICATION, EVALUATION

For all the above-mentioned positions, job descriptions are available and appear to be of excellent quality. Job postings are equally available.

It is important to signal that those postings are limited to applicants residing in Kuujjuaq.

It is to be noted that we observed significant discrepancy between what is described in the job descriptions and what staff understand their job to be or what the reality imposes on their job output.

The difficult staffing realities add serious stress for all levels and there is a real feeling of burnout eroding staff output and motivation.

- The group home coordinator and houseparents feel unable to provide and maintain culturally-adapted programming which guarantee transmission of the Inuit culture. They feel very inadequate as to role-modelling, which incorporates the values and cultural heritage of the Inuit, similar to what an elder could provide.

  Group home coordinator and houseparents expressed demands made in this area are unrealistic as they live with a real sense of disbelief that such is possible since fewer people in the community demonstrate an interest in fulfilling such a role since the elder have a diminishing place in the community. They feel they are being asked to do more than anybody else in the community is prepared to offer. They also feel very strongly that the adolescents in general have little interest in pursuing traditional life styles.

  We have to add that staff do not seem very implicated in community programs and that they feel the "bush-program" is not running adequately.

- From a group home administration point of view, both coordinator and houseparents have expressed negative experiences with the way shopping, budgeting is limited by the hospital authorities. They feel hospital administration is mistrustful of the Inuit houseparents' ability to handle money allocated for such things as clothing and equipment. Food is ordered via a shopping list handled via the hospital. They feel totally disempowered in this area.

- Both group home coordinator and houseparents suggested they should have more regularly held staff meetings and supervision. They also expressed a great need for training and enhancing recording skills.

- These staff expressed great satisfaction in terms of the basic care and upkeep of the house. The supervision of the resident children, their health and general well-being are a source of pride in their work.

  However, they feel maintaining good contact with families is hardly existing, and they expressed uneasiness in the area of confidentiality as they suggested Inuit context did not make it possible to respect an adequate level of confidentiality.

- Overall, these staff feel very stretched as the job expectations in terms of time and energy have been exacerbated by unavailability of relief staff. Further, they feel they do not meet the clinical requirements of the job, in that they feel formal aspects of providing therapeutic milieu are not incorporated.

- As to the coordinator's role more specifically, it was expressed good support was available in terms of what the Director of Professional Services and Rehabilitation brings into the program. Director is perceived as very supportive, however the need

for more coaching and training was strongly underlined as the coordinator felt inadequate vis-à-vis the formal requirements of the job.

Coordinator has maintained the group home in a "runnable" state. Her hands-on approach and the amount of time devoted in assisting line staff is to be seen as the ingredients which ensured group home survival.

- In terms of liaison functions, the coordinator felt contact with DYP and social assistants are minimal and stressed the point that admission decisions are beyond her authority and strongly wishes to have more input in the admissions process.

- An additional problem which affects the functioning of the group home is the language barrier. Houseparents generally do not speak English and educator and psycho-educator are not Inuit. Actually, one houseparent, a native, does not speak Inuktituk.

- As for the educator's role, satisfaction was expressed in terms of the recording output. Actually, files appeared to be kept up-to-date. However, this rests completely on the shoulders of the educator, which creates problems when absent. Group home log entries suffer, then as does the treatment plan updates. Educator sees his role as one of support to the coordinator, but appears to struggle somewhat in finding a place complementary to the houseparents. Basic care seems at times disconnected from activities responsibilities.

  Educator felt activities for boys were lacking. Houseparents seemed more at ease spending active time with the girls. Educator regretted not being able to get the "bush program" under way.

- All staff expressed the need to have input in decisions related to the duration of treatment as they showed real concern for the relatively high turnover rate in admissions.

- They all regretted not maintaining sufficient contact with school authorities.

In summary, it can be observed that:

- Staff feel very stretched; feel overloaded;
- Staff feel lack of support from community, DYP and social assistants at social service;
- Staff feel detached (isolated) from community;
- Staff feel they have maintained a relatively good team spirit;
- Staff are concerned with language issue impacting on communication/recording;

- Staff have no say in admissions and are concerned with the high admission rate;
- Staff are concerned with children's relatively short length of stay in group home. Social services authorize termination without ensuring parents can adequately receive child;
- Staff feel kids do not have sufficient activity programs adapted to their age and interests;
- Staff feel good about being able to provide basic care;
- Staff feel less good about their performance with regards to the clinical requirements of the job;
- Staff wanted clearer communication structure with school;
- Staff feel very alienated from hospital administration and overall service delivery structures in Kuujjuaq as with the settlements.

RECOMMENDATIONS WITH REGARD TO STAFFING ROLES

1 TO REVIEW ALL LINE FUNCTIONS, I.e. COORDINATOR, HOUSEPARENTS AND EDUCATOR AS TO BETTER REFLECT THEIR UNIQUENESS IN THE NATIVE CONTEXT.

A necessary role clarification should occur, which addresses the fact that the native staff are presently left without power and operate within a structure which does not sufficiently reflect their Inuit character. Such review should be done with staff's direct input.

2 TO URGENTLY REVIEW JOB QUALIFICATION REQUIREMENTS AND ADDRESS TRAINING NEEDS FOR PRESENT AND POTENTIAL INUIT STAFF IN A MORE INNOVATIVE WAY, AS TO RESPECT THE CULTURALLY SENSITIVE CHARACTER.

It appears that most of the training in the past focussed on a residential approach by displacing group home staff or newly hired employees to receive instruction in Val d'Or. The Inuit staff feel this strategy hindered their learning.

It is proposed to concentrate the education process on location in Kuujjuaq and focus on showing staff how to do the job using coaching techniques.

More formal aspects of teaching staff the child care and development aspects of the job could be done through a <u>series</u> of short (2 to 3 days) training seminars on location in Kuujjuaq.

GROUP HOME DEVELOPS AN INNOVATIVE APPROACH
H FAMILIES.

with families could be enhanced by inviting parents to spend time with
roup home, involve parents in fishing and hunting, bush program,
be on doing things with parents and children, rather than using
ted approaches as the only modus operandi. Modelling child care for
done by coordinator, houseparents and educator.

S.A.P. TOWARD ELABORATING A GROUP HOME POLICY
URES MANUAL (OPERATIONAL AND CLINICAL

uld be a complete team effort as to guarantee total group adherence.
cies and procedures exist on paper. Processing those with staff
ate could be a good start and provide more clarity for all staff on
nd program issues such as client communication, telephone calls,
medication, use of hunting weapons, use of back-up room,

gement process would greatly contribute to empower staff who, to
olated and alienated from the formal structures and process.

THE PRINCIPLE OF OVER-RESOURCING AS PART I.

taff require a significant amount of training-coaching and hands-on

oordinator should be able to count on assistance/coaching from a
CLINICAL CONSULTANT who could, through coaching,
n can be exercised.

should assist in a similar way the houseparents to carry out basic

s kind of an approach is geared toward native sensitivities, native
insisting they adapt to our structures and clinical approaches.

o hierarchical link between consultant and coordinator, neither
nt and child care worker as not to erode their authority. These
AFF function not LINE functions. They require staff with good
eu, high degree of tolerance and flexibility.

affing model should incorporate reasonable working shifts for the
ouse parent task is a difficult one and the model should not be
renuous working conditions.

should not work for longer stretches of 4 X 24 hours shifts per
lows house parents to develop better relationships with the
d to create a sense of permanency and promote continuity in
milieu.

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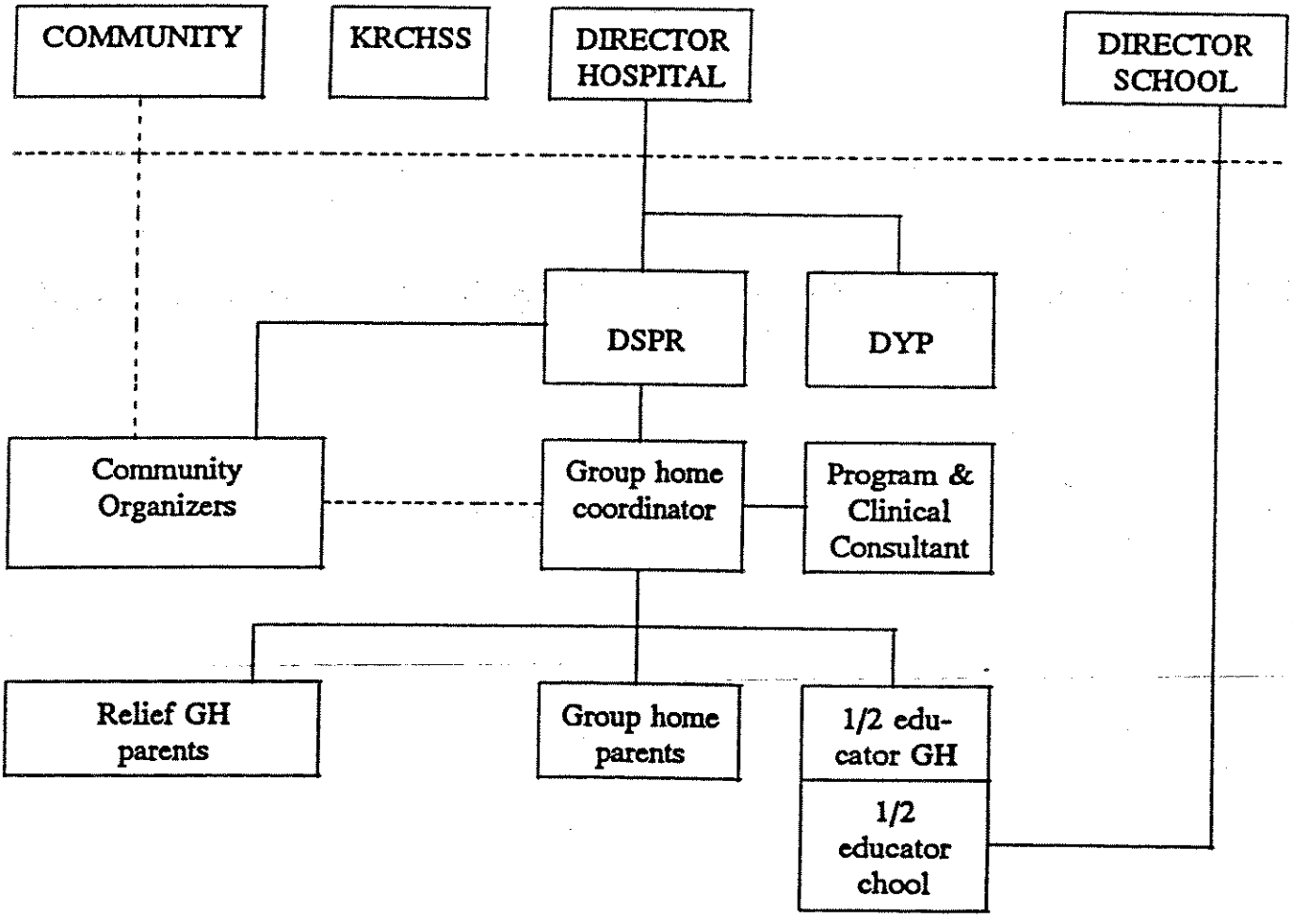
ANNEXE 1 GROUP HOME ORGANIGRAMME

