NUNAVIK REGIONAL BOARD OF HEALTH AND SOCIAL SERVICES

Health Plan

Block Funding Agreement

2019-2029

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

WORD FROM EXECUTIVE DIRECTOR

As Executive Director of the Nunavik Regional Board of Health and Social Services, I am proud to present you with our health plan. Many efforts from across our organization were invested in the preparation of this document. We believe it will provide you with an overview of the health and social services network in Nunavik as well as detailed information regarding the programs and services funded by your department.

In the upcoming years, we wish to continue to consolidate our work and ensure our actions are aligned with our population's needs. We will also pursue our work towards increasing interdepartmental collaborations, as well as with the regional health institutions. These partnerships will ensure that our concerted actions cover the continuum of care in an efficient manner. Although programs and initiatives funded by your department are already integrated within our regional priorities, this new type of funding agreement will provide us with the added flexibility to push this integration further and allow us to project ourselves in the future more easily.

In the past years, our relationship with your department has been strengthened and we wish to pursue these collaborations. We are grateful for this opportunity to increase the flexibility of our funding agreement and we appreciate the time and effort invested by your teams to support us in this initiative.

Minnie Grey
Executive Director
Nunavik Regional Board of Health and Social Services

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List of acronyms

ACJQ: Association des centres jeunesse du Québec
ADI : Aborignal Diabetes Initiative
AOM: Association of Ontario Midwives
ARHSS: Act Respecting Health and Social Services
CBHSSJB: Cree Board of Health and Social Services of James Bay
CHSLD: Extended-care residential hospital centre
CLSC: Local community service centre
CLWW: Community Liaison Wellness Worker
CPEJ: Child and youth protection centre
CPNP: Canada Prenatal Nutrition Program
CRDM: Centre de réadaptation en dépendances Montréal
DYP: Department of Youth Protection
FASD: Fetal Alcohol Spectrum Disorder
FCNQ: Federation of Cooperatives of New Quebec
FNIHCCP: First Nations and Inuit Home and Community Care Program
IHC: Inuulitsivik Health Centre (Hudson Coast)
INIHB: Insured/non-insured health benefits
INSPQ: Institut de Santé Publique du Québec
IPL: Individualized Paths to Learning
IPQ: Illusiliriniqmi Pigutjiutini Qimirruniq
IT: Information technology
ITK: Inuit Tapiriit Kanatami
KMHB: Kativik Municipal Housing Bureau
KI: Kativik Ilisarniliriniq (school board)
KRG: Kativik Regional Government
KRPF: Kativik Regional Police Force
MADO: Maladie à déclaration obligatoire
MEDEVAC: Medical evacuation
MNQ/NQM: Northern Quebec Module (Ullivik)
MSSS : Ministère de la Santé et des Services sociaux
NI: Nunalituguait Ikajuqatigiitut
NRBHSS: Nunavik Regional Board of Health and Social Services
NYHA: Nunavik Youth House Association
OSFQ: Ordre des Sages-femmes du Québec
PPO : Planning and programming officer
RPC: Regional Partnership Committee
RUIS: Integrated University health network
RSPC: Regional Suicide Prevention Committee
SIPPE: Services Intégrés en Périnatalité et en Petite Enfance
SHQ : Société d'habitation du Québec
SPLW: Suicide Prevention Liaison Worker
STBBI: Sexually transmitted and blood-borne infections
TB: Tuberculosis
UTHC: Ungava Tulattavik Health Centre

EXECUTIVE SUMMARY

Block Funding Agreement

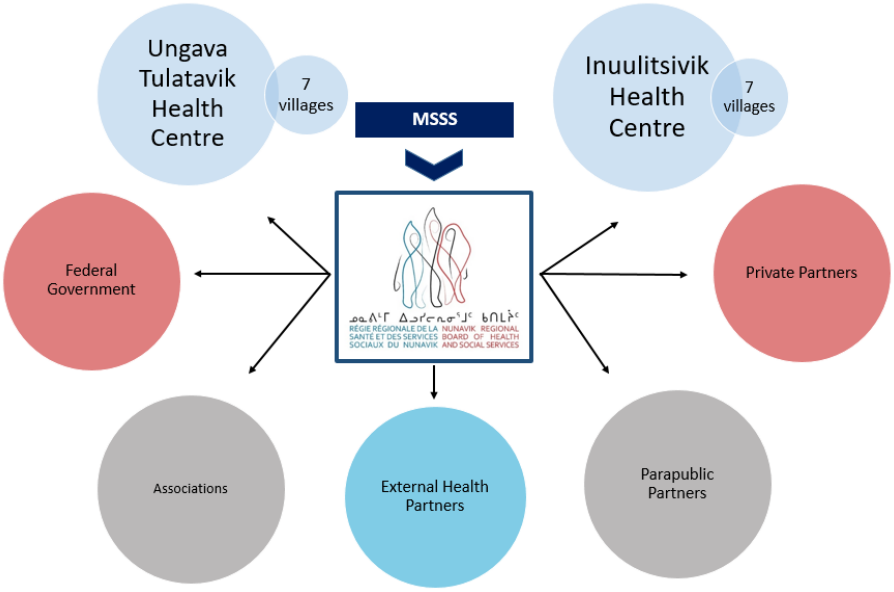
As of April 1, 2019, the Nunavik Regional Board of Health and Social Services (NRBHSS) hopes to sign a new contribution agreement with Indigenous Services Canada for a ten-year term (2019-2029), under block funding.

In order to obtain this type of multi-year agreement, the NRBHSS has developed a health plan to implement the programs and initiatives funded by Indigenous Services Canada, in line with provincial priorities and services.

The current contribution agreement with Indigenous Services Canada will include funding for approximately $ 8 million a year under a variety of health prevention and promotion programs and initiatives. In the coming years, the NRBHSS will continue to implement the health plan and update it to reflect the current health needs of the people of Nunavik.

Health and Social Services Network

The James Bay and Northern Quebec Agreement is the foundation for the current health and social services network in Nunavik. The agreement establishes the creation of the Nunavik Regional Board of Health and Social Services (NRBHSS) and the health establishments. It also defines the framework according to which funding is granted for immovable and operations in the health sector.



The NRBHSS was created in 1995 and its main mandate is to organize health and social service programs in the fourteen villages of the region, evaluate the effectiveness of these programs and ensure the users receive quality services adapted to their needs. These responsibilities include sound and efficient management of the financial resources allocated to the region for health and social services.

Profile

550 164 km^2
---
14 villages
-
Fly-in only

Municipal gov. system

No cellular service

Nomads until 1950s

Impacted by residential schools

Population of 13,188

34% of population is under 15

Inuktitut - mother tongue of 98% of Nunavik Inuit

49% live in crowded homes

39% live in homes in need of repairs

Crowded homes are conducive to health and social issues

18% high school graduation rate

60% have no certificate or degree

Only 19% have revenues of 40,000$ or more

37% live below the poverty line

Price of food - 52% higher than Quebec City

Overall cost of living - 29% higher than Quebec City

535 crimes per 1,000 residents

70% of major crimes committed under influence of alcohol or drugs

High percentage of binge drinking

44% of women admitted to drinking alcohol while pregnant

Smoking rate of 77%

Tuberculosis rate is 312,6 per 10,000 population

43% of reported injuries were transportation related

Chlamydia rate is 4,194 per 100,000 population

49% of women have been victims of sexual assault or attempts of sexual assault when they were minors
---
54% of adults reported having experienced one or more forms of physical violence
---
Suicide rates are 10 times that of the rest of the province

NRBHSS Priorities

Mental health
- Suicide prevention
- Enhance services for crisis, traumas and mental illnesses
- Healing services

Addictions
- Enhance local service offer
- Improve family oriented services

Youth in difficulty
- Prevent parental neglect
- Enhance child development services and education
- Review youth protection services to better reflect northern reality

Public health
- Community mobilization
- Food security
- Prevention and control of infectious diseases
- Healthy families

Physical health
- Optimize health trajectory
- Develop and expand service agreements
- Patriate services

Loss of autonomy
- Enhance access to services
- Support families
- Foster maintaining individual in environment of choice

Health and social network
- Patriate services
- Aging equipment and infrastructure
- Lack of employee stability
- Increase number of Inuit resources

The NRBHSS's priorities of action stem from the Ilusilirniqmi Pigutjiutni Qimirrnuniq (IPQ) process and the Parnasimautik consultations. The IPQ process started in 2009 and involved more than 40 different regional users, bodies and organizations. Several committees were created to conduct research, consultations and analysis to draft recommendations regarding services to improve and develop as priorities.

Parnasimautik was a regional consultation process that aimed at creating a comprehensive vision for the development of the region. The final report was presented to provincial government officials in 2015 as a reply to the Province's plan for the development of Nunavik *(Plan Nord)*.

Based on the orientation provided by these processes, the NRBHSS produces the Strategic Regional Plan (SRP). The strategic plan also provides a funding framework that includes the development required for Nunavik's health network. The latest SRP submitted to the MSSS covers the period of 2018 to 2025. The development of the Nunavik health and social services network is based on a global and integrated approach to the population's needs.

Strategic Regional Plan

- Centred on preventive services, front-line services and community involvement;
- Model for integrated provision of health and social services;
- Services provided at the community level whenever feasible;
- Services provided sub regionally and regionally whenever efficient in terms of costs and services according to the needs;
- Development of immovable, housing and equipment at a pace that matches service development;
- Development of technical-support systems.

Priorities and Federal Government Programs

The federal programs for which the NRBHSS receives funding all correspond to the established organizational priorities. Current planning of federal programs is complimentary to the provincial planning. The NRBHSS is continuously working to ensure appropriate coverage of the continuum of services.

Federal Functional Area Groups	NRBHSS Priorities						
	Youth in Difficulty	Mental Health	Addictions	Public Health	Physical Health	Loss of Autonomy	Health and Social Network
Healthy Child Development	X			X	X		
Mental Wellness		X	X				
Healthy Living				X	X		
Communicable Disease and Management				X	X		
Home and Community Care						X	
Health System Capacity	X	X	X	X	X	X	X

Federal Program Planning

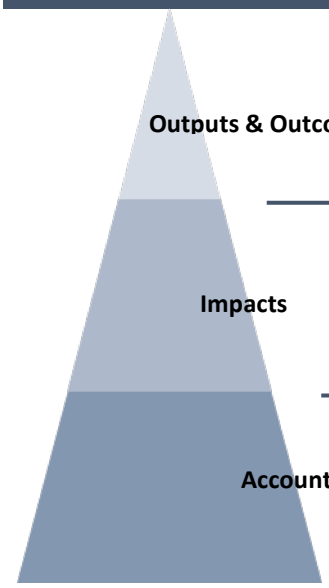
Federal Functional Area Group	Goals
Healthy Child Development	▪ Improve health of children by implementing an integrated continuum of services. ▪ Improve development of children by working upstream on protective factors. ▪ Reduce prevalence of fetal alcohol spectrum disorders (FASD) in future generations. ▪ Reduce number of children with tooth decay, by fostering adoption of good oral health practices.
Mental Wellness	▪ Promote healing and reconciliation among youth and inter-generational survivors through understanding of residential school impacts. ▪ Increase local mental wellness services by creating and supporting a Natural helper's network. ▪ Increase wellness in the population through awareness and prevention. ▪ Support Inuit traditional approaches to mental wellness through community-based and led initiatives. ▪ Develop culturally appropriate regional expertise on suicide prevention through capacity development.
Healthy Living	▪ Improve individual management of diabetes and diminish complications. ▪ Improve access to healthy store-bought food and country food. ▪ Support community-based and led healthy living activities. ▪ Reduce prevalence of smoking. ▪ Improve knowledge regarding nutrition and skills in choosing and preparing healthy foods.
Communicable Disease Control and Management	▪ Diminish the number of tuberculosis (TB) cases by implementing an integrated approach to fighting the disease. ▪ Diminish the number of TB cases by increasing the number of individuals being screened and complying with treatment. ▪ Decrease the prevalence of STBBIs in Nunavik, by improving knowledge and increasing the number of individuals being tested.
Home and Community Care	▪ Ensure equitable access to care and services in each community. ▪ Provide support adapted to the individual's condition, in a patient-partner approach. ▪ Foster maintaining individual in the living environment of his choice. ▪ Support the individual's family.
Health System Capacity	▪ Develop standardized knowledge and decision-aiding tools. ▪ Integrate Qanuilirpitaa data to federal planning. ▪ Enhance integration of federal and provincial planning.

Policies & Procedures

The health and social services network has a variety of policies and procedures in place, many of which are dictated by the provincial laws, but developed at a local level. Most policies and procedures are developed by the two health centres, who then deploy them in their respective CLSCs.

Examples: Ethical code of conduct, confidentiality of personal information, personnel evaluation process, personnel training policy, biomedical waste management, etc.

Evaluation



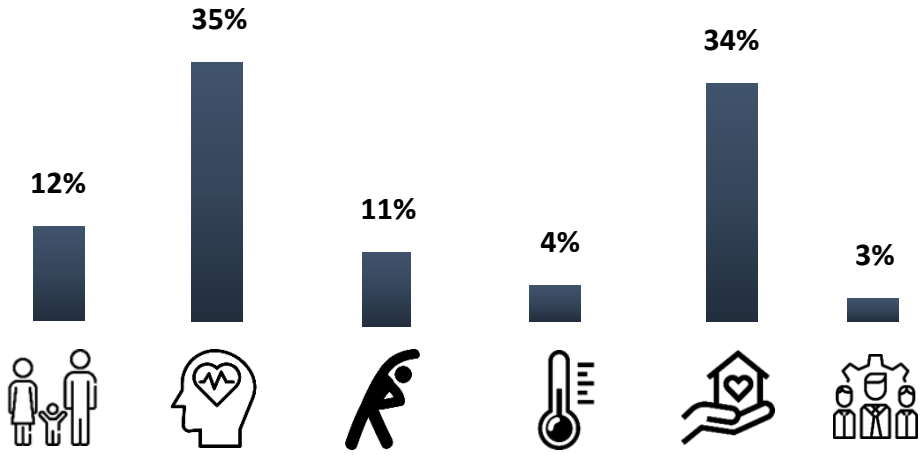
An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

In addition, the 2017 Qanuilirpitaa health survey will provide an updated portrait of the health status of Inuit in Nunavik. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

Budget

Indigenous Services Canada provides almost 9 % of the NRBHSS's budget, which amounts to approximately 10 million dollars annually.



1. JAMES BAY AND NORTHERN QUEBEC AGREEMENT

"The Constitution of Canada includes the *Constitution Act, 1867,* and the *Constitution Act, 1982*. It is the supreme law of Canada. It reaffirms Canada's dual legal system and also includes Aboriginal rights and treaty rights."[1] Article 35 of the Canadian Constitution stipulates the following in regards to the recognition of existing aboriginal and treaty rights:

*"**35.** **(1)** The existing aboriginal and treaty rights of the aboriginal peoples of Canada are hereby recognized and affirmed.*
__(2)__ In this Act, "aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada.
__(3)__ For greater certainty, in subsection (1) "treaty rights" includes rights that now exist by way of land claims agreements or may be so acquired."[2]

Hence, the rights associated with the James Bay and Northern Quebec Agreement (JBNQA) stem from the Constitution of Canada. The JBNQA serves as a pillar for understanding the relationship of the Inuit with the provincial and federal levels of government.

Signed in 1975, the JBNQA was the first major comprehensive land claim agreement in northern Canada. "Signatories to the JBNQA include the Government of Quebec, the James Bay Energy Corporation, the James Bay Development Corporation, Hydro-Québec, the Grand Council of the Crees (of Quebec), the Northern Quebec Inuit Association, and the Government of Canada. In addition to settling native land claims and providing financial compensation, the agreements defined aboriginal rights and established regimes for future relations between aboriginal peoples and non-Aboriginals in the region and among local, regional, provincial and federal governments. Harvesting rights were provided, land categories set out and resource management regimes set up. School boards were created, health services were restructured and regional governments were established." [3]

The agreement, led to the transfer, from the federal government to the provincial government, of most of the responsibilities concerning services for the Inuit communities, including, health and social services. At the time of the negotiations, the Inuit of Nunavik not only wanted to protect their territory and traditional way of life, but also sought to improve their quality of life by establishing better infrastructure and services such as housing, education, health, police, justice, and airports. Thus, the Inuit of Nunavik consciously chose open, public and non-ethnic institutions, such as the Nunavik Regional Board of Health and Social Services (NRBHSS).