The following is a suggested group home organigramme highlighting the hierarchy as per previously noted recommendations.

GROUP HOME ORGANIGRAMME



ANNEXE 2 SUMMARY JOB DESCRIPTION

COMMUNITY ORGANIZER

- Staff group home support committee and organize its implementation
- Staff other committee relevant to GH networking
- Organize community support and volunteer groups connected to the group home
- Ensure well developped communication between GH & All communities & community groups
- Provide teaching & coaching & orientation to Inuit volunteers & community groups related to GH mandate & activities (How to be a volunteer!)
- Establish a GH information network
  - News letter
  - Clarifications on what group home service is
  - TV CBC North contacts to explain group home program to wider population
- Develop alternative resources in the community
- Linkage with municipal, church, business & police authorities

ANNEXE 3 — GROUP HOME DATA SHEET

The group home statistical information is limited. Nonetheless, it has been possible to extract the following information related to actual days of presence of youth in the group home in terms of "Dépannage" and "Réadaptation".

We have attempted to look at the number of youth re-admitted to the group home after their return to their families. The statistics cover two periods : April 1st, 1990 to March 31st, 1991 and April 1st, 1991 to September 30th, 1991.

1st PERIOD				
		Placements	For a total of	Average days
Dépannage	L.J.C.	4	8 days	2.0
	L.P.J.	26	65 days	2.5
Réadaptation	L.J.C.	1	16 days	16
	L.P.J.	13	1272 days	98

2nd PERIOD				
		Placements	For a total of	Average days
Dépannage	L.J.C.	2	11 days	5.5
	L.P.J.	4	5 days	1.2
Réadaptation	L.J.C.	Nil	Nil	Nil
	L.P.J.	11	831 days	75.5

The average length of stays has slightly declined during the second period. It needs to be underlined that the busiest months are not incorporated in the figures for the second period, i.e. October, November and December.

Only L.P.J. placement took place in readaptation for the second period. Only 4 children returned to the group home for short stays only. This however could incorporate depannage.

Reasons for re-admission are not based on acting-out in the group home. Information gathered informaly suggest only two returns had to do with breakdown in family placement mostly because families had not been adequately prepared for childs return. Those returns home had been done on very short notice.

ANNEXE 4 — ACTION PLAN

TASKS TO BE ACCOMPLISHED (WHAT? WHO? WHEN?)

TASKS		RESPONSIBLE PERSON(S)	TARGET DATE
1	Constitution of group home community - support committee	Jean Gratton & Community organizer	05/06/92
2	Constitution of Réseau table	Jean Gratton	03/92
3	Constitution of Group home admissions table • Clarification admission • Clarification admission process	Jean Gratton Jean & Dorothy Mesher Jean & Dorothy	03/92 02/15/92 02/15/92
4	Constitution of School-Group home liaison table • Clarify school intake process and requirements	Dorothy Mesher & Margaret Kopiec Dorothy and Margaret	04/15/92 02/92
5	Hiring of two full-time community organizers • Prepare job description • Prepare posting • Interviews	Jean Gratton	04/92 02/92 02/92 02/92
6	Creation of newsletter involvement of • FM • TV • Youth committee	Community organizer	Summer 92 09/92
7	Clarify GH mission and philosophy	Jean & Program & Clinical consultant	03/92
8	Group home program objectives	Jean & Program & Clinical consultant	03/92
9	Group home name creation • Constitute planning committee • Advertize content and drawing content	Dorothy Mesher Dorothy & Program consultant	Spring 92 02/92 02/92

ANNEXE 4

ACTION PLAN

TASKS		RESPONSIBLE PERSON(S)	TARGET DATE
10	Review job description/qualification	Jean & Program & Clinical consultant	06/92
11	Overall staff training plan 92/93	Program & Clinical consultant	03/92
12	Train GH staff in budgeting	Accounting & Dorothy	02/92
13	Provide GH with budget	Hospital general Manager	04/92
14	Open applications outside of Kuujjuaq - modify housing policy	Hospital general manager	04/92
15	Constitute permanent GH relief pool	Jean Gratton	02/92
16	• Start weekly group home staff meetings • Start bi-weekly GH meetings with social service staff & call-in information from settlements before meetings • Start regular weekly GH residents meetings • Start individual residents log book • Review/prepare lunch and dinner menu's on weekly basis	Dorothy Dorothy House parents House parents House parents	11/15/92 12/01/92 11/15/92 11/01/92 11/01/92
17	Ensure close supervision	Jean & Dorothy	11/15/92
18	Develop innovative approcah to family work	Program & Clinical consultant	Summer 92
19	Hire Program & Clinical consultant • Job description • Posting • Planning out to possible card	Jean Gratton	03/92
20	Hire educator/school based GH educator	Jean Gratton	03/92

ANNEX 20

Annex 19

HÔPITAL DE L'UNGAVA HOSPITAL

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C.P. 149, Kuujjuaq, P.Q. J0M 1C0

Kuujjuaq

Kuujjuaq, le 18 mars 1992

M. Roger Richard
Liaisons nordiques
Ministère de la Santé
et des Services sociaux
1075, Chemin Ste-Foy - 12e étage
Québec (Québec)
G1S 2M1

Cher monsieur,

Nous vous soumettons, par la présente, une demande de révision de budget de fonctionnement du "Foyer de groupe" pour l'exercice financier 1992-1993.

Le foyer de groupe de Kuujjuaq a été réouvert en avril 1990 à la demande de la Ministre Lavoie-Roux et il offre des services de réadaptation à des adolescents(tes) tant de la côte de l'Hudson que de la Côte de l'Ungava.

Il en est à sa deuxième année de fonctionnement et vous trouverez à l'annexe I un tableau sommaire de ces deux derniers exercices financiers ainsi que les budgets alloués par le ministère dont voici un résumé:

	Heures Rémunérées	Heures Travaillées	Autres Dépenses	Total	Budget alloué
Réel 1990-1991	18 315 hres 221 690$	17 433 hres	100 899$	322 589$	239 008$
Projection 1991-1992	22 258 hres 236 477$	20 017 hres 165 181$	85 100$	321 577$	249 636$

.../2

HU 030

Il en ressort qu'en 1990-1991, l'excédent des dépenses sur le budget alloué a été de 83 851$ alors que pour l'exercice se terminant le 31 mars 1992, nous prévoyons que l'excédent des dépenses sur le budget alloué sera de 71 941$.

Quant au budget d'opération de l'exercice 1992-1993, nous prévoyons une dépense nettement supérieure aux revenus.

Pendant les deux premières années nous avons fonctionné du mieux possible avec les ressources du milieu. Ce mode de fonctionnement s'avère plutôt frustrant pour les intervenants, inefficace pour les enfants et inacceptable pour le milieu.

Il est impérieux d'améliorer le support professionnel aux intervenants locaux, aux enfants du foyer de groupe tout comme auprès de notre collaborateur le plus immédiat, soit l'école. Il est tout aussi important d'améliorer nos liens avec les milieux familiaux et sociaux des enfants ici concernés.

Un document intitulé "Consultation report, Kuujjuaq Group-Home", en parle d'une façon beaucoup plus élaborée en p. 26. L'Annexe I de ce même document nous fait voir l'organigramme du foyer de groupe et nous donne l'image des ressources minimales requises pour arriver à faire de la réadaptation une réalité au Nord. D'ailleurs ce document, dont copie est jointe, est un portrait de notre réalité et de nos besoins.

Le déficit de la prochaine année sera encore plus grand si en accédant à la demande de syndicalisation des employés "House-parents" nous devrions nous conformer à des horaires de 8 heures par jour au lieu de 24 heures par jour comme c'est le cas maintenant.

Cependant, nous luttons ferme pour garder le caractère familial du foyer de groupe et conserver sa philosophie actuelle.

Vous trouverez à l'annexe 2 le budget détaillé prévu pour 1992-1993 et qui tient justement compte de ces ressources nécessaires au fonctionnement du foyer de groupe.

Ce budget prévoit des charges d'exploitation totales de 488 580$ auxquelles il faut ajouter le coût de location de deux logements pour l'embauche de deux nouveaux employés spécialisés pour un montant de 75 000$ par année et le coût de remplacement des véhicules utilisés aux fins de déplacement des enfants admis au Centre d'accueil.

.../3

Nous vous remercions de l'attention que vous portez à nos besoins financiers et vous prions d'agréer, Monsieur, l'expression de nos sentiments distingués.