Although the JBNQA led to the transfer of funds and responsibilities from the federal to the provincial government, the Agreement Respecting the Implementation of the JBNQA stipulates that:

*"**2.** Agreement-in-principle The Government of Canada agrees to review in accordance with specific guidelines set out in paragraph 4.1 below and, if necessary, to develop and make recommendations on how to change federal program criteria in order to ensure that the Inuit of Quebec have equal access to all federal programs*

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[1] Department of Justice Canada. (2017, October 16). *The Canadian Constitution*. Retrieved from http://www.justice.gc.ca/eng/csj-sjc/just/05.html
[2] Department of Justice Canada. (2012). *A consolidation of the constitution acts 1867 to 1982*. Retrieved from http://laws-lois.justice.gc.ca/PDF/CONST_E.pdf
[3] Makivik Corporation. (2018, September 17). JBNQA. Retrieved from http://www.makivik.org/corporate/history/jbnqa/

on the same basis as other Indians and Inuit of Canada, as well as to all federal programs available to other Canadians.

4.1.1 *Federal programs and services shall be deemed to apply to the Inuit of Quebec unless the subject matter of such programs and services has been the object of special provisions and benefits under the JBNQA under which the Inuit of Quebec have access to equivalent benefit in the place and stead of such programs and services;*

4.1.2. *Federal programs and services shall be deemed to apply to the Inuit of Quebec unless responsibility for the delivery of such programs and services has been wholly assumed by Quebec pursuant to the provisions of the JBNQA, without reduction to such programs and services;*

4.1.3. *Federal programs and services shall be deemed to apply to the Inuit of Quebec unless the subject matter of such programs and services is under the exclusive jurisdiction of Quebec"*[4]*;*

The agreement also defines the provision of health and social services for the Nunavik region. Notably, Section 15 of the JBNQA, "Health and Social Services (Inuit)," establishes the framework according to which Quebec grants funding for immovable and operations in the health sector. It also establishes the creation of the NRBHSS and the health establishments, in order to provide services for permanent or temporary residents of the region (section 15.0.10). Section 15 of the JBNQA essentially proposes the organizational and structural details as well as the transfer conditions for the provision of health and social services post-1975.

"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."*[5]

"15.0.19 *The budget from the Province of Quebec to each establishment shall include funding for the support of health services which are not included in provincial programs for the general population <u>but which are provided to the Native people by the Department of National Health and Welfare or other agencies</u>".*[6]

Nevertheless, adjustments are necessary when the services, programs and envelopes are developed for Nunavik's clientele, given the adaptation measures stated under the *JBNQA*. The agreement details how funding or programs need to be adapted to the northern context, its geographic and cultural specificities, the fostering of employment for the Inuit and so forth.

*"**15.0.21*** *In implementing the Agreement, Quebec <u>should recognize and allow to the maximum extent possible</u> for the unique difficulties of <u>operating facilities and services</u> 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;

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[4] Indigenous and Northern Affairs Canada. (2010, September 15). *Agreement respecting the implementation of the JBNQA between her majesty the Queen in right of Canada and Makivik Corporation.* Retrieved from http://www.aadnc-aandc.gc.ca/eng/1100100030826/1100100030828#annexb

[5] N.D. *The James Bay and Northern Quebec Agreement (JBNQA)*. P. 197 Retrieved from http://extwprlegs1.fao.org/docs/pdf/que136636.pdf

[6] Ibid, p. 199

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."[7]

"Schedule 1 (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."*[8]

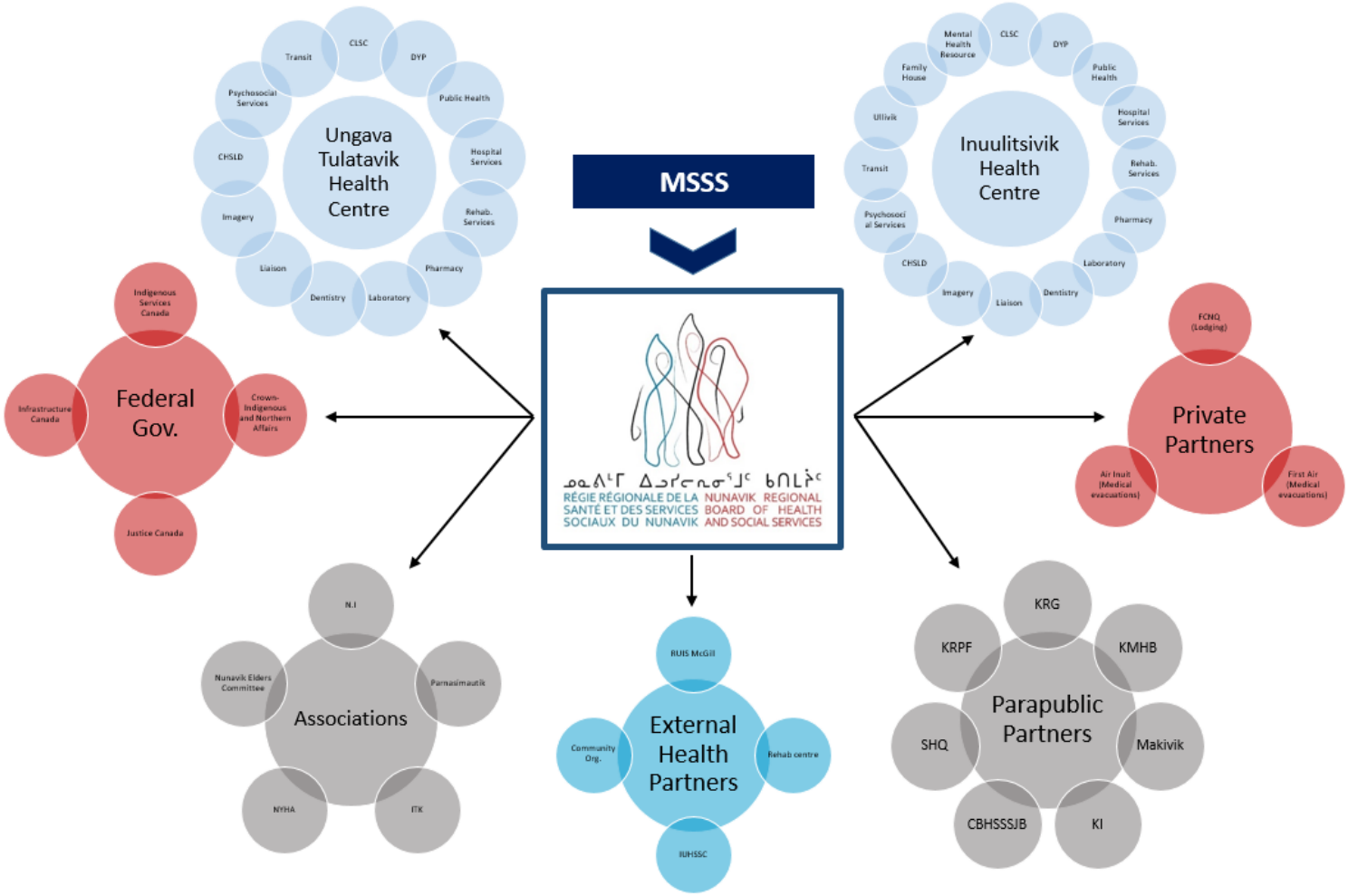
In spite of the advantages and true improvements for the Nunavik region since the signature of the JBNQA, the quality of life today indicates a jarring and preoccupying reality. The Inuit of Nunavik are entitled to the services of the same quality and the same nature as those offered in the rest of the province, whether basic or specialized services.

[7] Ibid, p. 200
[8] Ibid, p. 201

2. NUNAVIK HEALTH AND SOCIAL SERVICES NETWORK

Nunavik's health and social services network includes the Nunavik Regional Board of Health and Social Services (NRBHSS), the Inuulitsivik Health Centre (IHC) on the Hudson Coast and the Ungava Tulattavik Health Centre (UTHC) on the Ungava Coast. The NRBHSS is an organization dedicated to improving the health and well-being of the populations of the 14 communities on its territory. Its overall mission is to adapt the health and social service programs to the population's needs and to the region's realities.

Figure 1 Local Health Network - Nunavik



2.1 Nunavik Regional Board of Health and Social Services

Nunavik's health and social services network includes the Nunavik Regional Board of Health and Social Services (NRBHSS), the Inuulitsivik Health Centre (IHC) on the Hudson Bay and the Ungava Tulattavik Health Centre (UTHC) on the Ungava Bay. The signing of the JBNQA and supplementary agreements established guidelines for the development of health and social services in Nunavik. The organization of health care and social services is of provincial jurisdiction, but adapted to regional realities.

Given the size of its population and its cultural characteristics, Nunavik is unique in combining curative and preventive approaches in a more integrated manner. While it is an asset to deliver health and social services this way, interveners and health professionals in the Nunavik region face unique challenges such as isolation, lack of infrastructure, access to specialists and human resources in general.

The Nunavik Regional Board of Health and Social Services (NRBHSS) was created in 1995 under the S-4.2 *Act respecting health services and social services* (ARHSS). The NRBHSS's main mandate is to organize health and social service programs in the fourteen villages of the region, evaluate the effectiveness of these programs and ensure the users receive quality services adapted to their needs. These responsibilities include sound and efficient management of the financial resources allocated to the region for health and social services.

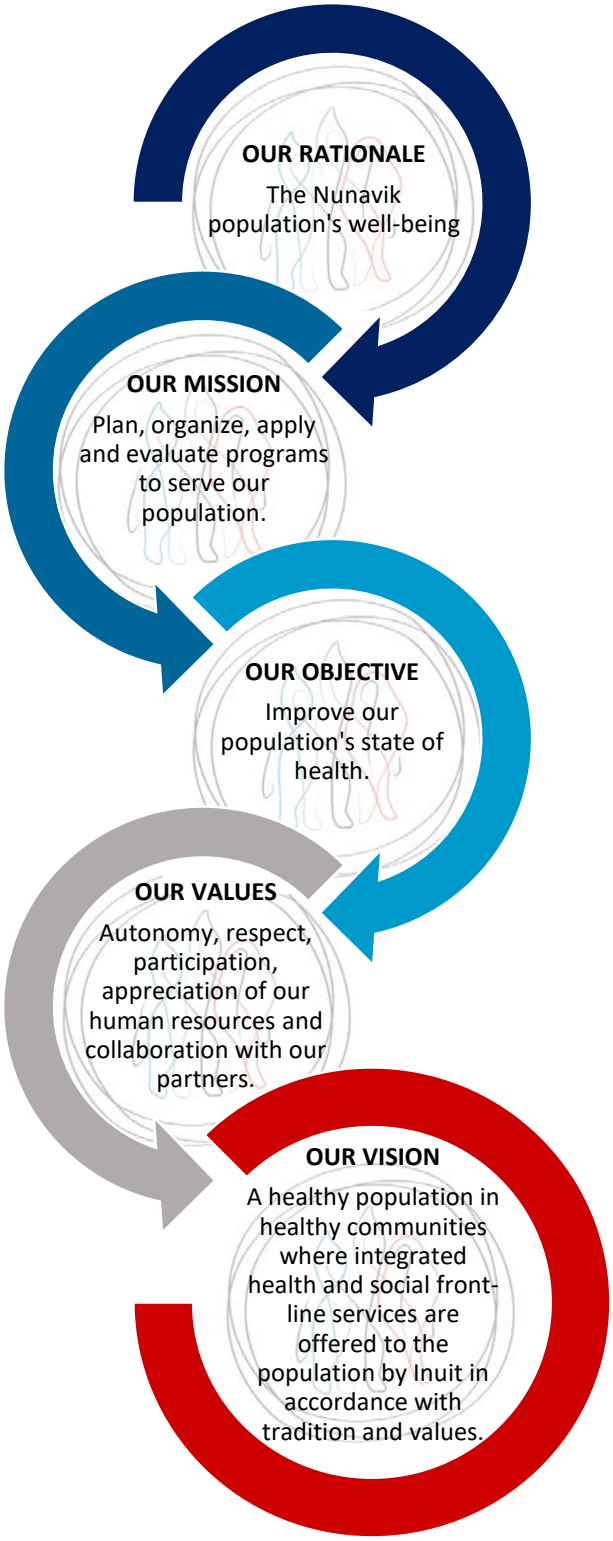
S-4.2 Act specifies in Article 100, the following functions for the NRBHSS. "The function of institutions is to ensure the provision of safe, continuous and accessible quality health or social services which respect the rights and spiritual needs of individuals and which aim at reducing or solving health and welfare problems and responding to the needs of the various population groups. To that end, institutions must manage their human, material, information, technological and financial resources effectively and efficiently and cooperate with other key players, including community organizations, to act on health and social determinants and improve the supply of services to the public. In addition, a local authority must elicit and facilitate such co-operation."[9]

The NRBHSS manages a budget of approximately 170 million dollars, destined to the health and social services of the population on its territory. Its offices are located in Kuujjuaq. Nunavik corresponds to administrative health region 17, under the *Ministère de la santé et des services sociaux* (*MSSS*). It is important to note that the NRBHSS is excluded from the O-7.2 act, an act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies). Article 2 of the Act specifies that: "This Act applies despite any incompatible provision of the Act respecting health services and social services (chapter S-4.2). It does not apply to the institutions and regional board governed, as applicable, by Parts IV.1 and IV.2 of that Act or to the Cree Board of Health and Social Services of James Bay established under the Act respecting health services and social services for Cree Native persons (chapter S-5)."[10]

[9] S-4.2 Act respecting health services and social services. Retrieved from http://legisquebec.gouv.qc.ca/en/showdoc/cs/S-4.2/20051130#se:100
[10] O-7.2 Act to modify the organization and governance of the health and social services network, in particular by abolishing the regional agencies. Retrieved from http://legisquebec.gouv.qc.ca/en/ShowDoc/cs/O-7.2#se:2

2.1.1 NRBHSS – Regional Organizational Structure

Figure 2 NRBHSS Mission and Values



The NRBHSS employs 123 Inuit and non-Inuit individuals, and is composed of seven departments:

Executive Management: This department ensures the administration of all the regional boards' activities and fulfilment of its mission. Its responsibilities also include prehospital services, the protection of the health and social system users and supporting the regional organizations in the adaptation of the services to the needs of the population. The executive management also ensures that services offered throughout the Nunavik network are available in Inuktitut, English and French. This includes the services of interpreters and translation in the three languages. It executes the decisions of the board of directors.

Administrative Services: This department assumes all administrative and human resource services. It is also responsible for fixed assets, capital projects and information technology (IT). The administrative services department is responsible for allocating operational budgets and ensuring follow-ups for contributions and subsidies.

In relation to the strategic planning, the department manages the development and follow-up of capital projects for short- to long-term investments for the entire health and social services network. The department also ensures support for the two health centres in the region on different files, such as budgeting and other financial services, as well as the maintenance of major assets, through different renovation and replacement projects.

Public Health: With the support of various partners, this department ensures the application of the regional public health program in accordance with the Act on health and social services. This includes occupational health and safety, screening for and management of infectious diseases, prevention of infections, promotion of health and well-being as well as screening for and management of diseases such as diabetes and tuberculosis.

The department establishes priorities, organizes services and allocates resources. It is responsible for the protection of public health, including the areas of infectious diseases and environmental contaminants. This sector includes the identification of potential health hazards and risks for the population and the implementation of the necessary corrective measures. The Department of Public Health also ensures the monitoring of the population's health status.

Inuit Values and Practices: This department ensures that Inuit values and practices are included within the mandate of the health and social services network. It provides an array of services such as traditional adoption, the Indian residential school program, the prevention of violence and abuse of the elderly, the midwifery education program and services, as well as the Brighter Futures program.