Minnie Grey
Directrice générale

MG/cbg

c.c.: M. Jean G. Gratton
Directeur des Services professionnels et de réadaptation
Mme Diane Petit
Directrice des Services administratifs par intérim

Annexe 2

CODE: 6940

HOPITAL DE L'UNGAVA — FOYER DE GROUPE - HYPOTHESES HOUSE PARENT A ENGAGE - AVEC 3 COUPLES DONT 1 A T.P.

CENTRE D'ACTIVITES: FOYER DE GROUPE

03/16/92

TITRE D'EMPLOI	ECHELLE SALARIALE CL.	ECHELLE SALARIALE ECH	SALAIRE SEMAINE	SALAIRES SUPPLEMENTAIRES HEURES	SALAIRES SUPPLEMENTAIRES MONTANT	CONGES FERIES HEURES	CONGES FERIES MONTANT	CONGES SPECIAUX HEURES	CONGES SPECIAUX MONTANT	SALAIRES SOIF DEPART HEURES	SALAIRES SOIF DEPART MONTANT	CONGES ANNUELS HEURES	CONGES ANNUELS MONTANT	SALAIRE ANNUEL HEURES	SALAIRE ANNUEL MONTANT	PRIMES NORD	PRIMES VIE CHERE	PRIMES BIS	AVANT. SOCIAUX R.R.E.	SALAIRE ANNUEL TOTAL HEURE	SALAIRE ANNUEL TOTAL MONTANT
COORDONNATEUR-A. MESSIER	11	52	793.57	0	0	91	2,115	0	0	0.00	0	140	3,454	1585.0	36,925	4,157	0		0	1,820	51,154
HOUSE-P. EDWARD MESHER		1365	160.50 /JR	63	662	9	1,401		0	6.70	1,102	16	2,303	159.5	26,240	5,726	0		0	4,684	37,512
HOUSE-PARENT		1365	150.10 /JR	63	630	9	1,304		0	6.70	1,030	16	2,153	159.5	24,523	5,726	0		0	4,684	35,444
HOUSE-PARENT		1365	150.10 /JR	63	630	9	1,304		0	6.70	1,030	16	2,153	159.5	24,523	5,726	0		0	4,684	35,444
HOUSE-PARENT		1365	150.10 /JR	63	630	9	1,304		0	6.70	1,030	16	2,153	159.5	24,523	5,726	0		0	4,684	35,444
CONSULTANT		52	885.13	0	0	91	2,380	56	1,452	67.20	1,743	140	3,431	1533.0	39,760	5,726	0		0	1,837	54,671
HOUSE-PARENT SUBSTITUT		1365	150.10 /JR	125	1,250	0	0	0	0	0.00	0	0	0	46.8	7,073	1,447	364		1,408	1,230	11,745
HOUSE-PARENT SUBSTITUT		1365	150.10 /JR	126	1,260	0	0	0	0	0.00	0	0	0	46.8	7,073	1,447	364		1,408	1,230	11,745
ORGANISATEUR COMMUNAUTAIRE		52	647.06	0	0	91	1,725	56	1,062	67.20	1,274	140	2,655	1533.0	29,874	5,726	0		0	1,887	41,516
EDUCATEUR		52	647.06	0	0	91	1,725	56	1,062	67.20	1,274	140	2,655	1533.0	29,874	5,726	0		0	1,887	41,516
					0		0		0		0		0		0					0	0
TOTAL AVANT LA PART DE L'EMPLOYEUR				504	5,072	1,137	13,559	168	3,577	778	6,404	1,784	28,956	22,175	248,791	52,118	731	0	3,288	28,357	356,900

PART DE L'EMPLOYEUR	ASSURANCE CHOMAGE (1.400 X 2.23% X SAT)	9,651
	REGIME DES RENTES DU QUEBEC (2.3 % x SAT)	8,119
	REGIME DE L'ASSURANCE MALADIE (3.450% X SAT)	12,219
	AUTRES DRSX X SAT(cst et assur	1,742
	TOTAL MASSE SALARIALE ET PART PATRONALE	388,439
	TOTAL DES AUTRES DEPENSES	100,100
	GRAND TOTAL	488,580

BUDGET 1991-92	REEL 1991-92	BUDGET 1990-91	REEL 1990-91	BUDGET 1989-90	REEL 1989-90	BUDGET 1988-89	REEL 1988-89	REEL 1987-88
184,825	236,477	56,466	202,487	169,233	68,230	N/D	51,686	N/D
39,448	85,100	182,780	120,103	226,187	26,973	N/D	103,880	N/D
244,273	321,577	239,246	322,590	396,420	117,203	N/D	155,546	N/D

G[illegible]E
SUMMARY 1990-1991 AND 1991-1992

	90-91 REAL EXPENSES	90-91 MSSS BUDGET	91-92 REAL EXPENSES PER.10	91-92 PROJECTION EXPENSES PER. 13	91-92 MSSS BUDGET	EXPLANATION OF DIFFERENCE WITH AS-471 1990-1991
Hours:	17,433		15,642	20,817		
Amounts:	$172,387		$129,875	$165,881		(Included 1990-5401.5, 1991-11042 hours paid in $ only)
PRIMES:						(Included 1990-2786 hours paid in others expenses (7530),
Amounts:	$20,275		$16,727	$21,106		Included contribution exceptionnelle $6720)
AVANTAGES SOCIAUX GENERAUX:						
Hours:	840		1,353	1,731		
Amounts:	$13,225		$15,971	$20,430		
AVANTAGES SOCIAUX PARTICULIERS:						
Hours:	42		290	504		
Amounts:	806		$7,775	$9,950		
EMPLOYER PARTS:	$14,997		$15,239	$19,501		
TOTAL SALARIED AMOUNTS:	$221,490		$184,787	$236,476		
TOTAL HOURS:	18,315		17,293	22,857		
OTHERS EXPENSES:	$100,899		68,226	$85,100		
TOTAL:	$322,389	$239,000	$253,013	$321,576	$249,636	

	90-91 REAL EXPENSES	91-92 REAL EXPENSES	91-92 PROJECTION EXPENSES	EXPLANATION
OTHERS EXPENSES:	$100,899	$68,226	$85,100	
DETAILED EXPENSES:				
CARGO MERCH.	7,608	4,812	6,150	
YOUNGS ALLOCATION	1,640	1,470	1,881	
LITERIE ET LINGERIE	315	2,211	2,830	
ALIMENTS	23,923	13,316	17,040	
HEATING-ELECTR.	7,335	5,737	7,342	
SUPPLIES AND MAINTENANCE	11,728	3,783	4,842	
LOISIRS	7,043	2,567	2,885	
OFFICE SUPPLIES	743	1,772	2,257	
PROFF. FEES	0	7,000	7,000	1990-Consultation Reseau
TELEPHONE	2,337	1,739	2,231	
AFFAIRS TRAVELS	5,007	8,789	11,257	
ESCORT TRAVELS AND FEES	5,462	3,419	4,632	
SOCIAL CASES TRAVEL	3,763	3,465	4,434	
TRADUCTION		519	664	
EMPLOYEES COLLECTIVE AGREEMENT EXPENSES	21,710	6,507	8,327	
TRAINING	1,354			
TOTAL	100,899	68,226	85,100	

ANNEX 21

ANNEX 20

Kuujjuaq, le 13 juin 1991.

M. Claude Arsenault,
Chef du Service des Programmes
aux personnes toxicomanes,
Direction générale de la réadaptation
et des services de longue durée,
Ministère de la Santé et des Services Sociaux,
Québec.

Monsieur,

Suite à votre lettre du 24 mai dernier, il nous fait plaisir de vous faire parvenir des réponses aux questions que vous soulevez.

1. Programmes régionaux de promotion et de prévention.

Premièrement, concernant l'élaboration de programmes régionaux de promotion de la santé et de prévention en toxicomanie, le Conseil Régional de la Santé et des Services Sociaux de la région Kativik s'est impliqué de la façon suivante:

Notre région (10A) a reçu seulement 27 147$ pour l'année 1990-91, pour des activités de prévention et de sensibilisation en alcoolisme et toxicomanie. Considérant le fait que le conseil Régional a très peu de ressources humaines en Planification et Programmation, nous avons demandé d'utiliser ce montant pour embaucher une consultante. Cette dernière a effectué une tournée des municipalités du territoire et a remis un rapport en mars 1990 (annexe 1).

Mme Sheila Cloutier a aussi été embauchée pour préparer, à l'hiver 1991, un projet de plan d'action en alcoolisme et toxicomanie (annexe 2), document qui a servi pour documenter et orienter les objectifs de Santé et de Bien-Etre pour notre région (annexe 3).

Comme vous le constaterez à la lecture des documents pré-cités, la démarche prônée par le conseil Régional et espérée par les communautés, en est une de prise en charge communautaire et individuelle. Les démarches, qui suivront en 1991-92, pour la réalisation d'un plan régional de services, seront basées sur le travail déjà fait et les orientations qui en résultent. Vous trouverez, en annexe 4, les objectifs du Conseil Régional Kativik en matière de prévention et d'intervention en alcoolisme et toxicomanie.

2) Bilan des activités en alcoolisme et toxicomanie.

Comme mentionné précédemment, la région n'a reçu aucun budget provincial autre que le 27 147$ pour oeuvrer en toxicomanie. Nous avons cependant d'immenses besoins autant en

terme de prévention, d'intervention communautaire que de travail au niveau désintoxication et réadaptation. Le Conseil Régional a donc supporté techniquement et monétairement différentes activités et groupes oeuvrant en promotion et intervention:

- Camps de jeunes à Kuujjuaq et Inukjuak;

- Groupes de jeunes dans chaque municipalité;

- Les Centres de Services Sociaux (Ungava et Inuulitsivik) pour projets de services de désintoxication pour les jeunes qui respirent des vapeurs de gaz et autres (présentation d'un projet novateur).