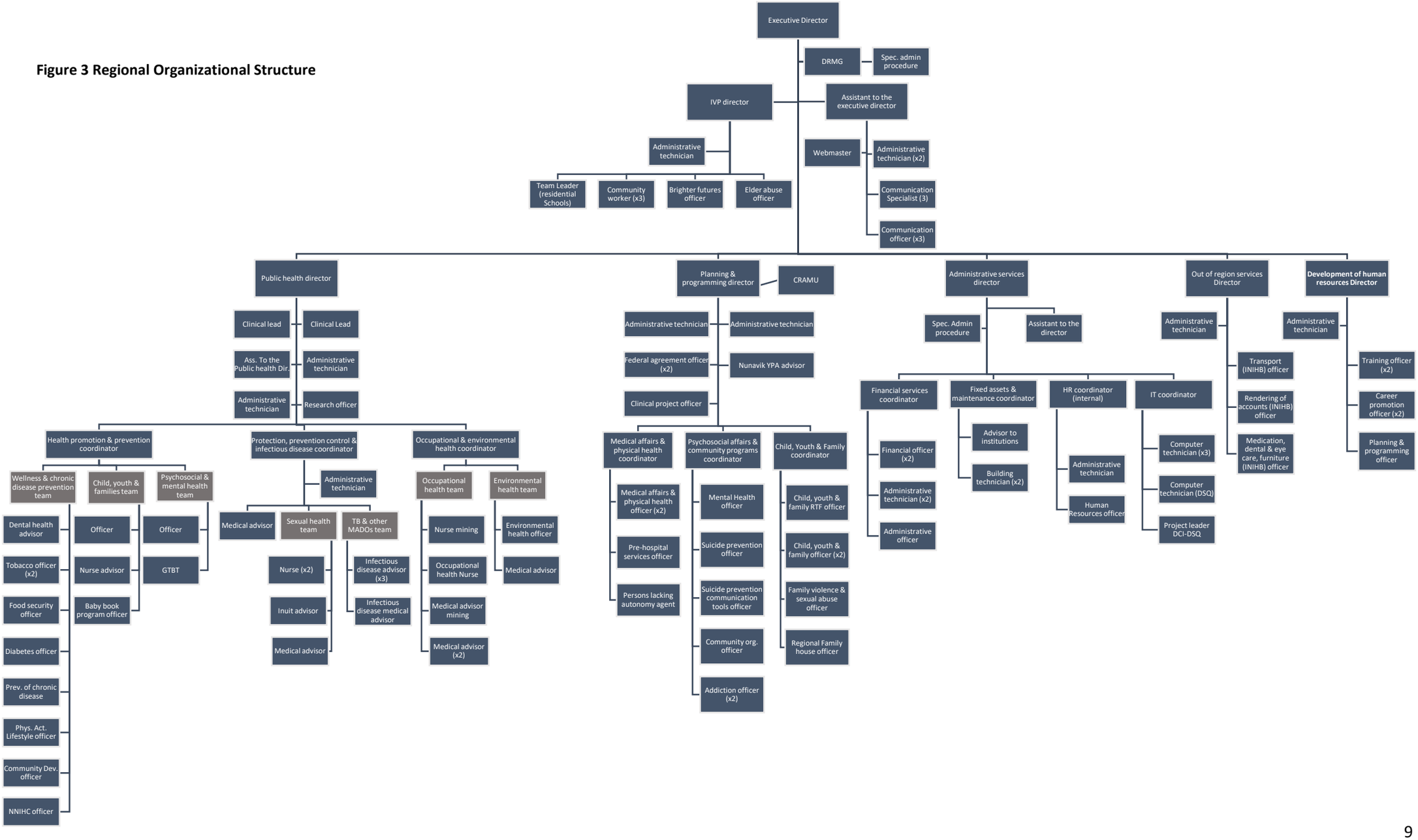
Out-of-Region Services: This department provides transportation and lodging services within (i.e. travel to health centres for services) and outside the region for users receiving health and social services. It also manages programs such as the insured/non-insured benefits (INIB) and the Ullivik installation in Dorval.

Regional Development of Human Resources: This department is responsible for the development of human resources in the health and social services network and for the development of strategies to overcome the multiple recruitment challenges faced by the region. The department ensures the planning, coordination and evaluation of training programs that meet the needs in terms of service provision in the health and social services network. It contributes to improving personnel-attraction and -retention measures and development of the Inuit succession plan. In collaboration with the Executive Management Department, the department supports the efforts to hire, maintain, train and mobilize Inuit personnel towards a sustainable workforce. They also have the responsibility of the Aboriginal Health Human Resources file.

Planning and Programming: This department organizes, coordinates, develops and evaluates regional health and social services. These responsibilities include the assessment of needs, asset mapping and definition of priorities for the Clinical Project. The programs and initiatives managed by this team include medical affairs, addictions, mental health and well-being, youth protection, rehabilitation for youth with adjustment difficulties, services against violence and abuse. The department of planning and programming also ensures the coordination of services offered by community organizations and the family-type and intermediate resources. Under the Planning and Programming department, there are also two resources dedicated to the management of the Indigenous Services Canada agreement that:

- Ensure proper development and management of the agreement;
- Ensure conformity of activities / Programs / Initiatives;
- Ensure continuity in accountability and develop indicators (implementation, performance and follow-up);
- Liaise between the NRBHSS and Indigenous Services Canada;
- Develop internal capacity.

Figure 3 Regional Organizational Structure



2.1.2 NRBHSS – Board of Directors

A Board of Directors (BOD) composed of 20 members oversees the NRBHSS. Anything concerning the NRBHSS and involving health decisions in Nunavik must receive approval from the BOD through a signed resolution. Aside from the functions related to administration, the BOD is responsible for identifying priorities regarding the population's needs in matters of health and social services. These priorities are submitted to the population through a public information session held annually by the NRBHSS.

Composition:

There are 14 individuals, each representing one Nunavik village, the executive director of each health centre (IHC and UTHC), one member appointed by the board of directors of each health centre from among the elected representatives of the villages, one member appointed by the Kativik Regional Government's (KRG) board of directors and the NRBHSS's executive director.

With the exception of the executive directors, the term of office is three years. At the expiry of the term, members remain in office until they are replaced or reappointed. The JBNQA requires a majority of Inuit members on the boards of the NRBHSS and other institutions.

Responsibilities of the BOD:

The BOD defines the strategic orientations of the NRBHSS and exercises its responsibilities, in accordance with the province-wide orientations, while fostering networking with the local, regional and provincial partners.
The BOD has the following responsibilities:

- Identifying the priorities regarding the needs of the population and the services to be offered to that population, accounting for the distinctive sociocultural and linguistic characteristics as well as the distinctive sub regional and socioeconomic aspects of the region, and developing orientations in this regard;
- Allocating equitably the human, physical and financial resources made available, accounting for the same distinctive characteristics as those contemplated in paragraph a) and ensuring their economical and efficient use;
- Appointing the executive director of the NRBHSS;
- Appointing the senior administrators;
- Appointing the regional service quality and complaints commissioner in accordance with section 63 of the Act respecting Health and Social Services;
- Adopting the strategic plan and the annual management report;
- Presenting the regional board's priorities regarding health services and social services and its annual activity report to the public at a public information meeting;
- Approving the management and accountability agreement;
- Approving the financial statements;
- Monitoring performance and accountability for results.

Members:

Composition of the Board of Directors, December 2017 (three-year mandate)

- Lucy Tukkiapik-Carrier, Chairperson, Kangirsuk representative;
- Louisa Grey, Vice-Chairperson, Aupaluk representative;
- Minnie Grey, Secretary, NRBHSS Executive Director;
- Qumaq Iyatiuk-Mangiuk, Executive Committee Member, Ivujivik representative;
- Sheila Ningiuruvik, Executive Committee Member, Quaqtaq representative;
- Elisapi Uitangak, Puvirnituq representative;
- Kitty Annanack, Kangiqsualujjuaq representative;
- Shirley White-Dupuis, Kuujjuaq representative;
- Jane Beaudoin, Inuulitsivik Health Centre Executive Director;
- Cora Fleming, Kuujjuaraapik representative;
- Mary Berthe, Tasiujaq representative;
- Parsa Kitishimik, Kativik Regional Government representative;
- Claude Gadbois, UTHC BOD representative;
- Josepi Padlayat, Inuulitsivik BOD representative;
- Ida Saviadjuk, Salluit representative;
- Alice Saggiak, Kangiqsujuaq representative;
- Larry Watt, UTHC Executive Director;
- Allie Nalukturuk, Inukjuak representative;
- Alice Tooktoo, Umiujaq representative;
- Jusepi Qaqutuk, Akulivik representative

The BOD has four sub committees mandated to work on specific issues and make recommendations to the board:

- **The audit committee:**
    - Meet with the Auditor General of Quebec prior to the interim audit to review the points on which the interim audit will focus;
    - Acquire, following the interim audit, recommendations from the Auditor General and improvements to internal control, as appropriate;
    - Follow up on the previous point following the financial year-end audit and recommend the March 31 financial statements for approval by the BOD;
    - Approve the four-year banking agreement, which is subject to a competitive bidding process and make a recommendation to the BOD.

- **The planning and evaluation committee:**
    - Make recommendations to the BOD regarding the adoption of regional plans, including those related to programs, organization of services, human resources, information resources, physician resources and accessibility to health services and social services in the English language;
    - Monitor and evaluate regional plans as well as the performance and productivity of the regional network;
    - Analyze recommendations from the Population Forum, Regional Multidisciplinary Commission, Regional Nursing Commission, Regional Department of General Medicine, Table of Heads of Department of Specialized Medicine, Regional Committee on Pharmaceutical Services, Regional Committee on access to English-language health and social services and recommend follow-up actions to the BOD.

- **The Resource Allocation and Management Agreement Monitoring Committee:**
    - Make recommendations to the BOD on methods, principles and criteria to be used for the allocation of resources to institutions and community organizations;
    - Using the methods, principles and criteria determined, analyze and make recommendations to the BOD, on the allocation of resources between institutions and community organizations;
    - Present the BOD with the management agreement to be concluded between the *Agence de Montreal* and the Minister of Health and Social Services, and to monitor the agreement;
    - Subject to the restrictions imposed by Act respecting Health and Social Services and its regulations, undertake any mandate given to it by the BOD regarding the allocation of resources.

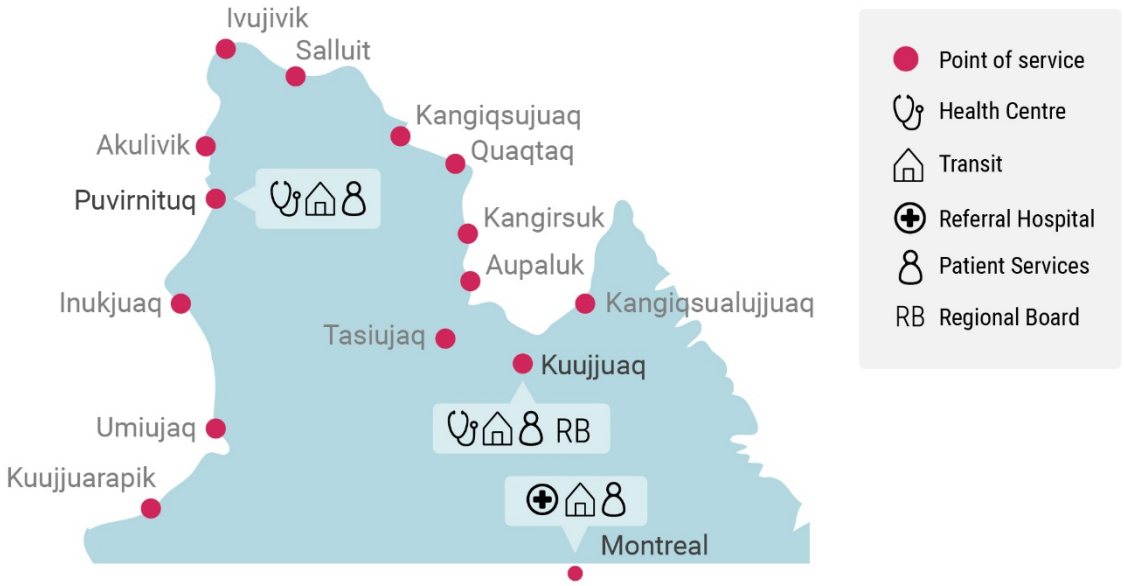
- **The users' committee:**
    - The users' committee performs the following functions, with respect to the population, and in accordance with the Act respecting Health and Social Services, section 212:
        - Inform users about their rights and obligations;
        - Promote the improvement of the quality of users' living conditions and assesses their degree of satisfaction;
        - Defend the collective rights and interests of the users and upon request, individual rights;
        - If necessary, accompany a user in the complaint process.

2.1.3 Health Centres – Inuulitsivik Health Centre and Ungava Tulattavik Health Centre

There are two health establishments in Nunavik: the Ungava Tulattavik Health Centre (UTHC), in Kuujjuaq, and the Inuulitsivik Health Centre (IHC), in Puvirnituq. Each health centre has a board of directors and essentially share the same administrative and strategic obligations.

Both health centres pursue several missions, such as attaining the objectives defined under the *Act respecting health and social services* and to participate in the process of community development by offering front and second-line health and social services that correspond to the population's needs.

Figure 4 Nunavik Health Service Map



The two health centres offer front-line services to their village's population, as well as second-line services to nearby associated villages. Both health centres have emergency and maternity departments. They also both offer the following medical, social and administrative services: day surgery, short-term care, long-term care, archives, radiology, dentistry, electrocardiography, laboratories, pharmacy, transit homes for patients, physiotherapy / occupational therapy, group homes and youth protection.

Each health centre administers the following services for the population on their respective coasts:

Local community service centres (CLSC)

The CLSCs offer routine, front-line health and social services, both preventive and curative, as well as physical rehabilitation and social reintegration to the population. The CLSCs also participate in public-health services. There is a CLSC point of service in each community. Services are available 24h a day, 7 days a week.

Social Services

Professionals in each village provide social services. They receive all those who need individual and / or family consultation with or without an appointment and provide care. These consultations cover various issues, such as mental health, addictions, bereavement, psychotherapy, and crisis intervention. Links are made with other Youth Protection, Rehabilitation and General Service Programs in CLSCs.

Child and youth protection centres (CPEJ)

As CPEJ, the health centres offer the services required by a youth's situation under the *Youth Protection Act* or the *Young Offenders Act* as well as services for child placement and adoption and family mediation.

Hospital Centre (Acute care)

Beds for acute care are available at both health centres. Centres offer diagnostic services and general and specialized medical care.

Extended-Care Residential Hospital Centre (CHSLD)

Beds for extended care are available at both health centres. Centres offer temporary or permanent substitute living environments, residential services, assistance and support to adults who, due to their loss of functional autonomy, can no longer remain in their regular living environment.

Specialized health services

Travelling teams of professionals (doctors, physiotherapists, occupational therapists, physical rehabilitation therapists, dentists, dental hygienists, audiologists, etc.) serve, on an ad hoc basis, all the villages in order to provide services to the population across the region.

There are permanent doctors in Puvirnituq, Kuujjuaq, Salluit and Inukjuak. These doctors provide services for the 24-hour emergency at the health centres and CLSCs, the observation beds and the maternity wards. Family physicians provide a wide array of health care services in Nunavik: emergency care, on-site or on-call care, tertiary care, air transfers, hospitalizations, and village tours, follow-up, walk-in clinics, and supervision of some care given by nurses or midwives, remote medicine by telephone or via satellite telehealth.

Transit homes in Kuujjuaq, Puvirnituq and Montreal (Ullivik):

When health services are required and cannot be provided in local CLSCs, individuals must travel to receive the services elsewhere. The liaison teams are responsible for organizing appointments in northern or southern health facilities depending on the health issues. They also organize the preparation of accommodation and travel, making appointments for patients and medically required escorts.

Air Evacuations and First Responders

In the villages of Kuujjuaq and Puvirnituq, patients in need of care can benefit from shuttle services managed by the health centres. These shuttles, called "patient services", transport clients who request them from their homes to the

health centre and vice versa. The patient services also handles the transportation of elective patients between the health centre and the airport, upon arrival or departure of a client. Depending on the nature of the medical need, patients travel from their community to their respective health centre or to Montreal for treatment. For travel from Nunavik villages to one of the regional health centres, each health centre ensures medical air transportation. For transfer to a Montreal hospital, the provincial hospital plane is used.

Table 1 Average time of transfer to nearest health centre and hospital[11]

Current average time of transfer between villages and the nearest Hospital Centre			
Hudson Bay *1		**Ungava Bay *2**	
Salluit	5:30	Tasiujaq	2:30
Ivujivik	5:00	Aupaluk	3:00
Akulivik	2:30	Kangirsuk	3:30
Inukjuak	2:45	Quaqtaq	4:00
Umiujaq	4:45	Kangiqsujuaq	5:00
Kuujjuarapik	6:00	Kangiqsualujjuaq	3:00
* 1: From Puvirnituq, add 8 hours to go to the tertiary centre. (Montreal)		* 2: From Kuujjuaq, add 6 hours to go to the tertiary centre. (Montreal)	

In all villages in Nunavik, excluding Kuujjuaq, teams of municipal first responders are involved in the stabilization and transportation of patients requiring urgent care to the community service point. An ambulance vehicle provided by the NRBHSS is, in the vast majority of villages in Nunavik, the only land vehicle able to transport a patient on a stretcher. For Kuujjuaq, the patient service drivers ensure this function.

[11] Average times provided by Health centres

Inuulitsivik Health Centre (IHC)

Located in Puvirnituq, the Inuulitsivik Health Centre is responsible for the seven villages along the Hudson Bay Coast: Akulivik, Inukjuak, Ivujivik, Kuujjuaraapik, Salluit and Umiujaq.