Vous trouverez, en annexe 5, les rapports de ces activités ainsi qu'un bilan général.

Il est important de préciser que la Commission Scolaire Kativik et le programme fédéral NAADAP (appelé ici Nunalituqait Ikajuqatigiitut) oeuvrent aussi en prévention et qu'il y a un urgent besoin de coordination des efforts de chacun. En ce sens, le poste de coordonnateur régional au niveau du CRSSS est le bienvenu et soyez assuré que le Conseil Régional fera de ce dossier l'une des grandes priorités pour l'année qui vient.

En terminant, nous aimerions vous faire part de notre déception face au fait que la région Kativik n'a reçu aucun montant pour la désintoxication et la réadaptation en 1991-92. Notre plan régional d'organisation de services devrait vous parvenir en mars 1992, et nous vous demandons d'inclure tout de suite un minimum de base pour notre région dans le budget prévu pour 1992-93. Nous serons alors prêts à concrétiser notre plan régional.

Espérant le tout à votre satisfaction,

Francine Tremblay,
Directrice de la Planification et de la Programmation.

cc. Lizzie Epoo York, directrice générale, C.R.S.S.S. Kativik.
Roger Richard, directeur, Liaison Nordique.

RÉPARTITION DU BUDGET DE RÉADAPTATION ET DE DÉSINTOXICATION

Le M.S.S.S. a précisé dans son document d'Orientations ministérielles à l'égard de l'usage et de l'abus des psychotropes son intention de faciliter l'accès à certains services en particulier la désintoxication médicale et les services internes de réadaptation pour jeunes, tout en favorisant le maintien de l'équité des ressources entre chaque région.
Dans cette optique, le budget pour ces activités est réparti comme suit:

1) Budget correspondant à des priorités régionales spécifiques:

a) Lits en désintoxication

Une situation d'urgence prévaut dans le région de Montréal, où un besoin d'augmenter l'accessibilité aux services de désintoxication a été identifié.

Région 06A: ... 1,0 M $

b) Services aux jeunes
A Montréal et à Québec, il est nécessaire d'assurer un minimum de services internes de réadaptation pour les jeunes.

Région 03 : ... 500,000 $
Région 06A: ... 500,000 $

2) Pour l'ensemble des régions

a) Chaque région reçoit un montant de base de 90,000 $

b) Un montant additionnel est octroyé à partir d'un calcul de sa richesse relative. Pour obtenir la richesse relative régionale, les budgets de désintoxication et de réadaptation des établissements sont additionnés.

c) Pour chaque région, un nombre estimé de consommateurs à risque relatif de développer des toxicomanie est calculé (Enquête Santé Québec).

d) Le rapport des budgets régionaux et des consommateurs à risque relatif nous donne un per capita régional et permet de calculer une moyenne provinciale.

e) Ce per capita moyen, de 41,96 par personne est comparé au per capita de chaque région et les montants sont octroyés aux régions dans le but de réduire au minimum (à l'intérieur du budget de 3,4 M $) l'écart entre la moyenne provincial et le per capita régional.

Conclusion :
1) La richesse de chaque région comprend l'ensemble des budgets tant de la désintoxication que de la réadaptation.
2) Les régions dont le per capita est beaucoup plus élevé que la moyenne reçoivent un montant minimal de 90,000 $ qui pondère le facteur "étendue de territoire"
3) L'écart entre les régions les plus pauvres et les plus riches est diminué.
4) La région 06C a la possibilité d'améliorer, à même sa nouvelle enveloppe, les services aux anglophones du grand Montréal (mission supra régionale)

ANNEX 22

Annex 21

Gouvernement du Québec
Ministère de la Santé et des Services sociaux
Direction générale de la prévention et des services communautaires

À L'USAGE DU MINISTÈRE
Numéro de dossier | Initiales

SUBVENTION

Formulaire de demande pour l'année 1992-93

N.B.: La subvention du ministère de la Santé et des Services sociaux est pour la période du 1er avril 1992 au 31 mars 1993. Cependant, l'exercice financier de l'organisme peut être différent.

Corriger l'étiquette s'il y a lieu (pour les anciens organismes)

Nom de l'organisme: ASSOCIATION DES FEMMES ARNAUTTIT.

Adresse civique: C. P. 586
(No rue, app.) KUUJJUAK
Municipalité — Code postal JOM 1CO — Téléphone (ind. rég.) 819- N° 1964-2505
Circonscription électorale provinciale Région 10-A

Adresse postale: Casier postal: 586 Succ. — Code postal JOM 1CO

Président(e): Malee Saunders — Téléphone (ind. rég.) 819 N° 964 2969

Responsable: Peggy Guay (coordonnatrice du Centre) — Téléphone (ind. rég.) 819 N° 964 2505

Compléter, s'il y a lieu: c'est-à-dire si vous n'avez pas de chèque

Nom du fiduciaire:

Adresse civique: (No rue, app.)
Municipalité — Code postal — Téléphone (ind. rég.) N°

Adresse postale: Casier postal: Succ. Code postal

Président(e): Téléphone (ind. rég.) N°

Service de soutien aux organismes communautaires
1075, chemin Ste-Foy, 7e étage
Québec, QC
G1S 2M1
(418) 643-5437

N.B.: Toute demande, pour être considérée, devra être complétée avec tous les documents obligatoires annexés.
Il est important de compléter chaque item et chaque feuille même si les renseignements demandés sont déjà contenus dans les documents joints à la présente demande. Les références aux documents ne remplacent pas les informations qui doivent

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1. RÉSOLUTION DE LA DEMANDE DE SUBVENTION AU MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

Conformément à une résolution proposée par Malee Saunders

appuyée par ~~Maggie Bertie~~ et acceptée à l'unanimité

au cours d'une assemblée du Conseil d'administration de l'organisme dûment convoquée et

tenue le le 11 février 1991. une demande de subvention pour l'année financière 1992-1993

est présentée au ministère de la Santé et des Services sociaux par le ou la président(e) et le ou la secrétaire.

au montant de 70 000$ $ concernant les opérations régulières de la corporation dont les

prévisions budgétaires apparaissent dans le présent formulaire.

Cette demande est faite en connaissance de cause des exigences et procédures du ministère de la Santé et des Services sociaux contenues dans le document "Programme de soutien aux organismes privés bénévoles et communautaires sans but lucratif" dans le domaine des services sociaux ou de la santé.

FAITE ET SIGNÉE À Kuujjuaq LE 5 juin 1991.

PRÉSIDENT(E) Malee Saunders
(nom en lettres moulées) (signature)

SECRÉTAIRE Vicky Gordon
(nom en lettres moulées) (signature)

2. COMPOSITION DU CONSEIL D'ADMINISTRATION

• Nommer les membres du conseil d'administration, spécifier leur fonction, leur date d'entrée au C.A. et leur représentation

Nom	Fonction au C.A.	Date d'entrée	Représentation* (provenance)	Téléphone
1. Malee Saunders	Présidente	1988	~~bénévole~~	819 964-2540
2. Madge Pomerleau	Vice-présidente	1990	"	819 964-2080.
3. Sapina Adams		1990	"	-
4. Vicky Gordon	Sec-trésorière	1990	"	-
5 Sheila Partridge		1989	"	-
6. ~~Susie Cordon~~		91-05	"	-
7 Winnie Adams		91-05	"	-
8. Winnie Adams		91-05	"	-
9. Victoria Tukkiapik		91-05	"	-
10. Vicky Gray		91-05	"	-

• Mentionner le nombre de réunions du conseil d'administration tenues au cours de votre dernière année d'opération complète.

• Indiquer le nombre de membres de votre organisme nombre 30 Toutes les semaines depuis l'ouverture du Shelter.

• Préciser ce que la personne représente soit les clientèles, les bénévoles, un service public, le secteur privé ou si elle est à l'emploi de l'organisme.

3. ASSEMBLÉE GÉNÉRALE

• Indiquer la date de votre dernière assemblée générale annuelle et donner le nombre de membres présents.

91-05-14 (date) 10 (nombre)

Lors de cette assemblée, préciser si les documents suivants ont été approuvés: - rapport annuel, rapport financier.

• Préciser s'il y a eu une ou des assemblées générales spéciales au cours de l'année : non ☒ oui ☐

Si oui, pourquoi .....

4. HISTORIQUE DE VOTRE ORGANISME

Nom de l'organisme Groupe de femmes Arnaumtiit

Pour les organismes qui n'ont pas fait de demande pour l'année financière 1991-92, fournir un bref historique de votre organisme (une (1) page maximum).
Cette pièce sera versée au dossier permanent avec la charte et les règlements

Les organismes qui ont produit un historique l'an dernier doivent simplement faire une mise à jour.

L'Association des femmes Arnautiit a débuté ses activités en 1986. Formée de 9 femmes de Kuujjuaq intéressées à travailler au niveau de la violence conjugale, notre groupe s'est adjoint des bénévoles pour réaliser les activités suivantes:

- -ateliers de couture pour les femmes;
- préparation de repas pour les activités communautaires de grande envergure (moyen de financement);
- amener des personnes âgées à des activités plein-air, des dîners de groupe;
- dépannage pour femmes en difficulté;
- soutien aux personnes aux prises avec des problèmes divers;
- etc... etc...

Notre groupe a demandé son incorporation au début de mai 1991, en particulier parce qu'il s'est vu confier la gestion d'un Centre d'hébergement pour les femmes victimes de violence à Kuujjuaq. Ce Centre, qui a ouvert ses portes officiellement le 14 mai 1991, a coûté plus de 350 000$ à la Communauté. Ont participé monétairement ou en main d'oeuvre pour la construction: les étudiants en menuiserie de la Kativik School Board, le Land Holding, la municipalité de Kuujjuaq, etc...