CLSC and hospital services:

- Short-term care: 17 beds
- Long-term care: 8 beds

Youth protection and rehabilitation services.

Each health centre has a specific file for which they are responsible for the whole region of Nunavik. The IHC manages the Ullivik establishment.

Ullivik

Ullivik, formerly known as the Northern Quebec Module (NQM), has a regional mandate for the Nunavik communities to provide a link between the health establishments in Montreal and Nunavik. Ullivik provides accommodation, transport and the services of nurses and interpreters in order to plan the stay of the Inuit receiving health care in Montreal. A new establishment was built in 2016, in Dorval, to better accommodate Inuit travelling to Montreal for medical reasons. The four-story building has 91 rooms and 143 beds. It is fully occupied on most days. The facility also accommodates Inuit clients' cultural practices. An arts and crafts room provides space for sewing and carving. A country food room with a large freezer and a stove allows residents to eat caribou, seal and fish harvested from their villages. IHC manages the Ullivik facility in Montreal.

Ungava Tulattavik Health Centre (UTHC)

Located in Kuujjuaq, the Ungava Tulattavik Health Centre is responsible for the seven villages along the Ungava Bay Coast: Aupaluk, Tasiujaq, Kangirsuk, Kangiqsualujjuaq, Kangiqsujuaq, Kuujjuaq and Quaqtaq.

CLSC and hospital services:

- Short-term care: 15 beds
- Long-term care: 10 beds

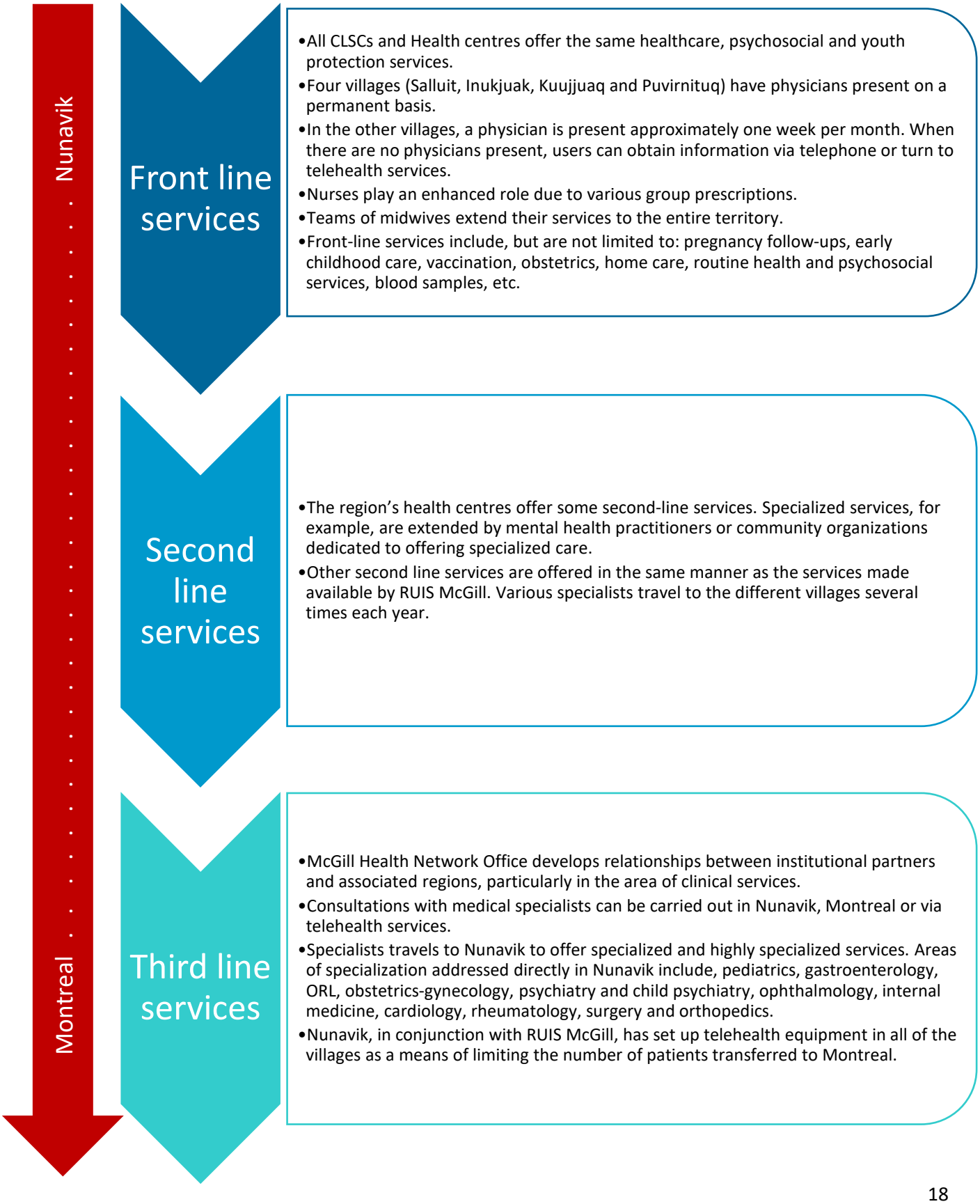
Youth protection and rehabilitation services.

As mentioned previously, each health centre has a specific file for which they are responsible for the whole region of Nunavik. The UTHC manages the coordination and access services for youth rehabilitation centres.

Rehabilitation Centres

The rehabilitation centres offer social rehabilitation and reintegration services to youth with behavioural, psychosocial or family difficulties. For that purpose, the centres receive youth with adjustment difficulties on referral. These services are accessible to all members of the communities, at all times and in their home community wherever possible. Further, those services encourage the population and individuals to assume responsibility for their overall health in all aspects by respecting the individual and collective values (cultural and traditional) of each community. The services ensure and contribute to pre-employment and on-the-job training to enable access the various available positions, whether in the direct provision of services or in support services (administration, maintenance, techniques, etc.).

Figure 5 Access to general and specialized health services



2.1.4 Other Health and Social Services Partners

In order to attain its mission, the NRBHSS works with a variety of partners. Some of these partners are listed in this section.

Community organizations:

Over a dozen community organizations are located across Nunavik. Most of their funding is provided by the MSSS (*Programme de soutien aux organismes communautaires* (PSOC)). These community organizations play an important role in the health and social services network. They are community-based and provide services and support adapted to the needs of the population. Examples of community organizations are presented below[12].

- **Associations and networks:**
    - **Saturviit:** Inuit Women's Association of Nunavik was created in 2006, with the mandate to promote women's interests in Nunavik and advocate for their rights. The mandate of the association is to: Support community projects that benefit women; Develop activities to eliminate violence against women and children and improve their well-being; Provide tools to help women fulfill themselves politically, economically, and socially; Advocate for women and children in Nunavik and Represent Inuit women of Nunavik at national provincial and regional meetings.[13]
    - **Qajaq Men's Network:** The Qajaq Network seeks to help men who are on a personal growth journey or who are experiencing difficulties. It promotes programs and services to enhance personal and collective well-being, fostering the development of healthier and safer communities while advocating equality between men and women. Services are available to all men in need from all communities.
- **Women shelters:** Provide physical and psychological support to women and their children who are victims of domestic violence and abuse (Ajapirvik, Initsiaq, Tungasuvvik).
- **Treatment centres:** Under the leadership of the Northern Village of Kuujjuaq and with the support of Makivik Corporation, Isuarsivik Treatment Centre is a community organization dedicated to offering specialized substance abuse services to local clients.
- **Family houses:** Qarmaapik house in Kangiqsualujjuaq provides resources to families ranging from parenting skills workshops to community kitchens.
- **Elders homes:** Tusaajiapik day centre provides activities for elders and individuals lacking autonomy in Kuujjuaq.
- **Mental health resources:** Supervised apartments for adults under 65 and without dependent children have been available in Inukjuak since 2004 and since 2007 in Puvirnituq and Kuujjuaq. These resources are in line with the MSSS's guidelines, to provide a supervised residential service for people with mental health issues. Within the supervised apartments, assistance is provided to promote social integration and better adherence to treatment. These services are intended for people transitioning to a complete reintegration into their community and those whose conditions require long-term placement.

[12] For a more complete and detailed list, please refer to the NRBHSS website: https://nrbhss.ca/en/departments/planning-and-programming/community-organizations

[13] Saturviit – Inuit Women's association of Nunavik. (2016). *2016 Annual report*. Retrieved from https://www.saturviit.ca/wp-content/uploads/Annual-report-2016-revised-english.pdf

RUIS McGill Health Network Office:

As an integral part of the McGill University Health Network (McGill RUIS), the primary goal of the McGill Network Office is to provide a link between the four affiliated teaching hospitals and, on the other hand, the regional authorities and their health centres. By creating this liaison service, it is possible to direct service requests to the appropriate areas (pediatrics, gastroenterology, O.R.L., obstetrics-gynecology, psychiatry and child psychiatry, ophthalmology, internal medicine, cardiology, rheumatology, surgery, physiatry, etc.) and facilitate the creation of service agreements between the various institutions.

Kativik Regional Government (KRG):

The Kativik Regional Government (KRG) was created in 1978, pursuant to the JBNQA. Many of the KRG's responsibilities are stipulated in the *Act respecting Northern Villages and the Kativik Regional Government* (Kativik Act). Other mandates have been delegated to the KRG by the region's municipalities and the Quebec government. The sectors in which the KRG currently delivers services include:

- Airport management and marine infrastructure maintenance.
- Regional and local economic development, as well as business development.
- Policing and civil security (Kativik Regional Police Force).
- Crime victim assistance.
- Inuit hunting, fishing and trapping support, as well as wildlife conservation.
- Environment and climate change research.
- Park development and management.
- Employment, training and income support.
- Childcare services.
- Municipal infrastructure development and drinking water monitoring.
- Internet access.
- Sports and recreation.

"The KRG also has the task of delivering technical assistance to the 14 Northern villages regarding management and municipal accounting, land use planning and development, legal affairs, engineering and public transit.(…) The KRG operates an administrative office, a station for the Kativik Regional Police Force (KRPF) and an airport in each community. " [14]

The NRBHSS works closely with this organization when it comes to providing services in communities and acting on the determinants of health.

Kativik Regional Police Force (KRPF):

The Kativik Regional Police Force (KRPF) was created in 1996 with the participation of the Solicitor General of Canada and the *Ministère de la Sécurité publique* in accordance with the JBNQA and pursuant to sections 369 and 370 of the *Act respecting Northern Villages and the Kativik Regional Government*.

[14] Kativik Regional Government. (2017). General information. Retrieved from http://www.krg.ca/kativik-regional-government/general-information

The mission of the KRPF and each of its members pursuant to the *Police Act* is to maintain peace, order and public security; to prevent and repress crime and offences under the law and municipal by-laws in the Kativik Region; as well as to apprehend offenders. The KRPF also applies the following guidelines in its relations with the communities:

- Uphold the principles of the Canadian Charter of Rights and Freedoms and Quebec's Charter of Human Rights and Freedoms.
- Provide professional services.
- Ensure courtesy and impartiality in the execution of policing services.
- Work with each community, as well as local and regional organizations, to prevent and resolve problems that affect safety and the quality of life.
- Act within the Canadian judicial system to address community problems.
- Promote a creative and responsible environment in which all KRPF officers are able to deliver community-based services.[15]

The NRBHSS works closely with KRPF when it comes to preventing problems that affect safety and the quality of life of the population (addictions, violence, suicide, etc.).

Kativik Ilisarniliriniq School Board (KI):

The Kativik Ilisarniliriniq school board was created in 1975, under the *James Bay and Northern Quebec Agreement (JBNQA)*. Under the JBNQA, the Kativik Ilisarniliriniq is granted the power and jurisdiction to develop and deliver specific educational services and programs consistent with Inuit culture. The mission of the Kativik Ilisarniliriniq is therefore twofold. On the one hand, it acts as a regular regional school board for all Nunavik residents. On the other hand, it also acts as an exclusive Inuit institution with unique powers and jurisdictions that aim to protect, maintain, and develop the Inuit language, culture, and way of life.

Since 1978, the Kativik Ilisarniliriniq has been the exclusive provider of academic services to the population of Nunavik. The education programs developed by the school board are offered in all schools of the 14 Nunavik communities, in Inuktitut as first language and in French and English as second languages. The school board operates 17 primary and secondary schools as well as five adult education centres.[16]

The NRBHSS works closely with the organization in regards to delivering accredited training for health workers.

Makivik:

Makivik, which in Inuktitut means "To Rise Up," has the mandate to protect the rights, interests and financial compensation provided by the JBNQA, "the first comprehensive Inuit land claim in Canada, and the more recent offshore *Nunavik Inuit Land Claim Agreement* that came into effect in 2008.The Corporation's distinct mandate ranges from owning and operating large profitable business enterprises and generating jobs; to social economic development, improved housing conditions, to protection of the Inuit language and culture and the natural environment.

[15] Kativik Regional Government. (2017). Kativik Regional Police Force. Retrieved from http://www.krg.ca/krg-departments/public-security/kativik-regional-police-force

[16] Kativik Ilisarniliriniq. (2018). School Board – About. Retrieved from https://www.kativik.qc.ca/school-board/about/

- To receive, administer, distribute and invest the compensation money payable to Nunavik Inuit, as provided for in the JBNQA;
- To relieve poverty, to promote the welfare, advancement, and education of the Inuit;
- To foster, promote, protect and assist in preserving the Inuit way of life, values and traditions;
- To exercise the functions vested in it by other Acts or the Agreement; and
- To develop and improve the Inuit communities and to improve their means of actions.[17]

The NRBHSS works closely with this organization when it comes to politics and acting on the determinants of health. Makivik is the only organization mandated to advocate politically, the needs of the Nunavimmiut at the federal level.

Société d'habitation du Québec (SHQ) :

The *Société d'habitation du Québec* (SHQ) is the main provincial government institution responsible for housing. As part of its mission, the SHQ has been active in Nunavik for over 30 years, to ensure adequate housing conditions for residents of the region.[18] The SHQ collaborates closely with the KMHB for the implementation of the Home ownership and renovation program.

The Kativik Municipal Housing Bureau (KMHB):

At the request of the KRG, the Kativik Municipal Housing Bureau (KMHB) was established in 1999 under the provision of the Act respecting the SHQ. Its mandate is to manage and maintain social housing in the Northern Villages of Nunavik. In 2011, the KMHB launched the Pivallianiq initiative. Implemented in all 14 Nunavik communities, this awareness, information and policy program is based on three components with the purpose of maintaining dwellings and equipment, fighting vandalism through youth awareness and embellishing the living environment of Nunavimmiut.[19] The KMHB also has a program promoting home ownership and residential renovations that allows Inuit families to benefit from a Quebec government subsidy covering 75% of the cost of building a new home.

The NRBHSS works closely with this organization regarding the improvement of Nunavik's social housing situation.

Inuit Tapiriit Kanatami (ITK):

Inuit Tapiriit Kanatami (ITK) is the national representational organization for Canada's 60 000 Inuit, the majority of whom live in four regions of Canada's Arctic, specifically, the Inuvialuit Settlement Region (Northwest Territories), Nunavut, Nunavik, and Nunatsiavut (Northern Labrador). It includes 53 communities and encompasses roughly 35 percent of Canada's landmass and 50 percent of its coastline. ITK represents the rights and interests of Inuit at the national level through a democratic governance structure that represents all Inuit people. It advocates for policies, programs and services to address the social, cultural, political and environmental issues facing the people. [20]

The NRBHSS collaborates with ITK when it comes to negotiating funding at the National level. ITK is also available to develop the capacity of the NRBHSS employees by offering workshops on monitoring, evaluation, etc.

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[17] Makivik Corporation. (2018). Mandate. Retrieved from http://www.makivik.org/corporate/makivik-mandate/

[18] Société d'habitation Québec. (2018). Nord-du-Québec. Retrieved from http://www.habitation.gouv.qc.ca/english/industry/nord_du_quebec.html

[19] Kativik Municipal Housing Bureau. (2017). Pivallianiq Program. Retrieved from http://www.omhkativikmhb.qc.ca/pivallianiq/

[20] Inuit Tapiriit Kanatami. (2018). Who we are. Retrieved from https://www.itk.ca/national-voice-for-communities-in-the-canadian-arctic/

2.1.5 Overview of Health and Social Services Offered

The strategic regional plan that is produced for the MSSS offers an overview of available resources across the region. Please refer to annex 9.2 for the tables detailing the resources per community and organization for general services, physical health, mental health, addictions, physical and intellectual impairments, loss of autonomy, youth in difficulty, human resource development and public health. A more summarized portrait of the available services is presented below.