Aucune subvention gouvernementale n'a été reçue pour le centre (construction, entretien, fournitures, personnel). Le groupe Arnautiit a reçu 50 000$ du gouvernement fédéral pour un projet de formation en vue de mieux comprendre et d'intervenir au niveau de la violence familiale. Cette subvention doit être utilisée pour des activités de formation échelonnées sur une année, à compter du 1er avril 1991. Copie du rapport intérimaire et budgétaire est annexée au présent formulaire. Ce montant a aussi servi à embaucher une coordonnatrice pour recueillir des dons afin de meubler le Shelter et travailler avec les membres du conseil d'administration pour former des bénévoles, tenir des activités de sensibilisation face à la violence et aussi assurer des services jour et nuit au Shelter depuis qu'il a commencé à recevoir des femmes victimes de violence, soit la mi-janvier.1992.

Depuis janiver, le Centre accueille des femmes et des enfants en provenance de tout le territoire. Plusieurs sont référées par les services sociaux ou l'hôpital. Le comité Arnautiit a procédé à l'embauche d'une coordonnatrice comme mentionné précédemment pour organiser la formation des bénévoles mais aussi travailler au niveau des femmes hébergées. Le travail de soirée et des fins de semaine est assuré par des bénévoles. Le quart de minuit à 8 heures du matin est assuré par une travailleuse embauchée à titre de surveillante de nuit.

La présente demande de subvention se situe au niveau de l,embauche de personnel pour aider les femmes hébergées: une coordonnatrice et deux travailleuses Inuit. Le groupe a obtenu du Land Holding de ne pas payer les frais de chauffage et d'entretien pour le restant de l'année 1991-92 mais à compter d'avril 1992, il faudra envisager des frais à ce niveau.

Le Conseil Régional de la Santé et des Services Sociaux a accordé au groupe Arnautiit une subvention de 36 000$ dans le cadre du programme de recherche "Etudes, Analyse et Intervention en santé communautaire". Cela servira à recueillier des données sur notre clientèle pour mieux orienter nos services et ceux des différents intervenants du monde de la santé et des services sociaux.

Votre organisme offre des services depuis le _____ 19_____

5. TERRITOIRE DESSERVI

Identifier le territoire desservi et la population correspondante

Régions Kativik 10-A (Territoire) — 7 000 habitants. (Population)

S'agit-il d'un territoire Provincial ☐ Régional ☒ Sous-régional ☐ Local ☐

Le Shelter de Kuujjuaq est le seul sur le territoire Kativik. Nous recevons déjà des femmes référées par l'hôpital de l'Ungava. Inuulitsivik commencera à nous en référé dès que nos services seront plus complets : plus de personnel.

6. PÉRIODE D'OUVERTURE *(Pour l'année en cours)*

	JANV.	FEV	MARS	AVRIL	MAI	JUIN	JUIL	AOÛT	SEPT.	OCT	NOV	DEC.
Mois de fonctionnement	X	X	X	X	X	X	X	X	X	X	X	X

	L	M	M	J	V	S	D	TOTAL
Jours d'ouverture	X	X	X	X	X	X	X	7
Nombre d'heures par jour	24	24	24	24	24	24	24	168

Autre accessibilité à l'organisme. (préciser) Des bénévoles peuvent aider les femmes 24 heures sur 24.

Tous les dispensaires des villages et travailleurs sociaux accueillent et refèrent des femmes.

7. RESSOURCES HUMAINES

Personnel bénévole de votre organisme (pour l'année en cours)

Spécification concernant les bénévoles	Nombre	Total heures/année
Bénévoles impliqués dans l'administration	7	
Bénévoles disponibles auprès des clientèles	25	
Autres bénévoles (préciser)	membres des autres organismes tels KRCHSS, KSB, KRG, conseil municipal, etc... toujours prêtes et prêts à aider selon le besoin.	
	Aussi plusieurs dons en linge, lingerie, nourriture, etc...	
TOTAL		

7.2 Personnel régulier rémunéré travaillant dans votre organisme (temps partiel et temps plein)

Nom de l'employé(e)	Fonction dans l'organisme	Salaire incluant avantages sociaux	Total heures/année	
Peggy Guay	Coordonnatrice (45 h.semaine)	16$/heure	2340 h.	(37 44
Interprètes	Pour assister la coordonnatrice	20$/heure	500 h.	(10 00
Gardiennage de nuit	(56 heures /semaine)	10$/heure	2912 h.	(29 12
Besoin pour une travailleuse de soir:	(45 h./semaine)	15$/heure	2 340 h.	(35 10
Besoin pour travailleuse de fin de semaine:	(28 h /sem)	15$/heure	1456	(21 84
TOTAL		133 500$	9 548	

7.3 Personnel occasionnel rémunéré travaillant dans votre organisme

Type de travail (P.D.E., DEFI) travaux communautaires, EXTRA, stagiaire, autres (préciser)	Nombre de personnes	Salaire versé	Total heures/année
(inclus dans tableau précédent)			

8. RAPPORT SYNTHÈSE DES ACTIVITÉS DE LA DERNIÈRE ANNÉE COMPLÈTE D'OPÉRATIONS DE VOTRE ORGANISME

1. Activités liées à la dispensation de services directs aux clientèles: (aide, entraide, accueil-information, écoute, animation, accompagnement, intervention spécifique, hébergement, conférences, sorties de groupe etc.)	Type de clientèles desservies	Nombre de personnes rejointes		Fonctionnement de votre organisme. Indiquer la proportion en % du temps consacré à ce type d'activités
		de façon régulière	de façon occasionnelle	
- Organisation du Shelter - Accueil de femmes depuis la mi janvier 1992. - Dépannages divers - Aide aux personnes handicapées , femmes en difficulté., etc... - Ouverture du shelter depuis la mi-janvier ce qui impliquer accueil, logement, référence, accompagnement, etc...		5 femmes et 8 enfants.		
	Total			
2- Activités liées à l'organisation du bénévolat (recrutement - formation orientation - planification - séances de sensibilisation - coordination etc.)	Type de personnes impliquées	Nombre de personnes impliquées		
		de façon régulière	de façon occasionnelle	
- Rencontres publiques, émissions de radio, activités diverses pour impliquer les organismes et autres groupes au niveau du bénévolat. - Activités de formation par rapport à la violence, document joint en annexe. - Sollicitations diverses pour meubler le shelter et commencer nos activités.				
	Total			
3- Activités liées au fonctionnement général de l'organisme: gestion administrative, réunion du C.A. - planification - programmation - évaluation - concertation - coordination - promotion - secrétariat - autofinancement etc.	Type de personnes impliquées	Nombre de personnes impliquées		
		de façon régulière	de façon occasionnelle	
réunions hebdomadaires pour les activités administratives.	Pour de plus amples renseignements, s.v.p vous adresser à Peggy Guay, notre coordonnatrice ou à Madge Fomerleau notre vice-présidente.			
	Total			
			TOTAL	100%

Ce rapport synthèse peut servir de rapport d'activités pour l'organisme qui a reçu l'année précédente une ou des subventions totalisant un montant inférieur que 25 000 $ du gouvernement du Québec. Cependant ce rapport doit être entériné par le conseil d'administration.

Signature _____ Nom en lettres moulées _____ Président(e)

Signature Malee Saunders, présidente. Nom en lettres moulées _____ Titre

9. CLIENTÈLE DE VOTRE ORGANISME

• Identifier la clientèle prioritaire visée par votre organ... décrire ses caractéristiques et ses besoins particuliers.
• Pour les regroupements (federation association etc...) préciser les principales fonctions et fournir en annexe la liste de vos membres

- Femmes victimes de violence et leurs enfants pour hébergement .
- Personnes sans foyer (itinérantes).
- Population en général pour des dépannages, et pour les activités de sensibilisation et de prévention face à la violence.

10. RELATIONS AVEC LES ORGANISMES ET LES RESSOURCES DU MILIEU

Préciser la nature des rapports que votre organisme entretient avec les ressources du milieu (CRSSS, CSS, CLSC, DSC, CH, CAR, CAH, Organismes communautaires et autres instances. Municipalité, commission scolaire, fabrique, etc...).

Services Sociaux :- collaboration avec les travailleurs sociaux pour de l'intervention auprès des femmes victimes de violence.
- collaboration aussi avec les travailleurs communautaires et les comités de santé.

Organisme d'éducation et de prévention en alcool et toxicomanie (Nunalitugait Ikajugatigiitut): collaboration avec les intervenantes de ce programme.

Justice: collaboration avec les policiers, les officiers de probation, etc...

Conseil régional de la Santé et des Services Sociaux: collaboration pour l'identification des besoins des femmes du territoire, aide pour obtenir des subventions, aide pour l'incorporation, soutien financier pour aller visiter des centres-de femmes hors région.

Société Makivik: Services juridiques. Municipalité: Centre des femmes.

Indiquer si vous avez des ententes particulières: oui ☐ non ☐

Si oui, préciser _____

11. HÉBERGEMENT (Statistiques sur la clientèle)

• Les organismes d'hébergement qui ont reçu l'Annexe 1 sont tenus de la remplir.
• Pour les autres organismes d'hébergement, compléter la section suivante.

• Cocher le type d'hébergement: ☑ hébergement simple (accueil gîte, couvert) ☐ hebergement d'accompagnement d'orientation et de transition ☐ hébergement avec activités de readaptation et de réinsertion sociale

• Capacité d'hébergement 16 (nombre de places) • Nombre de jours d'ouverture dans une année 365 • Capacité d'hébergement annuelle 5840 (nombre de places x par le nombre de jours d'ouverture)

• Hebergement réel _____ (nombre de personnes hebergées x par jours d'hebergement) • % d'occupation _____ (100 x jours d'hebergement reels ÷ la capacité d'hebergement annuelle)

• Contribution financière des personnes hébergées Par jour _____ Par semaine _____ Par mois _____

• Durée moyenne de séjour par personne hébergée _____

• Nombre de personnes hébergées pendant l'année _____

Répartir ce nombre selon l'âge et le sexe

Âge	Sexe: Femmes	Sexe: Masculin
0-12 ans		
13-18 ans		
19-30 ans		
31-50 ans		
51 ans et plus		

NANCES

Nom de l'organisme Arnautiit

Année financière débutant le 1er avril et se terminant le 31 mars N° dossier

DÉPENSES	90-91 Exercice précédent (1)	91-92 Exercice courant — Cumulatif au 30 sept. 91 (2)	91-92 Exercice courant — Estimé pour l'année complète 12 mois (3)	92-93 Prévisions budgétaires (4)
faires et avantages sociaux			4 950$	133 500$
ais de logement				
- Loyer			0$	38 400$
Taxes - assurances, etc.				
Total				
ais administratifs (honoraires, frais de banque, etc...)			2 000$	5 000$
ais de bureau			6 000	12 000$
Papeterie, téléphone, etc.				
Total				
ais relatifs à la pension des hébergés			24 000	52 000$
utres dépenses (spécifier)			(Formation et recherche) 51 860$	0 000
Total				
TOTAL DES DÉPENSES			28 810	240 900$

REVENUS	90-91 Exercice précédent (1)	91-92 Exercice courant — Cumulatif au 30 sept. 91 (2)	91-92 Exercice courant — Estimé pour l'année complète 12 mois (3)	92-93 Prévisions budgétaires (4)
• Gouvernement du Canada — Type de programme Santé et Bien Etre			50 000	10 000$
PDE Art. 26				
• Gouvernement du Québec				
— Service de soutien aux org. comm.			0	70 000$
— CRSSS (maintien à domicile)			0	0
— CSG				
— Autres sources de MSSS				
— Autres sources du gouv. du Québec — JCRSSS (Programme de recherche)			36 000	0
• Municipalité Services et local				
• Centraide			1 000	3 000$
• Contributions des hébergés			0	2 000$
• Autofinancement et autres Kujuamit				35 000
Total			87 000$	120 000
TOTAL DES REVENUS				

Pour remplir cette section tenir compte de l'année financière de votre organisme.
Les chiffres fournis doivent être conformes à vos états financiers.

90-91 Exercice précédent (1)		
Surplus (déficit)	Ligne 25 moins Ligne 12	(1 810)
	Solde du début	
	Surplus (déficit) cumulatif	0

Cette page de revenus peut servir de rapport financier pour un organisme qui a reçu l'année précédente une ou des subventions totalisant un montant inférieur que 25 000 $ du gouvernement du Québec. Cependant ce rapport doit être entériné par le conseil d'administration.

Signature: Président(e) — Malee Saunders (Nom en lettre moulées)

Signature: Trésorier(ère) — Vicky Gordon (Nom en lettre moulées)

13. JUSTIFIER, S'IL Y A LIEU, L'AUGMENTATION DE VOS PRÉVISIONS BUDGÉTAIRES 92-93 ÉNONCÉES À LA PAGE PRÉCÉDENTE (page 8)

L'Association des femmes Arnautit a reçu de la Communauté le mandat de gérer un Centre de Femmes et une Maison d'hébergement pour femmes victimes de violence. Les besoins de financement se situent au niveau des frais courants entourant l'édifice (électricité, chauffage, etc...); ainsi que de l'embauche de personnel pour oeuvrer auprès des femmes (coordonnatrice, surveillante de nuit, travailleuse de soir); ainsi que des frais entourant l'hébergement des femmes et des enfants (nourriture, vêtements, etc...).

14. PRIORITÉS POUR LA PROCHAINE ANNÉE
Indiquer vos priorités

- Fournir aux femmes Inuit en difficulté un abri temporaire à court terme et des services de "counselling".
- Commencer à opérer le centre des femmes.
- Donner de l'information sur les services offerts par le Centre
- Parler de violence et commencer à agir.
- Héberger les femmes en difficulté.

15. DOCUMENTS COMPLÉMENTAIRES OBLIGATOIRES

Le formulaire "Demande de subvention" ***doit être accompagné*** des documents permettant d'évaluer adéquatement le projet présenté. À cet effet, cocher la case correspondante aux documents annexés à votre demande.

- Charte de l'organisme, si vous n'avez pas fait de demande pour l'année financière 91-92 ou des lettres patentes supplémentaires, s'il y a lieu. ☒
- Règlements généraux de la corporation si vous n'avez pas fait de demande pour l'année financière 91-92 ou s'il y a eu des modifications en cours d'année. ☒
- Rapport financier de la dernière année d'opérations de l'organisme dûment accepté par les membres en assemblée générale et signé par le président et le trésorier du Conseil d'administration. *Selon les obligations découlant de l'article 93 de la Loi sur l'administration financière et du règlement sur le rapport financier des institutions subventionnées, tout organisme recevant du gouvernement une subvention de 25 000 $ et plus doit produire des états financiers vérifiés par un comptable public.* ☐
- Rapport annuel de la dernière année d'opérations dûment accepté par les membres en assemblée générale avec les statistiques à l'appui. ☐
- Feuille intitulée "Synthèse de la demande de subvention" dûment complétée. ☒

Formulaire rempli par: Peggy Quay, (avec l'aide de Francine Hudon du Conseil Régional Kativik)

Fonction au sein de l'organisme Coordonnatrice du Shelter Arnautit, (Kuujjuak)

La date limite de réception d'une demande de subvention pour l'année financière 1992-1991 est fixée au* 1ER NOVEMBRE 1991 *pour tous les organismes. Le cachet de la poste fait foi du respect de la date limite.

Adresser votre demande au:

Service de soutien aux organismes communautaires
1075, chemin Ste-Foy, (7e étage)
Québec, QC
G1S 2M1
Tél.: (418) 643-5437

PROGRAMME DE SOUTIEN AUX ORGANISMES COMMUNAUTAIRES

Gouvernement du Québec
Ministère de la Santé et des Services sociaux
Direction générale de la prévention et des services communautaires

SYNTHÈSE DE LA DEMANDE DE SUBVENTION

N° dossier

Nom de l'organisme

Résultats de l'exercice financier précédent (surplus/déficit) — Surplus — Déficit

Classification Clientèle — Activités — 1. Service — 2. Ponctuelle — 3. Groupe — 100%

Hébergement — Capacité résidentielle — Capacité annuelle — Hébergement réel — % d'occupation

Subvention année 1991-92 Accordée — Demandée — Subvention année 1992-93

FINANCES — Revenus	EXERCICE PRÉCÉDENT 1990-91	EXERCICE COURANT 1991-92 au 30 sept. 91	EXERCICE COURANT 1991-92 estimé 12 mois	PROCHAIN EXERCICE 1992-93
• Gouvernement du Canada			50 000	10 000
Type de programme				
PDE Art. 25			0	70 000
• Gouvernement du Québec				
Prog. soutien aux organismes communautaires				
C.R.S.S.S. (maintien à domicile)				
C.S.S.			36 000	0
Autres sources du M.S.S.S.				
Autres sources du Gouv. du Québec				
• Municipalité			1 000	3 000
• Centraide			0	2 000
• Contribution des hébergées				35 000
• Autofinancement - Autres KUUJUAMIIT				
TOTAL			87 000	120 000
FINANCES — Dépenses				
Frais salariaux			4 950	133 300
Frais de logement			0	38 400
Frais administratifs			2 000	5 000
Frais de bureau			6 000	12 000
Frais d'hébergement			24 000 51 860	52 000 0
Autres				
TOTAL			88 810	240 900

Objets de la charte *(s'il n'y a pas eu de demande l'année précédente)*

Fournir aux femmes inuit en difficulté un abri temporaire à court terme et des services de counselling. - Promouvoir et renforcer la compréhension de l'identité inuit, de sa culture et de son patrimoine, tant parmi les femmes inuit du Nord québécois (le Nunavik) que dans la population en général. - Offrir des locaux appropriés: où les femmes inuit pourront profiter de services de référence et de "counselling" leur permettant d'utiliser les ressources de la collectivité; où les femmes inuit pourront recevoir des services d'orientation leur permettant d'acquérir plus d'autonomie, au besoin.

Synthèse des activités de la dernière année du ... au ...

L'organisme existe depuis 1986. Jusqu'à tout récemment, les bénévoles du comité s'occupaient de donner des services à la population en général ayant besoin d'aide. L'année qui s'achève a été consacrée à des activités de financement, mais surtout à la structuration du groupe en vue de se doter d'une incorporation et surtout de se préparer à donner des services concrets aux femmes victimes de violence et à leurs enfants. Ainsi les femmes du g oupe ont-elles présenté des demandes de subvention, visité d'autres centres de femmes, donné des activités de formation, meublé le Shelter et finalement commencé à héberger des femmes victimes de violence et leurs enfnats.

Priorités pour la prochaine année

- Héberger des femmes victimes de violence provenant de tous les villages.
- Donner de l'information sur les services offerts par le Centre
- Former des bénévoles et intervenantes.
- Parler de violence et commencer à agir.
- Héberger les femmes en difficulté.
- Faire une étude de besoin sur l'utilisation du Centre.

Recommandation

Gouvernement du Québec
Ministère de la Santé et des Services sociaux
Direction générale de la prévention et des services communautaires

PROGRAMME DE SOUTIEN AUX ORGANISMES COMMUNAUTAIRES

SYNTHÈSE DE LA DEMANDE DE SUBVENTION

N° dossier

Nom de l'organisme: Groupe d'Entraide Ikayuraqsuttut Pigavatsiangittunia

Région | Date de l'incorporation

Période d'ouverture: mois / jours/sem. / heures/sem.