Table 2 Regional Health and Social Services - Basket of Services

SERVICES		Other*	McGill RUIS	IHC	UTHC	NRBHSS
GENERAL SERVICES	Public health promotion and prevention			√	√	√**
	Reception, information, support and personalized references			√	√	
	Nursing			√	√	
	Support for diagnoses			√	√	
	Nutrition			√	√	√**
	Physiotherapy			√	√	
	Perinatal care, early childhood, youth in schools,			√	√	
	Psychosocial and psychological interventions			√	√	
	Emergency and disaster interventions			√	√	√
	Complete prenatal follow-up by midwife			√	√	
	Medical consultations			√	√	
	Community interventions			√	√	√
	Ullivik			√		
PHYSICAL IMPAIREMENT	Public health promotion and prevention			√	√	√**
	Prevention – Planning and programming					√
	First line general services			√	√	
	First line specific services			√	√	
	First line specific services in communities			√	√	
	Second line services (ambulatory)	√	√	√	√	
	Second line services (specialized)	√	√	√	√	
	Third line services (Highly specialized)	√	√			
INTELLECTUAL DISABILITY	Public health promotion and prevention			√	√	√**
	Prevention – Planning and programming					√
	First line general services			√	√	
	First line specific services			√	√	
	First line specific services in communities	√				
	Second line services (ambulatory)		√	√	√	
	Second line services (specialized)	√	√	√	√	
	Third line services (Highly specialized)	√	√			

SERVICES		Other*	McGill RUIS	IHC	UTHC	NRBHSS
YOUTH IN DIFFICULTY	Public health promotion and prevention			√	√	√**
	First line general services			√	√	
	First line specific services 0-18 years old			√	√	
	First line specific services in communities 0-18 years old			√	√	
	Second line services (specialized)			√	√	
	Third line services (Highly specialized)	√	√	√	√	√
LOSS OF AUTONOMY	Public health promotion and prevention			√	√	√**
	Prevention – Planning and programming					√
	First line general services			√	√	
	First line specific services	√	√	√	√	
	First line specific services in communities			√	√	
	Second line services (non ambulatory)	√	√	√	√	
	Second line services (ambulatory)		√	√	√	
	Third line services (Highly specialized)	√	√	√	√	√
ADDICTIONS	Public health promotion and prevention	√		√	√	√**
	Prevention – Planning and programming					√
	First line general services			√	√	
	First line specific services	√	√	√	√	
	First line specific services in communities			√	√	
	Second line specific services	√	√			
	Third line services (Highly specialized)	√	√			
MENTAL HEALTH	Public health promotion and prevention			√	√	√**
	Prevention – Planning and programming					√
	First line general services			√	√	
	First line specific services			√	√	
	First line specific services in communities	√				
	Second line services (ambulatory)		√	√	√	
	Second line services (specialized)	√	√	√	√	
	Third line services (Highly specialized)	√	√			
PHYSICAL HEALTH	Chronic diseases	√	√	√	√	
	Emergency and acute specialized and highly specialized care		√	√	√	
	Oncology CLSC program		√	√	√	√
	Medical staff		√	√	√	√
	Referral processes	√	√	√	√	
	Specialties, oral surgery and oncology		√	√	√	
	Regional coordination					√
	Clinical tools	√	√	√	√	√
	Service agreements	√	√	√	√	√

* "Others" refer to community organizations and independent organizations.

** The asterisks following the brackets for the column identified "NRBHSS" usually refer to prevention and public health promotion and are integrated into all existing programs.

2.1.6 Policies and procedures

The health and social services network has a variety of policies and procedures in place, many of which are dictated by the provincial laws or ministerial policies[21]. Most policies and procedures are developed by the two health centres, who then deploy them in their respective CLSCs. That being said, some policies are entirely established by the MSSS, such as most of the human resources related ones (hiring process, salaries, benefits, etc.).

Local and regional policies are developed by the Health centres and the NRBHSS. The Board of Directors of the Health centres or the NRBHSS then adopt said policies. A variety of administrative and clinical policies and procedures are in place in the region, below are examples of policies and procedures in place, and developed in the region.

Administrative policies and procedures	Clinical policies and procedures
Internal governance policies	Management and retention of medical files
Regional management policies	Refusal of treatment
By-laws that govern the BODs actions	Management of biomedical waste
Organizational chart and job descriptions	Loan of medical equipment
Personnel training	Missed appointment
Performance evaluations	Death in the home
Client information confidentiality	Management of drugs and medical equipment
Occupational health and safety	Regional user transportation policy
Management of incident and accident reports	
Complaint management	
Ethics code	

The NRBHSS has a variety of emergency plans in place, including pandemic plans for tuberculosis and influenza, and a regional civil security plan. The plans are developed in collaboration with the Health centres who themselves have specific emergency plans based on their needs and reality. There are annual tabletop exercises in each community for mass arrival of casualties (orange code) and every three years, communities organize a practical exercise.

Policies, procedures and emergency plans can be provided upon request.

[21] Ministère de la santé et des services sociaux. (2018). Publications du ministère de la Santé et des Services sociaux. Retrieved from http://publications.msss.gouv.qc.ca/msss/types/politique

3. POPULATION PROFILE AND RESOURCES

3.1 Characteristics of Nunavik's Territory

"Prior to 1975, life for Nunavik Inuit consisted essentially of hunting, fishing and trapping pursuits. Communities lacked all but the most rudimentary services. Drinking water supply consisted of untreated water hauled from a river or lake to each home and stored in large containers. Human waste in garbage bags was placed outside each home for removal to local garbage dumps. Housing consisted of wood-framed, plywood structures that lacked adequate insulation; they were small and crowded, without any form of air ventilation or humidity control. Oil lamps were used for lighting, and oil-burning stoves provided heating in winter. Schools were often housed in buildings converted from some other function. Health services consisted of nursing stations in only the larger communities. Supplies came to the communities by annual sealift. Marine and air transportation infrastructure did not exist. After the signing of the James Bay and Northern Quebec Agreement (JBNQA), Nunavik Inuit had to very quickly adapt.

While harvesting methods and patterns have changed, the importance of wildlife for food security and for Inuit culture, language and identity have not. Country food, such as caribou, Arctic char, ptarmigan, seal, walrus and beluga, among many other species, continues to be vital to the health and way of life of Nunavik Inuit."[22]

The Nunavik region covers the territory located north of the 55th parallel, a surface area of 550 164 km^2, which corresponds to one third of the province of Quebec. It is the northernmost region of Quebec and the most remote.

The ecosystems are unique and fragile. More specifically, they are sensitive to climate change and disturbances caused by human and industrial activities. The effects of climate change are already visible in Nunavik. New species of plants and animals have been observed on the territory. Some zoonosis still unknown to the inhabitants of Nunavik are beginning to emerge and pose new health problems.

Climate change is also affecting the quality and thickness of the ice. These changes increase the risk of accidents during winter activities and sometimes make food resources less accessible. The melting of permafrost also needs to be closely monitored as it can pose significant technical challenges for existing and future installations.

Access:

There are no road or rail links between villages or with the other regions bordering Nunavik. Thus, all travel is by air, as is the transport of most consumer goods. Seasonal (four months of the year) maritime shipping to and from the South is established. These two modes entail additional costs (storage, financing, handling, fuel, etc.). Such factors contribute, on the one hand, to a higher cost of living, and on the other, to a greatly limited variety and quantity of merchandise available.

Maritime transport is vital for the region. Necessities such as food, fuel and building materials are transported to ships' bridges and holds during the summer and fall to replenish northern villages. Only two sea freight companies serve the region. All villages have marine infrastructure for the shipment of goods. Sea transport is only beginning

[22] Makivik Corporation, Kativik Regional Government, Kativik School Board, Nunavik Landholding Association, NRBHSSS, Youth Association of Nunavik. (2014, November 14). *Parnasimautik Consultation report*. Retrieived from https://www.cerp.gouv.qc.ca/fileadmin/Fichiers_clients/Documents_deposes_a_la_Commission/P-202.pdf, p. 7

to be explored for its economic and community development potential and employment opportunities. The region occupies a strategic location in relation to the opening of the Northwest Passage, which could be conducive to partnerships with neighbouring Aboriginal groups, governments and industrial stakeholders. As with mineral exploitation and land transport development, questions are being asked about the impacts of increased sea transport activities on wildlife, subsistence harvesting and the Nunavik Inuit way of life.

Between 1984 and 1991, airports were built in every community except Kuujjuarapik and Kuujjuaq, where facilities were already in place. Then and still today, along with the homes, schools and health centres constructed during the same period, airports have had the most meaningful impact on living conditions in the region. To this end, the *Ministère des Transports du Québec* and the KRG approved in 2012, a renewed plan for airport infrastructure improvement.

Communications:

Telecommunications and broadcasting are essential to communities. Telecommunications refer to the Internet, landline and cellular telephony, while broadcasting refers to radio and television. Due to the high levels of investment required in infrastructure and programming capacity, the technologies currently in place in the region are poor compared to the country's urban regions. Taqramiut Nipingat Inc. has the mandate to develop broadcasting services in Nunavik.

Landline telephony infrastructure in the communities has reached the end of its useful service life: it does not support digital services or 911-emergency services, and only a limited number of long-distance lines are available in the smaller communities. Cellular telephony service, for its part, was available in Nunavik from 2010 to 2015 through Nunacell, a subsidiary of the Makivik Corporation. Since 2015, there has been no cellular telephony service available in Nunavik.

Broadband Internet service delivered via satellite has been available in every community since 2004 through Tamaani Internet, a KRG initiative. Tamaani maintains over 500 corporate and organizational points of service for customers that include the Kativik Regional Police Force, the Kativik Ilisarniliriniq (School Board), the Nunavik Regional Board of Health Social Services, the *Sureté du Québec*, and the *Ministère de la Justice*. It also services more than 2,300 residential modems.

Municipal government:

Section 12 of the JBNQA stipulates that each village on the Inuit Territory shall have a local government. The services provided by the municipal offices are health and hygiene, town planning and land development, public services, traffic and transportation, recreation and culture. For an example, they provide daily sewage disposal/lagoons, run the fire departments, organize recreational/cultural activities, maintain the roads, ensure garbage removal/disposal, lighting, heating/power and snow removal. The Nunavik Village municipalities (NV) are a public government, meaning any Canadian citizen, ordinarily a resident of the village for at least thirty-six months, who has no municipal debts, no contracts with nor is working for NV, no convictions of any crime under Canadian law is eligible to run. There is one mayor and two to six councillors depending on the population of the village. One of the members of the council is appointed as representative to the KRG. Elections for municipal councils are much like municipal elections in the rest of Canada. Anyone aged 18 or over, who holds Canadian citizenship, and has resided on the territory for at least 12 months is eligible to vote.

3.2 Cultural Identity

Inuit identity has been severely challenged in the last century. Conversion to Christianity in the beginning of the 20th century, transition from a nomadic lifestyle to sedentary community life in the 1950s and the adaptation to modern technology have affected the way Inuit live. Gradually, traditional ways of life that require specific skills and knowledge has been eroding. Inuit youth now see themselves as belonging to a global culture as they partake in the Internet, listen to popular television shows, follow clothing trends, literature, etc. Elders, on the other hand, often feel unable to connect with the younger generations, and pass on traditional knowledge, skills and values.

The present altered state of Inuit identity, culture and language cannot be isolated from the radical changes in lifestyle and environment, which have influenced the Inuit way of life in the past sixty-plus years. The first systematic encounter with Qallunaaq "civilization" was with fur traders in the course of the 1800s, followed by Christian missionaries.

These two influences first altered the traditional patterns of Inuit life, but their direct impacts were minimal in comparison to what would follow in the 1950's and 1960's. The necessity for access to medical services during the prevalence of tuberculosis coincided with the government establishing schools in scattered settlements, which eventually grew into today's villages. English-only formal education was one of the first systematic collisions Inuit children experienced, with other elements that would erode their cultural identity.

The federal government ran the first formal education system in the Arctic. After completing lower grades in communities, Inuit students were sent to residential schools located far from their home environment. These experiences further separated young Inuit from their families and homes. Whatever was gained in knowledge and new skills designed to incorporate educated Inuit into the work force came at the cost of them losing touch with their origins. The generations of "schooled" Inuit lost much of their language, their Inuit culture, and as a result, their identity.

> *«The historical trauma disrupts adaptive social and cultural patterns and transforms them into maladaptive ones that manifest themselves in symptoms. In short, historical trauma causes deep breakdown in social functioning that may last for years, decades or even generations. »* [23]

Approximately 80,000 people alive today went to residential schools operated by the Government of Canada, and among those, are 350 are Nunavimmiut.

The NRBHSS recognizes the importance of culture and identity as a health determinant. That is why the department of Inuit Values and Practices (IVP) was created within the organization. The IVP department manages a variety of health programs, but also ensures Inuit values and practices are an integral part of the Health and social services network and the services provided to the population.

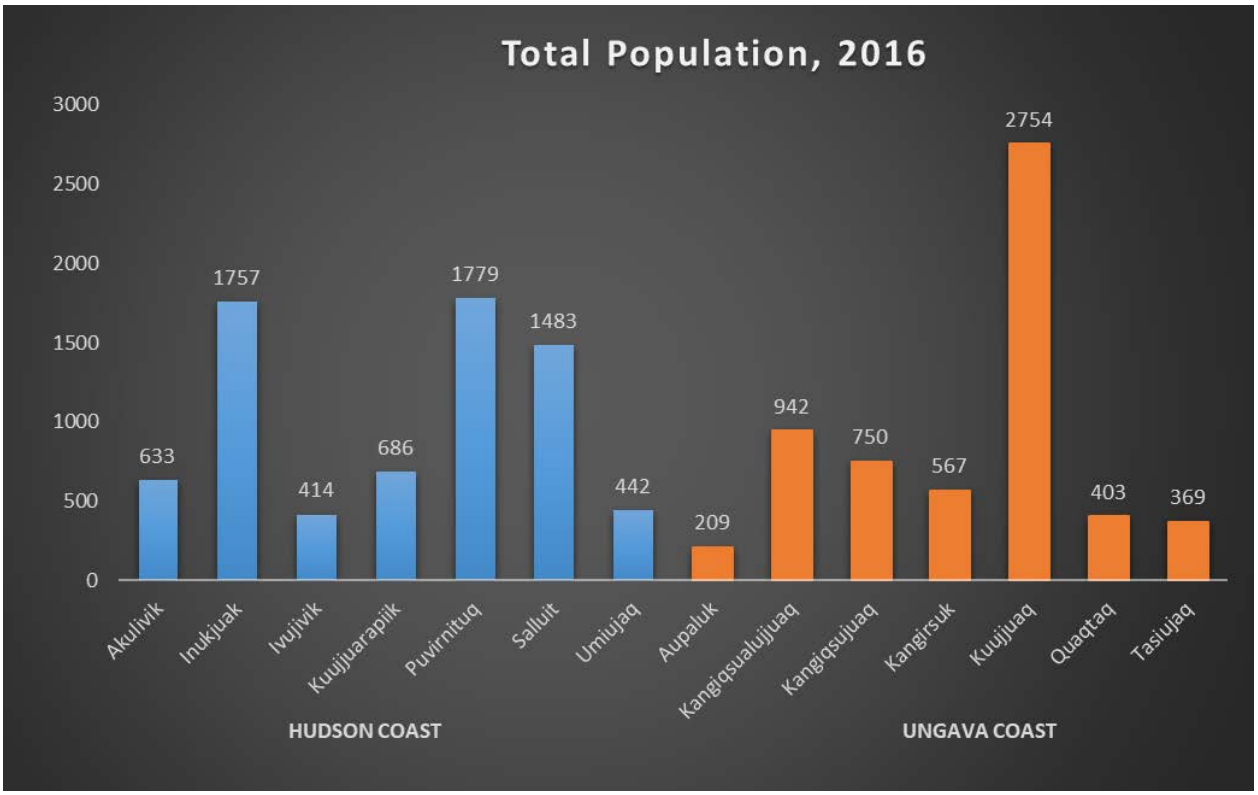
[23] Masecar, D., *What is working, What is hopeful*, funded by First Nations Inuit Health Branch, Health Canada, 2006. Retrieved from http://www.douglas.qc.ca/uploads/File/what-is-working-report.pdf, p. 25

3.3 Demographic Profile

According to the census data of 2016[24], Nunavik's population is now up to 13 188 out of which 11 795 are Inuit. This is an average increase of nine percent since the census in 2011, which is more than double the average population growth of the rest of the province. Among the four regions of Inuit Nunangat, Nunavik had the fastest growing population (23,3%) over the 2006-2016 period.[25] The most populous villages are Kuujjuaq, Puvirnituq, Salluit and Inukjuak. Such a high growth rate will have as consequences, among others, of increased pressure on infrastructure and health services.