Résultats de l'exercice financier précédent (cumulatif): Surplus: / Déficit: / Sur:

Classification Clientèle

Activités | Nbre de personnes rég. | % de temps

1. Service
2. Bénévolat
3. Gestion

100%

Hébergement

Capacité quotidienne:
Capacité annuelle:
Hébergement réel:
% d'occupation:

Personnel

Bénév. ____ Heures/an ____
Régulier ____ Heures/an ____
Occasionnel ____ Heures/an ____

	Subvention année 1990-91 Accordée	Subvention année 1991-92 Demandée	Recommandée

FINANCES — Revenus	EXERCICE PRÉCÉDENT 1989-90	EXERCICE COURANT 1990-91 30 sept. 90	EXERCICE COURANT 1990-91 estimé 12 mois	PROCHAIN EXERCICE 1991-92
• Gouvernement du Canada				
Type de programme				
PDE Art. 25				20 000$
• Gouvernement du Québec				
Prog. soutien aux organismes communautaires				
C.R.S.S.S. (maintien à domicile)				
C.S.S.				
Autres sources du M.S.S.S				
Autres sources du Gouv. du Québec				
• Municipalité				500$
• Centraide				1 000$
• Contribution des hébergés				
• Autofinancement - Autres				21 500$
TOTAL				
FINANCES — Dépenses				
Frais salariaux				0$
Frais de logement				0$
Frais administratifs				500$
Frais de bureau				3 000$
Frais d'hébergement				9 000$
Autres				9 000$
TOTAL				21 500$

Objets de la charte *(s'il n'y a pas eu de demande l'année précédente)*

- Fournir aux personnes âgées, handicapées et dansle besoin des services d'escorte, des services de repas à domicile, ou des visites à domicileé - Organiser des activités permettant aux personnes âgées, handicapées ou dans le besoin de bénéficier de sorties de loisir. - Participer avec d'autres organismes autoctones à améliorer la qualité des services offerts aux personnes handicapées, âgées ou dans le besoin. - Obtenir concernant les objets ci-dessus, des subventions ou d'autres biens par l'entremise ~~de levées de fonds, et gérer ces sommes. (suite sur charte ci jointe, annexe 1)~~

Synthèse des activités de la dernière année du premier avril au présentement.

- Visite de personnes âgées hospitalisées lors de la fête des mères.
- Visites à domicile auprès de certaines personnes âgées pour divers services.
- Démarches pour des locaux et recrutement de bénévoles.
- Structuration de l'organisme: incorporation, début de rencontres structurées.

Priorités pour la prochaine année

- Avoir un local genre "Disciple D'Emmaus", vente à bas prix de linge et articles divers.
- Organiser une rencontre/semaine pour les personnes âgées (communautaire).
- Support individuel à domicile pour personnes âgées et personnes handicapées.
- Amener les personnes âgées aux festivités communautaires.

Recommandation

Gouvernement du Québec
Ministère de la Santé et des Services sociaux
Direction générale de la prévention et des services communautaires

A L'USAGE DU MINISTERE
Numéro de dossier | Années

C I

C I

SUBVENTION

Formulaire de demande pour l'année 1991-92

***N.B.:** La subvention du ministère de la Santé et des Services sociaux est pour la période du 1er avril 1991 au 31 mars 1992. Cependant, l'exercice financier de l'organisme peut être différent.*

Corriger l'étiquette s'il y a lieu (pour les anciens organismes)

Nom de l'organisme: Groupe d'Entraide Ikayuresuttut Piqayatsiangittuniq, inc.

Adresse civique: (No rue app.)

Municipalité: Kuujjuaq — Code postal: JOM 1CO — Téléphone ind. rég.: 819 — N°:

Circonscription électorale provinciale:

Adresse postale: Casier postal: — Succ. — Code postal:

Président(e): Peggy A. Cuay — Téléphone ind. rég.: 819 — N°: 964

Responsable: — Téléphone ind. rég.: — N°:

Compléter, s'il y a lieu: c'est-à-dire si vous n'avez pas de charte

Nom du fiduciaire: (demande d'incorporation déjà envoyée le 28 avril 1991)

Adresse civique: (No rue, app.)

Municipalité: — Code postal: — Téléphone ind. rég.: — N°:

Adresse postale: Casier postal: — Succ. — Code postal:

Président(e): — Téléphone ind. rég.: — N°:

Service de soutien aux organismes communautaires
1075, chemin Ste-Foy, 7e étage
Québec, QC
G1S 2M1
(418) 643-5437

***N.B.:** Toute demande pour être considérée, devra être complétée avec tous les documents obligatoires annexés.*

Il est important de compléter chaque item et chaque feuille même si les renseignements demandés sont déjà contenus dans les documents joints à la présente demande. Les références aux documents ne remplacent pas les informations qui doivent

1. RÉSOLUTION DE LA DEMANDE DE SUBVENTION AU MINISTÈRE DE LA SANTÉ ET DES SERVICES SOCIAUX

Conformément à une résolution proposée par Peggy A Guay

appuyée par Ingo Berendes et acceptée à l'unanimité

au cours d'une assemblée du Conseil d'administration de l'organisme dûment convoquée et

tenue le 8 mars 1991 une demande de subvention pour l'année financière 1991-1992

est présentée au ministère de la Santé et des Services sociaux par le ou la président(e) et le ou la secrétaire,

au montant de 20 000$ $ concernant les opérations régulières de la corporation dont les

prévisions budgétaires apparaissent dans le présent formulaire.

Cette demande est faite en connaissance de cause des exigences et procédures du ministère de la Santé et des Services sociaux contenues dans le document "Programme de soutien aux organismes privés bénévoles et communautaires sans but lucratif" dans le domaine des services sociaux ou de la santé.

FAITE ET SIGNÉE À Kuujjuaq LE 5 juin 1991

PRÉSIDENT(E) Peggy Guay (nom en lettres moulées) Peggy Guay (signature)

SECRÉTAIRE Hélène Duquette (nom en lettres moulées) Hélène B. Duquette (signature)

2. COMPOSITION DU CONSEIL D'ADMINISTRATION

• Nommer les membres du conseil d'administration, spécifier leur fonction, leur date d'entrée au C.A. et leur représentation

Nom	Fonction au C.A.	Date d'entrée	Représentation* (provenance)	Téléphone
1 Guay, Peggy A.	Présidente	91/03		-
2 Berendes, Ingo	Vice-président	91/03		-
3 Boily Diane	Trésorière	91/04		-
4 Duquette Hélène	Secrétaire	91/04		-
5 White-Dupuis, Shirley		91/04		-
6 Abraham, Minnie		91/04		-
7				-
8.				-
9.				-
10.				-

• Mentionner le nombre de réunions du conseil d'administration tenues au cours de votre dernière année d'opération complète.

nombre 4 réunions générales de constitution d'organisme.

* Préciser ce que la personne représente soit les clientèles, les bénévoles, un service public, le secteur privé ou si elle est à l'emploi de l'organisme.

3. ASSEMBLÉE GÉNÉRALE

• Indiquer la date de votre dernière assemblée générale annuelle et donner le nombre de membres présents.

Date _____ Nombre _____

Lors de cette assemblée, préciser si les documents suivants ont été approuvés: - rapport annuel, rapport financier.

• Préciser s'il y a eu une ou des assemblées générales spéciales au cours de l'année : non ___ oui ___

Si oui pourquoi .....

4. HISTORIQUE DE VOTRE ORGANISME

Nom de l'organisme Groupe d'Entraide I-P

Pour les organismes qui n'ont pas fait de demande pour l'année financière 1990-91, fournir un bref historique de votre organisme (une (1) page maximum).
Cette pièce sera versée au dossier permanent avec la charte et les règlements

Les organismes qui ont produit un historique l'an dernier doivent simplement faire une mise à jour.

Le Groupe d'Entraide Ikayurasuttut Piqayatsiangittuniq, inc. a débuté ses activités il y a quelques mois alors que deux résidents(es) de Kuujjuaq ont décidé de s'impliquer au niveau de l'entraide envers les personnes âgées et personnes handicapées.

Ce qu'elles veulent offrir ce sont des services de "repas à domicile"; vente à très bas prix de vêtements et articles divers; repas communautaires; accompagnement lors de visites à l'hôpital, d'activités communautaires ou d'excursions dans la nature; aide pour ménage et activités de la vie quotidienne.

Le comité s'est adjoint d'autres membres bénévoles (environ 8) décidés à oeuvrer dans le même domaine.

La municipalité a fourni un local pour les "vêtements à bas prix"; le Centre Hospitalier prête un local pour les réunions; la mission catholique prête une salle pour les activités communautaires.

La subvention demandée vise à couvrir les dépenses de fonctionnement du comité, défrayer l'essence pour les sorties; mais surtout pour offrir des repas et payer certains services non couverts par le programme de maintien à domicile des établissements.

Votre organisme offre des services depuis le _____ 19____

5. TERRITOIRE DESSERVI

Identifier le territoire desservi et la population correspondante

Région 10-A Kativik — 1200

(municipalité de Kuujjuaq)

S'agit-il d'un territoire Provincial ☐ Régional ☐ Sous-régional ☐ Local ☐

6. PÉRIODE D'OUVERTURE *(Pour l'année en cours)*

	JANV.	FÉV.	MARS	AVRIL	MAI	JUIN	JUIL.	AOÛT	SEPT.	OCT.	NOV.	DÉC.
Mois de fonctionnement				X	X	X	X	X	X	X	X	X

	L	M	M	J	V	S	D	TOTAL
Jours d'ouverture	X	X	X	X	X	X	X	
Nombre d'heures par jour	variable selon le besoin.							

Autre accessibilité à l'organisme. (préciser) _____

7. RESSOURCES HUMAINES

7.1 Personnel bénévole de votre organisme

Spécification concernant les bénévoles	Nombre	Total heures/année
Bénévoles impliqués dans l'administration	3	45
Bénévoles disponibles auprès des clientèles	10	40
Autres bénévoles (préciser)		
		85
TOTAL		

* L'organisme est en développement. Ce nombre d'heures risque d'autmenter considérablement dans les semaines qui viennent.