Specific populations per community are available via the 2016 Statistics Canada census, but do not distinguish between Inuit and non-Inuit.

Figure 6 Population by village, 2016 [26]



More than half of all Nunavimmiut (54,5%) live on the Hudson Coast, while 44,5% live on the Ungava Coast. Nunavik has a young population: one out of every three inhabitants (34%) is under age 15. The average age is 26[27], a little

[24] Statistics Canada. (2017, October 25). Aboriginal peoples in Canada: Key results from the 2016 Census. Retrieved from http://www.statcan.gc.ca/daily-quotidien/171025/dq171025a-eng.htm

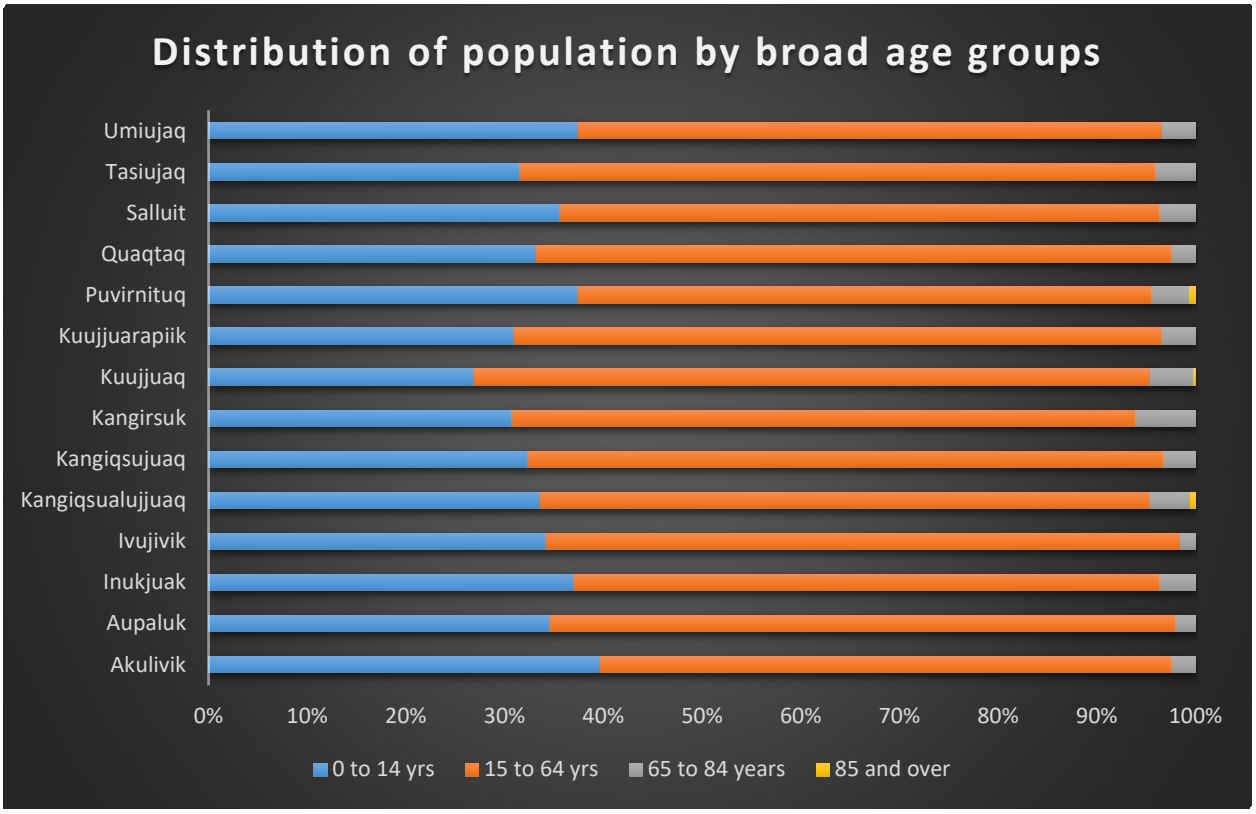
[25] Idem

[26] Statistics Canada. (2018, May 30). Census Profile, 2016 Census. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

[27] Idem

less than half that of the province as a whole (41,9)[28]. "The average number of children per woman in Nunavik is one of the highest in Quebec: it reaches 3.2 children per woman in Nunavik and 1.6 in Quebec for the period 2004-2008."[29]

Figure 7 Distribution of population by broad age groups, 2016 [30]

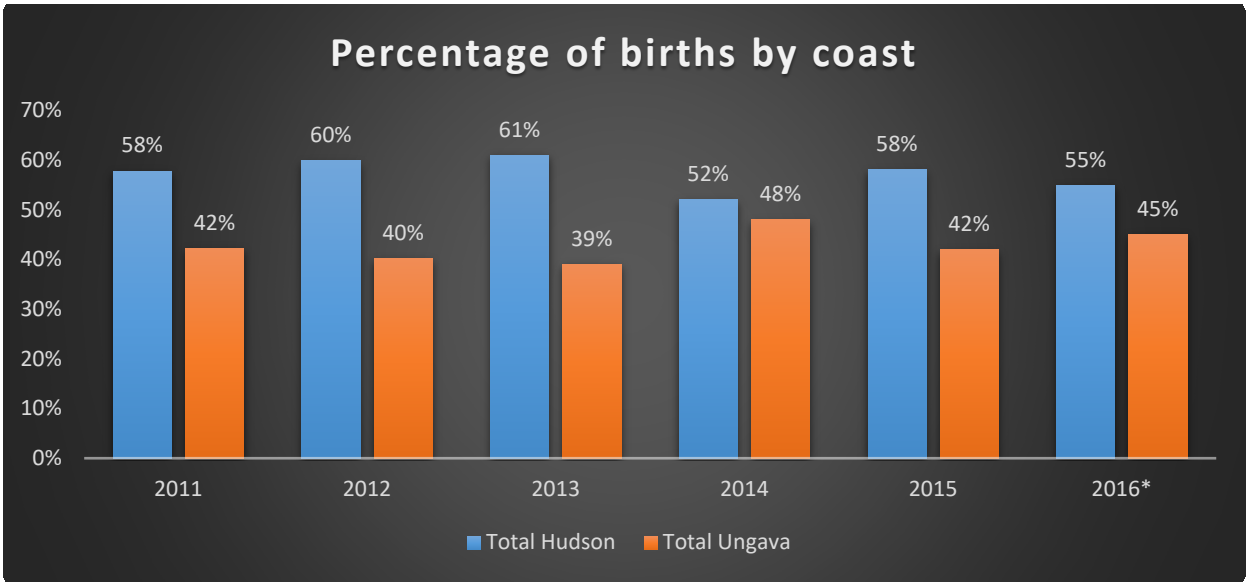


[28] Statistics Canada. (2018, May 30). Age and sex Highlight Tables, 2016 Census. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/as/Table.cfm?Lang=E&T=31

[29] NRBHSS with the collaboration of INSPQ (2011). *Health Profile of Nunavik 2011: Demographic and Socioeconomic Conditions, Government of Québec*, 32 pages and appendices. Retrieved from https://www.inspq.qc.ca/pdf/publications/1589_PortraitSanteNunavik2011_ConditionsDemoSocioecono_VA.pdf, p. 6

[30] Statistics Canada. (2018, May 30). Census Profile, 2016 Census. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/prof/index.cfm?Lang=E

Figure 8 Number of births per coast, 2011-2016*[31]



*Provisional data

According to the 2011 census, Inuktitut is the mother tongue of 98% of Nunavik Inuit[32]. Although the language spoken by most in Nunavik is Inuktitut, English is the language most often used in the workplace, due to the former preponderance of the federal government in the region's administration.

Children and families are a priority population for the NRBHSS. The organization believes that investing in promotion and prevention for children and their families will contribute to building stronger and healthier communities. Various health and social programs as well as partnerships are in place and being developed in order to support this population.

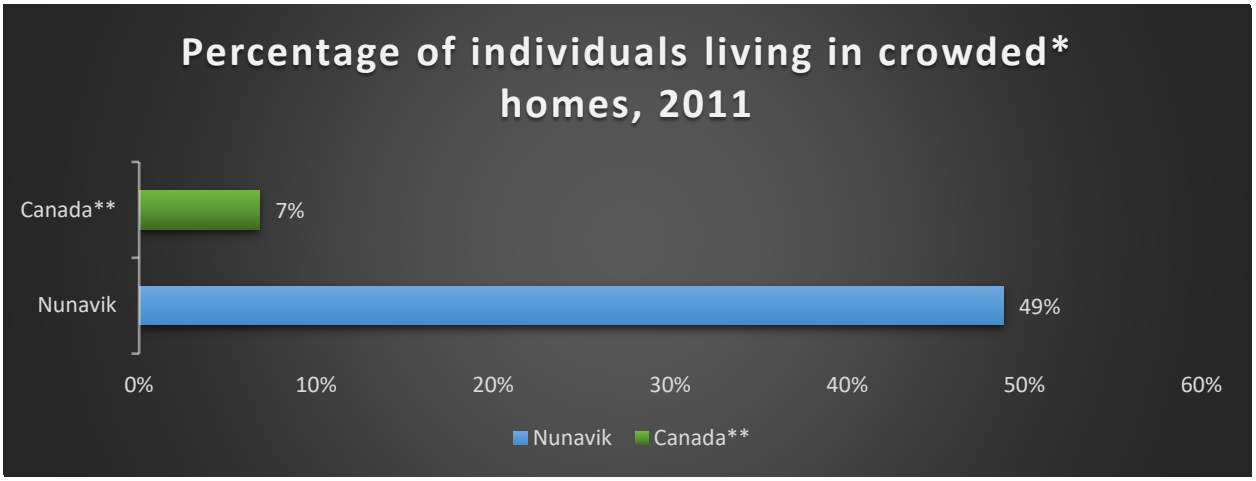
[31] MSSS. Fichier des naissances vivantes, 2011-2015 fermé, 2016 provisoires. Compilation Direction de la Santé Publique du Nunavik, 6 septembre 2018.

[32] Statistics Canada. (2016, March 29). Inuit: Fact Sheet for Nunavik. Retrieved from https://www150.statcan.gc.ca/n1/pub/89-656-x/89-656-x2016016-eng.htm

3.4 Housing

Housing is an important issue that greatly influences the health and well-being of a population. According to the 2011 National Household Survey and the 2012 Aboriginal Peoples Survey from Statistics Canada, 49% of Inuit in Nunavik lived in crowded homes and 39% lived in homes in need of major repairs.[33] Moreover, this same Survey found that 23% of the households in Nunavik counted 6 or more people, as compared to 2% of households in the rest of Quebec. Adequate, safe and sufficient housing continues to be a priority.

Figure 9 Crowded homes*, 2011 [34]



*More than one person per room

** The Canada population excludes those who reported being an Aboriginal person, that is, First Nations, Métis or Inuk and/or those who reported Registered or Treaty Indian status.

There appears to be a link between the health condition of Nunavimmiut and overcrowding. Cases of active tuberculosis have grown steadily from 2012 to 2015 reaching 360 cases per 100,000 as compared to 3 cases per 100,000 for the whole province.[35] "During the 1997 evaluation of the Hearing and Otitis program in one of the Nunavik communities, the data revealed that the risk of chronic otitis among children increases when several children share the same bedroom."[36]

Overcrowding creates conditions conducive to the emergence of social problems and makes it more difficult to eradicate them. Some families who do not themselves have particular issues live with others who do, meaning that their children are exposed to other people's problems on a daily basis. Lack of privacy exacerbates tension. Homes

[33] Idem

[34] Idem

[35] Ministère de la santé et des services sociaux. (2017). *Épidémiologie de la tuberculose au Québec – Rapport 2012-2015*. Retrieved from http://publications.msss.gouv.qc.ca/msss/fichiers/2017/17-266-01W.pdf, p.11 and 13

[36] Déry, S. and Zoungrana, H. (2009, December). *The housing situation in Nunavik: A public health priority*. Retrieved from http://www.krg.ca/images/stories/docs/Parnasimautik/Annexes/ENG/Annex%204%20The%20housing%20situation%20in%20Nunavik%20a%20public%20health%20priority%20eng.pdf, p. 12

are noisy and people who are less tolerant may lose their temper. Children, from a very young age, will often witness sexual acts or conflicts between adults. [37]

Pressure on the housing supply in Nunavik is primarily caused by a new family formation in a young and growing population. As a result of the housing shortage in Nunavik, a significant number of Inuit have left the region in search of a better life in the southern regions of Quebec, mostly in and around the Montreal area. While some have been able to find gainful employment in the south, many cannot and eventually find themselves part of a growing number of homeless Inuit in the south. "Inuit represent 10 percent of the aboriginal population in Montreal, but they count for 45 percent of homeless aboriginal people in the city." [38]

Although the KMHB is the main organization responsible for housing in the region, the NRBHSS considers housing as an important health determinant. In the future, the NRBHSS wishes to strengthen its collaboration with the KMHB in order to ensure to limit the impact the housing context may have on the population's health.

[37] Inuit Tapiriit Kanatami. (2007, April 22). *Social Determinants of Inuit Health in Canada: A discussion paper*. Retrieved from http://www.inuitknowledge.ca/sites/naasautit/files/attachments/ITK_Social_Determinants_paper_2007.pdf, p. 12

[38] Makivik Corporation. (2012, November). *Mémoire sur l'itinérance Inuit à Montréal*. Retrieved from http://homelesshub.ca/sites/default/files/INUIT%20HOMELESSNESS%20-%20FRAPRU%20MEMOIRE%20FRANCAIS%20PRESENTE%20LE%207%20NOVEMBRE%202012%20A%20MONTREAL.pdf

3.5 Education

The school system in Nunavik, as we know it today was conceived following the signing of the JBNQA in 1975. The Kativik Ilisarnilriniq (KI) school board of Nunavik oversees the schools in the region. The teaching programs are based on those existing in Quebec and Canada, but adapted to the specific needs of Inuit. The education offered in the region covers kindergarten to high school (all five years) and is available in all communities. School programs are tailored to local needs and emphasize traditional culture and language. The first three years of elementary schooling are in Inuktitut, followed by education in English or French. Culture is integrated throughout the student's education pathway. Whereas school attendance rates have significantly increased over the last decade, graduation rates are still low. Dropout rates are high in the region. In 2014-2015, the high school graduation rates after seven years were of 18%, compared to 78,8% for the province (cohort of 2008).[39]

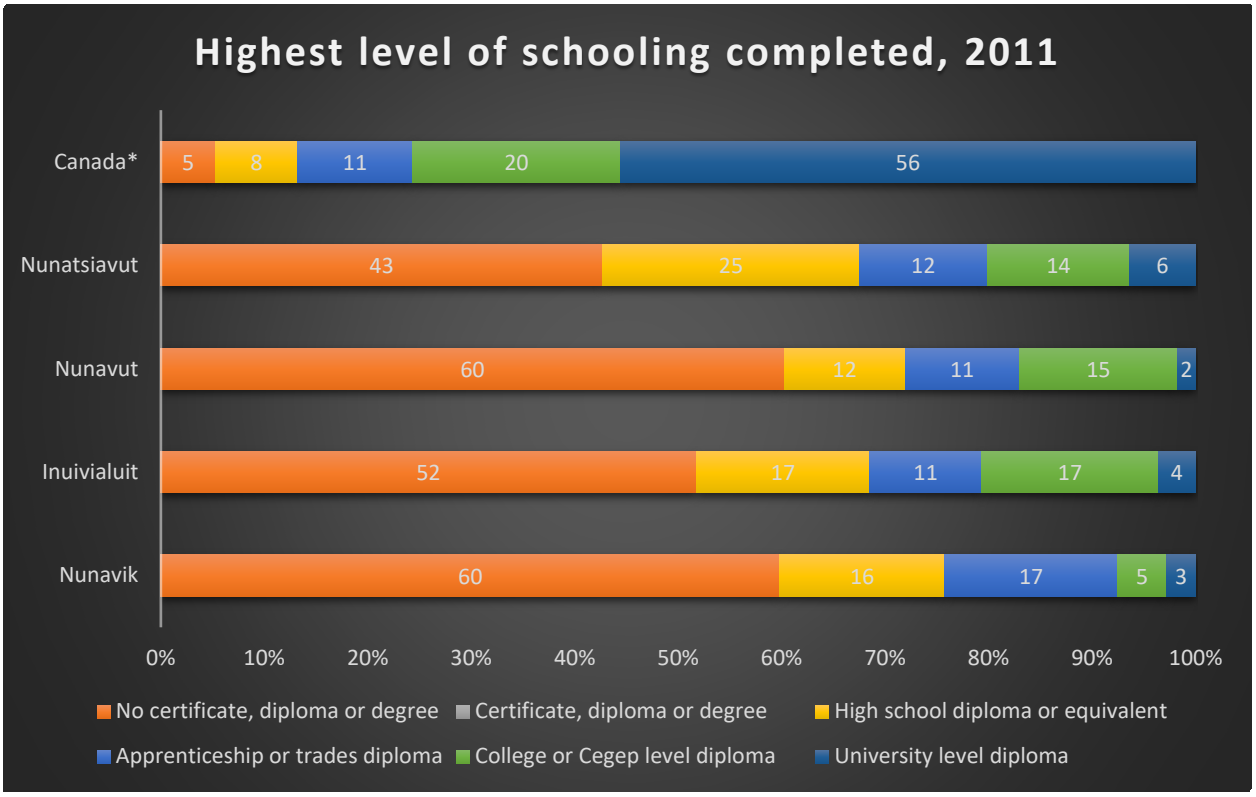
The KI school board also offers adult education, distance education and vocational and technical training in a few communities. With respect to college and university studies, Nunavimmiut youth must continue their studies outside the region. This uprooting and cultural change can be difficult for many young people in the pursuit of their studies. The 2011 National Household Survey and the 2012 Aboriginal Peoples Survey from Statistics Canada surveys indicated that a little over "24% of Inuit aged 25 to 64 in Nunavik had a certificate, diploma or degree from a trade school, college or university. The comparable percentage for their non-Aboriginal counterparts was 87%. (…) There was also a difference in the proportion of Inuit and non-Aboriginal people with "no certificate, diploma or degree". In 2011, 60% of Inuit aged 25 to 64 did not have a certificate or degree. The corresponding percentage for the non-Aboriginal population was 5%. "[40] Education has a direct impact on the type of employment and individual's revenue. In 2011, 55,2% of Nunavik Inuit with no certificate, diploma or degree were employed. [41]