7.2 Personnel régulier rémunéré travaillant dans votre organisme (temps partiel et temps plein)

Nom de l'employé(e)	Fonction dans l'organisme	Salaire incluant avantages sociaux	Total heures/année
Aucun			
	TOTAL		

7.3 Personnel occasionnel rémunéré travaillant dans votre organisme

Type de travail (P.D.E., DEFI) travaux communautaires, EXTRA, stagiaire, autres (préciser)	Nombre de personnes	Salaire versé	Total heures/année
Aucun.			

9. CLIENTÈLE DE VOTRE ORGANISME

- Identifier la clientèle prioritaire visée par votre organisme et décrire ses caractéristiques et ses besoins particuliers.
- Pour les regroupements (fédération, association, etc.) préciser les principales fonctions et fournir en annexe la liste de vos membres

- Personnes âgées de Kuujjuaq.
- Personnes handicapées.
- Personnes dans le besoin.

10. RELATIONS AVEC LES ORGANISMES ET LES RESSOURCES DU MILIEU

Préciser la nature des rapports que votre organisme entretient avec les ressources du milieu (ORSSS, CSS, CLSC, DSC, CH, CAR, CAH, Organismes communautaires et autres instances. Municipalité, commission scolaire, fabrique, etc...).

Conseil Régional de la Santé et des Services Sociaux de la région KativiK: soutien technique au groupe et aide pour obtenir son incorporation et des subventions de fonctionnement.

Mission catholique de Kuujjuaq: salle pour les activités communautaires.

Municipalité de Kuujjuaq: salle pour vente de linge à prix réduit.

Hôpital d'Ungava: local pour réunions.

Indiquer si vous avez des ententes particulières: oui ☐ non ☐

Si oui, préciser _____

11. HÉBERGEMENT (Statistiques sur la clientèle)

- Les organismes d'hébergement qui ont reçu l'Annexe 1 sont tenus de la remplir.
- Pour les autres organismes d'hébergement, compléter la section suivante.

Ne s'applique pas.

- Cocher le type d'hébergement: ☐ hébergement simple (accueil plus couvert) ☐ hébergement d'accompagnement d'orientation et de transition ☐ hébergement avec activités de réadaptation et de réinsertion sociale
- Capacité d'hébergement _____ (nombre de places)
- Nombre de jours d'ouverture dans une année _____
- Capacité d'hébergement annuelle _____ (nombre de places x par le nombre de jours d'ouverture)
- Hébergement réel: _____ (nombre de personnes hébergées x par jours d'hébergement)
- % d'occupation _____ (100 x jours d'hébergement réels ÷ la capacité d'hébergement annuelle)
- Contribution financière des personnes hébergées: Par jour _____ Par semaine _____ Par mois _____
- Durée moyenne de séjour par personne hébergée _____
- Nombre de personnes hébergées pendant l'année _____

Répartir ce nombre selon l'âge et le sexe

AGE	SEXE Féminin	Masculin
0-12 ans		
13-18 ans		
19-30 ans		
31-50 ans		
51 ans et plus		

APPORT SYNTHÈSE DES ACTIVITÉS DE LA DERNIÈRE ANNÉE COMPLÈTE D'OPÉRATIONS DE VOTRE ORGANISME

ctivités liées à la dispensation de services directs aux clientèles: , entraide, accueil-information, écoute, animation, accompagnement, intervention ifique, hébergement, conférences, sorties de groupe etc.)	Type de clientèle desservie	Nombre de personnes rejointes		Fonctionnement de votre organisme. Indiquer la proportion en % du temps accordé à ce type d'activités
		de façon régulière	de façon occasionnelle	
- Notre organisme en est à ses débuts d'opération. Auparavant les personnes s'impliquaient de façon individuelle sans concertation et regroupement: visites à domicile, etc...				
	Total			
ctivités liées à l'organisation du bénévolat (recrutement - formation orientation rification - séances de sensibilisation - coordination etc.)	**Type de personnes impliquées**	**Nombre de personnes impliquées**		
		de façon régulière	de façon occasionnelle	
Recrutement de bénévoles. Promotion des services de l'organisme. Démarches pour avoir des locaux				
	Total			
ctivités liées au fonctionnement général de l'organisme: gestion administrative, ion du C.A. - planification - programmation - évaluation - concertation - coordina- - promotion - secrétariat - autofinancement etc.	**Type de personnes impliquées**	**Nombre de personnes impliquées**		
		de façon régulière	de façon occasionnelle	
Démarches pour des subventions. Démarches pour l'incorporation.				
	Total			
			TOTAL	100%

apport synthèse peut servir de rapport d'activités pour l'organisme qui a reçu l'année précédente une ou des subventions totalisant un montant inférieur que 25 000 $ du gouvernement du Québec. Cependant ce rapport doit être né par le conseil d'administration.

me Peggy Guay — Président(e) (nom en lettres moulées)

Signature Peggy Guay — (Nom en lettres moulées)

9c-06-06 — Titre

NCES

de l'organisme: Groupe d'Entraide

ée financière débutant le Avril 1991 et se terminant le 31 mars 1992. N° dossier:

DÉPENSES	90-91 Exercice précédent Complet 12 mois du au (1)	90-91 Exercice courant Cumulatif au 30 sept. 90 mois (2)	90-91 Exercice courant Estimé pour l'année complète 12 mois (3)	91-92 Prévisions budgétaires (4)
s et avantages sociaux				0
le logement				0
				0
ance				0
dministratifs				500$
le bureau				3 000$
ahis à la prévention des mauvais				9 000$
dépenses spéc. Activités communautaires				5 000$
Matériel pour repas à domicile				4 000$
TOTAL DES DÉPENSES				21 500$

REVENUS	90-91 Exercice précédent Complet 12 mois du au (1)	90-91 Exercice courant Cumulatif au 30 sept. 90 mois (2)	90-91 Exercice courant Estimé pour l'année complète 12 mois (3)	91-92 Prévisions budgétaires (4)
• Gouvernement du Canada				0$
Type de programme				
PDE Art. 25				0
• Gouvernement du Québec				
— Service de soutien aux org. comm				20 000$
— CRSSS (maintien à domicile)	(Soutien technique)			0
— CSS Ungava Hôpital	(local)			0
— Autres sources du MSSS				
— Autres sources du gouv. du Québec				0
Mission catholique	(salle communautaire)			0
• Municipalité				0
• Centraide				0
• Contributions des hébergés	bénéficiaires (repas.)			500$
• Autofinancement et autres Vente de linge				1 000$
TOTAL DES REVENUS				21 500$

mplir cette section avec compte de l'année financière de votre organisme.
fres fournis doivent être conformes à vos états financiers.

89-90 Exercice précédent (1)		
Surplus (déficit)	Ligne 24 moins Ligne 12	21 500$
	Solde du début	21 500$
	Surplus (déficit) cumulatif	0

Cette page des finances peut servir de rapport financier pour un organisme qui a reçu l'année précédente une contribution inférieure ou montant maximum que 25 000 $ du gouvernement du Québec. Cependant ce rapport doit être entériné par le conseil d'administration.

Peggy Guay
(Nom en lettres moulées)

Signature: Président(e)

Diane Boily
(Nom en lettres moulées)

Signature: Trésorier(ère)

6

13. JUSTIFIER, S'IL Y A LIEU, L'AUGMENTATION DE VOS PRÉVISIONS BUDGÉTAIRES 91-92 ÉNONCÉES À LA PAGE PRÉCÉDENTE (page 6)

- Achat de matériel pour les repas à domicile.
- Repas aux personnes âgées.
- Activités communautaires pour personnes âgées.

* Nous avons les bénévoles, les locaux mais aucun argent pour fonctionner.

14. PRIORITÉS POUR LA PROCHAINE ANNÉE
Indiquer vos priorités

- Avoir un local pour accomoder les personnes dans le besoin: genre "Disciples d'Emmaus".
- Offrir aux personnes âgées et handicapées une rencontre de groupe par semaine et des activités diverses avec collation.
- Visite à domicile chez des personnes âgées: support, aide pour ménage, repas.
- Aider les personnes âgées et handicapées à participer aux festivités et activités communautaires.

15. DOCUMENTS COMPLÉMENTAIRES OBLIGATOIRES

Le formulaire "Demande de subvention" ***doit être accompagné*** des documents permettant d'évaluer adéquatement le projet présenté. À cet effet, cocher la case correspondante aux documents annexés à votre demande.

- Charte de l'organisme, si vous n'avez pas fait de demande pour l'année financière 90-91 ou des lettres patentes supplémentaires, s'il y a lieu. (projet) ☒
- Règlements généraux de la corporation si vous n'avez pas fait de demande pour l'année financière 90-91 ou s'il y a eu des modifications en cours d'année. ☐
- Rapport financier de la dernière année d'opérations de l'organisme dûment accepté par les membres en assemblée générale et signé par le président et le trésorier du Conseil d'administration. *Selon les obligations découlant de l'article 69 de la Loi sur l'administration financière et du règlement sur le rapport financier des institutions subventionnées, tout organisme recevant du gouvernement une subvention de 25 000 $ et plus doit produire des états financiers vérifiés par un comptable public.* ☐
- Rapport annuel de la dernière année d'opérations dûment accepté par les membres en assemblée générale avec les statistiques à l'appui. ☐
- Feuille intitulée "Synthèse de la demande de subvention" dûment complétée. ☒

Formulaire rempli par: Peggy A Guay (avec l'aide de Francine Hudon du Conseil Régional Kativik)

Fonction au sein de l'organisme Présidente.

La date limite de réception d'une demande de subvention pour l'année financière 1991-1992 est fixée au* 1ER NOVEMBRE 1990 *pour tous les organismes.
Le cachet de la poste fait foi du respect de la date limite.

Adresser votre demande au:

Service de soutien aux organismes communautaires
1075, chemin Ste-Foy, (7e étage)
Québec, QC
G1S 2M1
Tél. (418) 643-5437