[39] Ministère de l'Éducation. (2018, Février 15), *Diplomation et qualification par commission scolaire au secondaire 2017*. Retrieved from http://www.education.gouv.qc.ca/fileadmin/site_web/documents/PSG/statistiques_info_decisionnelle/taux_diplomation_secondaire_CS_Edition2017_CD.PDF, p. 12 and 14,

[40] Idem

[41] Idem

Figure 10 Highest level of schooling Nunavik and Canada [42]



*The Canada population excludes those who reported being an Aboriginal person, that is, First Nations, Métis or Inuk and/or those who reported Registered or Treaty Indian status.

In order to take part in the regional efforts being made surrounding education in Nunavik, the NRBHSS has a department dedicated to the development of human resources. As part of its mandate, this department works in collaboration with Colleges and Universities to develop accredited training for Inuit on topics pertaining to health and social services.

[42] Statistics Canada. (2016, March 29). Inuit: Fact Sheet for Nunavik. Retrieved from https://www150.statcan.gc.ca/n1/pub/89-656-x/89-656-x2016016-eng.htm

3.6 Revenue and Employment

Another information provided by the National Household Survey for the Aboriginal population of 2011 is the average income after-tax of Nunavik's population aged 15 years and over, which was of $25,502[43], compared to $30,268[44] for the province. This might not seem like an important gap, but considering the high cost of living in the North, any discrepancies have an important impact on households.

Still according to the 2011 National Household Survey and the Aboriginal Peoples Survey of 2012, the employment rate for Inuit aged 25-64 living in Nunavik who did not have a certificate, a diploma or a degree was 55.2%. Employment rates were higher among those who had studied. For example, the employment rate for Inuit with a post-secondary qualification was 79.3%. The median total income was also higher for Inuit with a higher level of education. The median total income (rounded to the nearest $ 1,000) in Inuit aged 25 to 64 ranged from $ 24,000 for those who did not have a certificate, a diploma or a degree to $ 43,000 for someone with post-secondary qualifications.

The overall unemployment rate in Nunavik in 2011 was approximately 14%, significantly higher than Quebec as a whole, at 8.1% in 2011. In addition, nine (or 65%) of the 14 Nunavik communities' unemployment rate is higher than the overall Nunavik unemployment rate, and some communities are significantly higher with unemployment rates between 16% and 21%. The non-working population rate was at 41% in 2011. This means that more than 40% of Nunavimmiut are either unemployed (or looking for employment), or have left the labour force because they cannot find employment or because they collect social assistance, or they are unable to work.

According to The Nunavik Inuit Health Survey of 2004[45], Inuit also have limited opportunities for higher-paying and steady jobs. Survey results reveal that 70% of participants aged 15 and over were employed at the time of the study. Among people who worked only 67% had a full-time job, indicating a large proportion of people with a precarious job status.

The latest data available, from the Kativik Regional Government's 2011 survey "Jobs in Nunavik"[46], shows that there were 4,179 regular full-time jobs in the region in 2011. This includes jobs in all Nunavik communities (3,171) and jobs outside communities – mainly those in the mining sector (1,008). Inuit beneficiaries held 2,124 jobs (51%) ; non-beneficiaries held 2,055 (49%).

The Nunavik labour market has continued to grow in the last 20 years since the Kativik Regional Government began conducting job surveys. For example, the number of full-time jobs increased almost 3 times (267%) from 1993 to 2011. The number of jobs held by beneficiaries grew by 1,145 (or 116%) between 1993 and 2011. The number of

[43] Statistics Canada. (2013). Nunavik, Inuit Region, Quebec (Code 640002) (table). National Household Survey (NHS) Aboriginal Population Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-011-X2011007. Ottawa. Released November 13, 2013. Retrieved from http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/aprof/index.cfm?Lang=E

[44] Statistics Canada. 2013. Quebec (Code 24) (Table). National Household Survey (NHS) Profile. 2011 National Household Survey. Statistics Canada Catalogue no. 99-004-XWE. Ottawa. Released September 11, 2013. Retrieved from http://www12.statcan.gc.ca/nhs-enm/2011/dp-pd/prof/index.cfm?Lang=E

[45] Plaziac, C., St-Laurent, D. and Rochette, L. (2007*). Qanuippitaa? How are we? Socio-Demographic Portrait*. Retrieved from https://www.inspq.qc.ca/pdf/publications/658_esi_sociodemo.pdf, p. 5

[46] Kativik Regional Government. (2011). *Jobs in Nunavik – Results of a survey of Nunavik employers in 2011*. Retrieved from http://www.krg.ca/images/stories/docs/Employment_and_Training/English/Les%20Emplois%20au%20Nunavik%202011%20eng%2003_22.pdf, p. 11

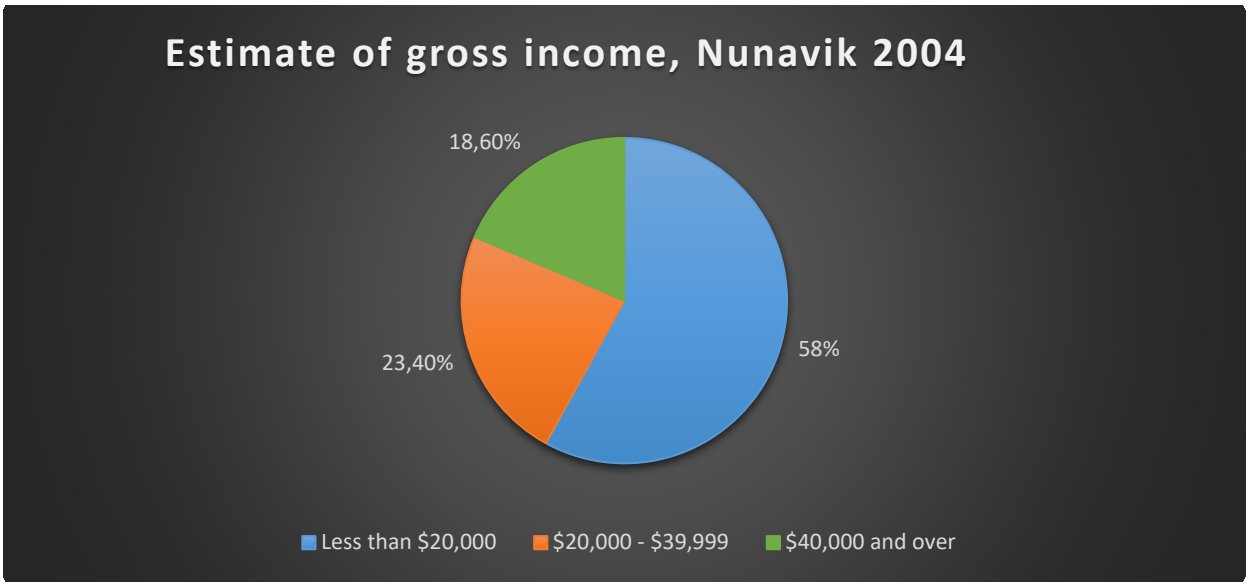
jobs held by non-beneficiaries increased by 1,470 (or 250%) in the same period, more than double the growth of jobs held by beneficiaries.

There were 3,713 part-time jobs in Nunavik in 2011, including regular part-time jobs (less than 30 hours per week on a regular basis), seasonal part-time and casual part-time jobs. This number is significant because part-time jobs represent approximately 47% or almost half of all the jobs in Nunavik. Beneficiaries held approximately 71% of all these part-time jobs, non-beneficiaries held 29%.

The job portrait for men and women in Nunavik changes markedly if we consider jobs in, and outside of the communities. For example, in Nunavik as a whole, men hold 60% of full-time jobs and women 40%. In the communities, men hold 50% of full-time jobs while women hold 50% of full-time jobs. In the mining sector, men hold 90% of full-time jobs and women hold 10%. There is, unfortunately, no data available in Nunavik on how many Nunavimmiut participate in the traditional non-wage economy of *maqaittiit.* This type of economy includes hunting, fishing and trapping.

According to a recent report[47], there are approximately 800 Nunavik Inuit living permanently in Montreal. They make up about 10% of the city's Aboriginal population. About 45% of Montreal's Nunavik Inuit work for regional organizations or companies with offices and activities in the urban region and live in residential areas. The remaining 55% of urban Nunavik Inuit are low-income individuals or the homeless who live in or close to the downtown core.

Figure 11 Estimates of total gross personal income (15 years old and over), Nunavik, 2004[48]



[47] Makivik Corporation, Kativik Regional Government, Kativik School Board, Nunavik Landholding Association, NRBHSSS, Youth Association of Nunavik. (2014, November 14). *Parnasimautik Consultation report*. Retrieved from https://www.cerp.gouv.qc.ca/fileadmin/Fichiers_clients/Documents_deposes_a_la_Commission/P-202.pdf, p. 120

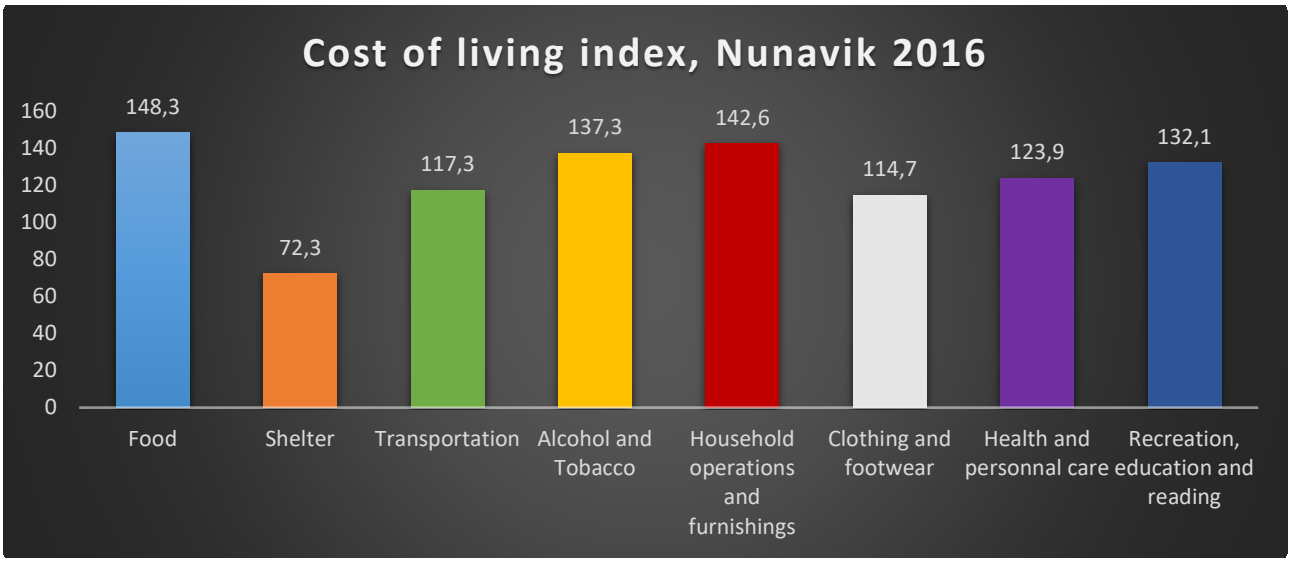
[48] Institut National de Santé Publique du Québec. (2018). *Nunavik Inuit Health Survey 2004*. Retrieved from https://www.inspq.qc.ca/en/expertise/aboriginal-health/nunavik-inuit-health-survey-2004

3.7 Cost of Living

Research[49] was done to determine the extent of poverty of Inuit throughout the Canadian Arctic. Based on data from the 2006 Census as well as on the cost of the Northern Food Basket as determined by Aboriginal Affairs and Northern Development Canada (Now Indigenous Services Canada), researchers found that over 37% of Nunavik Inuit lived below the poverty line. This rate is roughly three times higher than that observed in Canada and Quebec.[50]

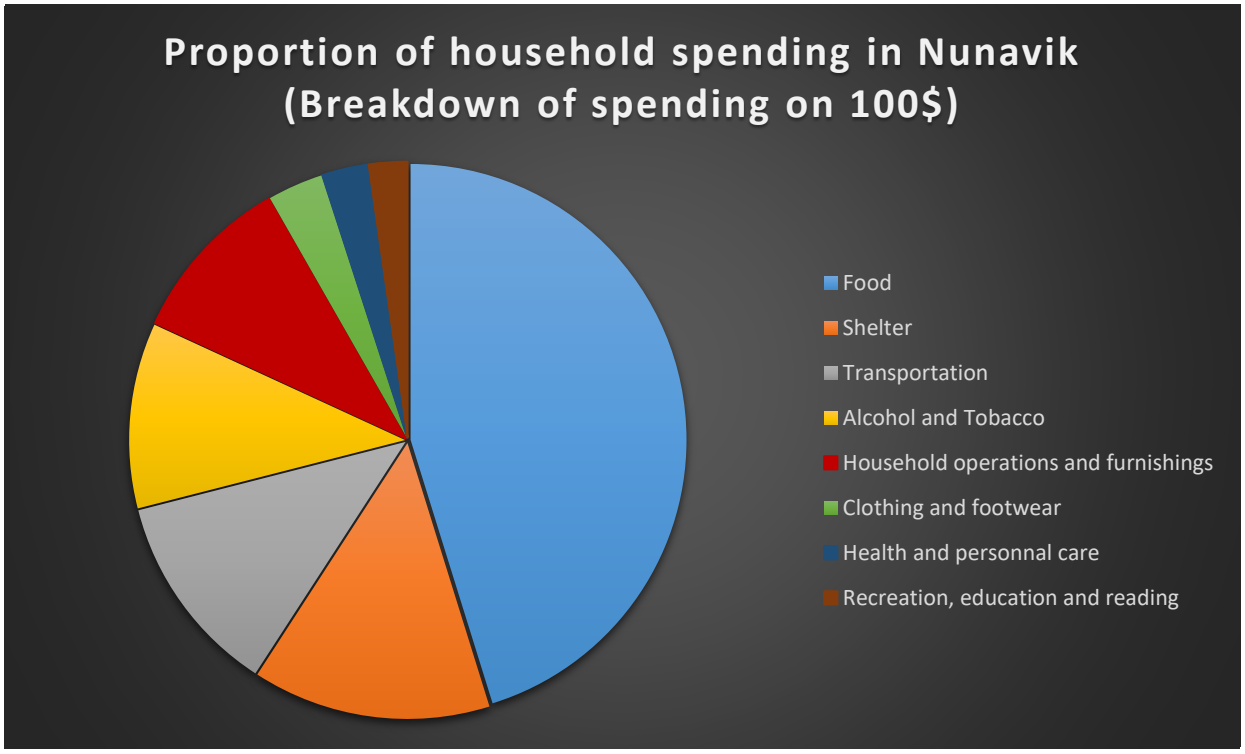
A monitoring of consumer prices in Nunavik, compared with Quebec City prices was done between 2011 and 2013.[51] This comparison found the price of food to be 52% higher in Nunavik, similarly household products were 107% higher, and personal care products were found to be 66% higher. For many families in Nunavik providing for necessities is a daily struggle. Food insecurity is a constant factor in the lives of many Nunavimmiut. When compared to Quebec City, it costs 28, 7% more to live in Nunavik.[52]

Figure 12 Cost of living index in Nunavik by spending component, Nunavik 2015-2016[53]



[49] Duhaime, G and Édouard, R. (2015) Monetary Poverty in Inuit Nunangat, *Arctic Institute of North America*, 68(2), 223-232. Doi: 10.14430/arctic4481. Retrieved from http://chaireconditionautochtone.fss.ulaval.ca/documents/pdf/2015-Monetary-poverty.pdf
[50] Idem
[51] Idem
[52] Robitaille, J. Génard, E., Lévesque, S. and Duhaime, G. (2018). *The cost of living in Nunavik in 2016*. Retrieved from http://www.nunivaat.org/documents/Publication/the-cost-of-living-in-nunavik-in-2016-revised-and-expanded.pdf, p.14
[53] Ibid, p.15

Figure 13 Proportion of household spending in Nunavik on 100$ [54]



Food insecurity is a widespread problem in Nunavik. A number of studies have indicated that around one of every four families is afflicted by food insecurity in the region.[55] This phenomenon, involves various nutritional problems experienced by specific populations, for example: vitamin deficiencies among young women of childbearing age, iron deficiency anemia in children, etc. The 2004 health survey showed that traditional food accounted for only 11% of the daily energy intake of Nunavik youth. Yet, it has been demonstrated that eating traditional food items has a highly positive effect on the quality of the diet of Arctic populations.[56]

The NRBHSS has several initiatives in place aiming to improve the food security in the region, which include the implementation of the Regional food security action plan.

[54] Idem

[55] Nunavik Regional Board of Health and Social Services with the collaboration of Institut national de santé publique du Québec (2011). *Health Profile of Nunavik 2011: Demographic and Socioeconomic Conditions, Government of Québec*, 32 pages and appendices. Retrieved from https://www.inspq.qc.ca/pdf/publications/1589_PortraitSanteNunavik2011_ConditionsDemoSocioecono_VA.pdf, p. VII

[56] Centre for Indigenous People's Nutrition and Environment – McGill University. (2018). Benefits of traditional foods. Retrieved from https://www.mcgill.ca/cine/research/food/benefits

3.8 Economy

Nunavik's local economy is developing, but the region faces important challenges, such as small and isolated markets, high cost of living and doing business, low consumer purchasing power and low levels of education among the local labour force.

Social economy is an important part of the region's development. It is comprised of collective initiatives aimed at serving whole communities and promoting social well-being. This includes the many local organizations, committees and groups already at work in the communities. These organizations, committees and groups along with the northern village municipalities make substantial contributions to community life and remain the foundation of local development in the future.

The community cooperative associations and the *Fédération des cooperatives du Nouveau-Québec* (FCNQ) have been important players in local economic development. The cooperative movement in Nunavik has been inspired from the beginning by a clear vision of autonomy. Cooperatives are the biggest employer of Nunavimmiut. They employ community members at all levels of operations, as general managers, store managers, cashiers, clerks, bank tellers and warehouse workers.

Another key player in local economic development are the landholding corporations, which were established pursuant to the JBNQA to receive title of Category I land on behalf of their Inuit members, which includes the use of these lands for commercial, industrial, residential and other purposes. The landholding corporations share many common interests with the Kativik Regional Government and the northern village municipalities, such as responsibilities for local land use, local development projects, roads and trails, construction issues, traditional subsistence harvesting activities and wildlife conservation.

The FCNQ[57] also owns and operates 13 hotels in as many villages. Village landholding corporations[58] own other hotels and restaurants. Together, these establishments represent nearly 135 jobs, 50 of them part-time. The FCNQ stores provide retail and food goods alongside Northern stores (a subsidiary of the NorthWest Company) in the majority of the villages. Private enterprise is emerging and taking up more and more space in some communities. Altogether, these businesses provide nearly 420 jobs in the region, including 150 part-time jobs. Two banking institutions offer direct services to Nunavik clients and both are based in Kuujjuaq, namely the *Caisse Desjardins* and the Canadian Imperial Bank of Commerce (CIBC). The FCNQ provides the services of banking counters for other northern villages.

Tourism has been identified as a major driver of economic growth by the governments of Canada and Quebec as well as regional stakeholders. Regional stakeholders approved the Nunavik ACCORD strategy, focusing on the development of Quebec, Canadian and international tourism in the region, for implementation in 2011. The KRG has moved ahead with a community-based tourism initiative aimed at human resources capacity building and training. The projects supported promote business, adventure and cultural tourism (Nunavik parks, cruise lines, adventure tourism companies and fishing and hunting). The National park Tursujuq was officially created and the Ulittaniujalik park project received environmental and social impact approval in 2013, adding to the regions' growing park network.

[57] La fédération des coopératives du Nouveau-Québec. (2014). Who we are. Retrieved from http://www.fcnq.ca/en/qui-nous-sommes
[58] Nunavik Landholding Corporations Association. (N.D). About the NLHCA. Retrieved from http://www.nlhca.ca/about/

Fishing and hunting outfitters are characterized by caribou hunting, salmon and arctic char fishing. The region has approximately 50 outfitters operating over 200 fixed or mobile camps. Inuit have exclusive rights to operate these outfitters on Category I and II lands. The different providers offer an average of 140 seasonal jobs, more than half of which are granted to local populations. There are numerous construction contractors in Nunavik. In 2011, they accounted for nearly 550 jobs, 130 of them held by local residents.

The production of electricity, spearheaded by Hydro-Québec, is carried out at fourteen thermal fuel oil steam plants (one in each village). The government corporation provides jobs to 27 workers in the region, 23 of them Inuit. The buildings and residences are almost exclusively heated with oil-fired boilers. Each village has oil tanks and tankers for delivery. The FCNQ, Nunavik Petro Inc. and Halutik companies share the management of petroleum products in the region.

The transport sector (air and maritime) is one of the primary services provided to the region's consumers, and accounts for 415 jobs on the territory (115 of these part-time). The airlines serving Nunavik on a daily basis are Air Inuit and First Air. They offer scheduled and chartered flights. Other airlines also serve the northern villages for charter flights.

There are currently two operating mines in Nunavik, the Xstrata Nickel Raglan mine and the Canadian Royalties Inc.'s Nunavik Nickel Project mine. There is also significant mining exploration being carried out in the region. These exploration activities employ close to 375 prospectors, with almost 75 of them being Inuit residents of villages close to the prospected sites.

"As mineral exploration and mining activity is expected to increase in the coming years, Nunavik Inuit are concerned about the effects of mining development on their way of life and on the wildlife and lands where they have practised subsistence harvesting for millennia. Wildlife and lands that are essential and important for subsistence harvesting must be protected, along with archaeological and traditional burial sites." [59]

While the economy generated by the mining sector is valued, the precarious condition of the region's health and social situation lets one presume that a rapid or massive development could have various negative effects. The impacts of this development are already being felt in some communities that are receiving mining royalties or through which large numbers of workers are passing. As seen in other Aboriginal communities in Canada faced with major mining activity, the lack of financial management experience and resources to help cope with family conflict and stress are two factors leading to increased use of mind-altering substances affecting the physical and mental health of individuals.[60]

That being said, employment remains a key contributor to local economic development. Nunavimmiut should occupy local jobs, as much as possible. To this end, tailored training programs, positions adjusted for on-the-job training, and apprenticeships will continue to form an integral part of a sustainable employment strategy. As in the mining and construction sectors, progressively higher targets for local employees should be negotiated. With 58% of current jobs requiring vocational or post-secondary schooling, increased efforts are also needed to encourage Nunavik youth to stay in school and attain higher levels of educational achievement.

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[59] Makivik Corporation. (2018). Nunavik Mining Policy. Retrieved from http://www.makivik.org/current/nunavik-mining-policies/

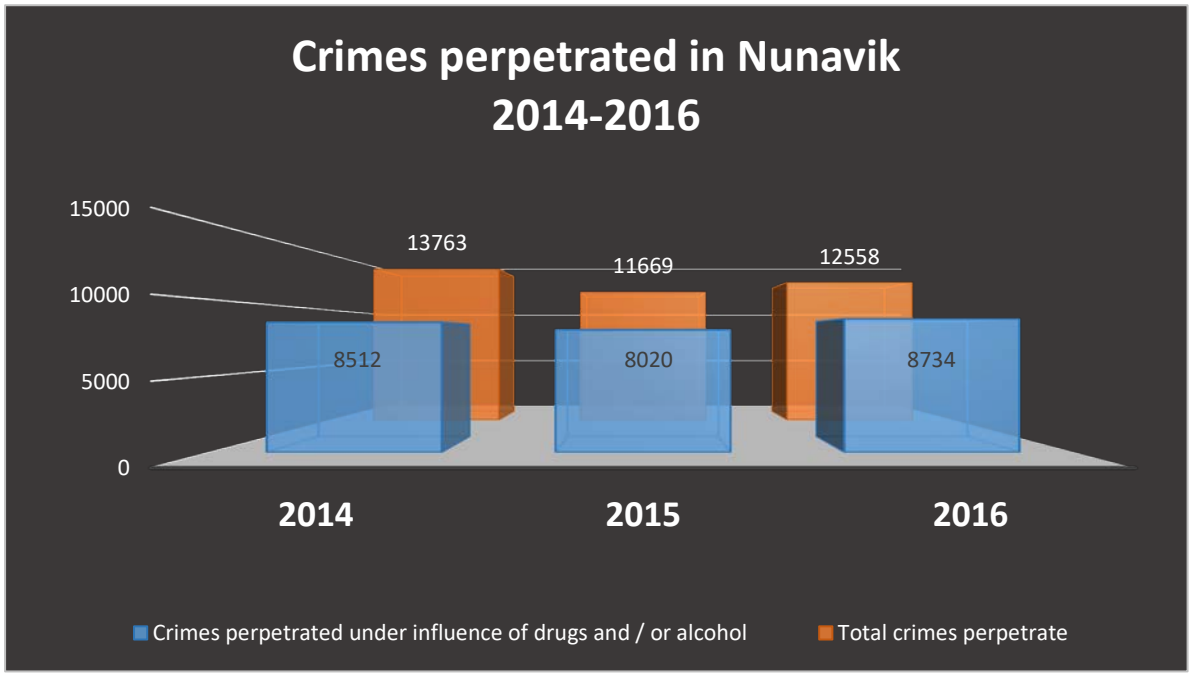
[60] Gibson, G. and Klinck, J. (2005). Canada's Resilient North: The Impact of Mining on Aboriginal Communities, *Journal of Indigenous Wellbeing*, 3(1), 115-139. Retrieved from http://caid.ca/JAICH2005v3n1p115.pdf

3.9 Crime Rates

The level of recorded crimes in Nunavik is alarming especially when compared to that of the whole province. In 2012, the number of crimes per 1 000 inhabitants in Nunavik was 535.3 while for the whole of Quebec, that number was only 42.2. The data also indicates that crime rates keep increasing in Nunavik while it tends to diminish in the rest of the province. [61]

As demonstrated by the data in the table below the most important contributing factor to Nunavik criminality is drugs and or alcohol abuse. Approximately 70% of all Nunavik major crimes (assaults and sexual crimes) are committed while under the influence of drugs and/or alcohol.

Figure 14 Crimes perpetrated in Nunavik 2014-2016[62]



The problems associated with the administration of justice in Nunavik are largely a consequence of the magnitude of the social problems and the poorly adapted mechanisms of the judicial process as a whole. Regulation policies should be generated by an analysis of social problems, coupled with an awareness of the results of the mechanisms currently applied in the communities. In this way, the regulation structures could be established and consolidated based on the region's realities.

Nunavik has a project aimed at reconstructing social regulation known as the *Saqijuq Project,* which means a change in the wind direction in Inuktitut. The general objectives are to curb alcohol and drug abuse in order to reduce the physical and psychological harm they cause, as well as the resulting over judicialization:

[61] Kativik Regional Police Force. (2016). *Annual Report, 2016*, N.D.
[62] Idem

- To raise awareness and mobilize as many individuals as possible in the fight against drug and alcohol abuse;
- To put together various support programs to help the individuals in need;
- To adapt justice, health and public safety services to Nunavik specific realities;
- To favour the coordination between the various organizations working in Nunavik;
- To put in place any additional services required, especially treatment and rehabilitation facilities for substance abuse problems;
- To ensure that Inuit core values and elder participation are at the heart of all related initiatives.

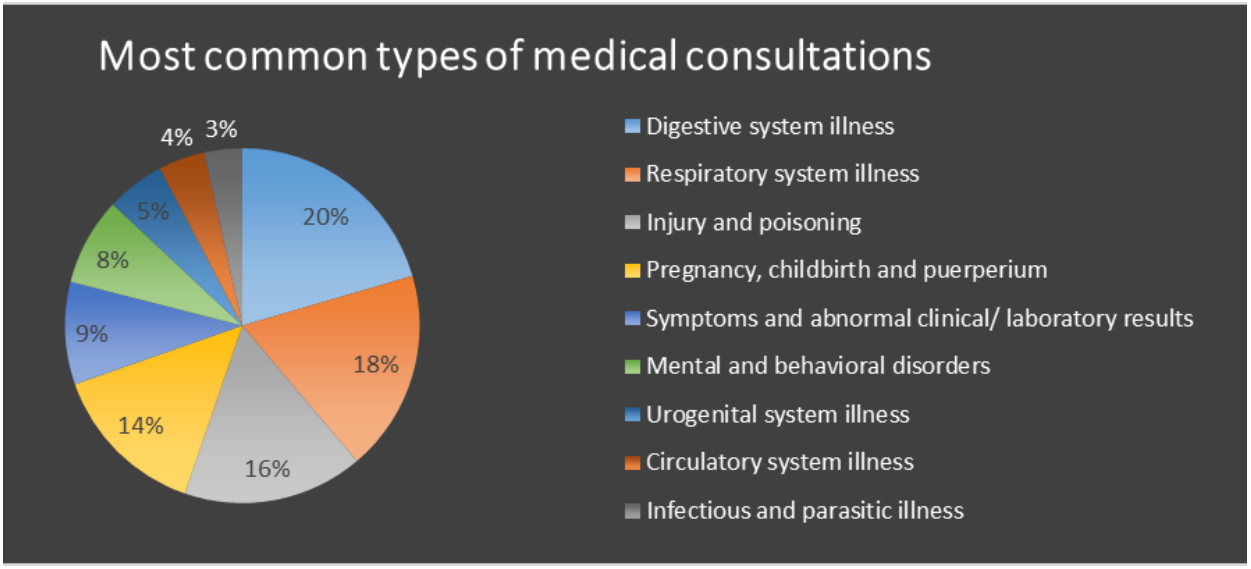
To overview the implementation of the *Saqijuq Project*, the government of Quebec, the KRG and Makivik agreed to create the *Saqijuq Nunavik Quebec Coordination Table,* which is composed of representatives of the MSSS, the Ministry of Justice, the Ministry of Public Safety, the KRG and the Makivik Corporation. The overall work of the *Saqijuq Nunavik Quebec Coordination Table* is under the direction of a Board of Governance, which is under the joint responsibility of the Minister for Social Services and Youth Protection and the Chair of the Nunavik Regional Partnership Committee. The board is composed of the Deputy Ministers from the participating provincial government departments and representatives of the KRG and the Makivik Corporation.

Health and social issues such as addictions for example, can lead to criminal activity and violence. In light of this, the NRBHSS is an active participant in the Saqijuq project and is working upstream, to take action on some of the risk factors associated with criminality.

3.10 Health and Social Profile

Life expectancy has risen over the past few years, paradoxically along with the recent onset of diseases of civilization as well as numerous pathologies that individuals survive today, but which would have been fatal, not to mention undiagnosed, not so long ago.

Figure 15 Most common types of medical consultations, Nunavik 2017[63]



In 2004, the Qanuippitaa survey was conducted on the Inuit population of Nunavik's state of health. The results revealed that for physical health, there was a high prevalence of risk factors (obesity, smoking, use of psychotropic substances, poor eating habits, lack of physical activity, etc.) contributing to the deterioration of the state of health.

The Qanuippitaa health survey (2004) revealed the following information (Please refer to Survey highlights for more detailed information)[64]:

- High percentage of people who regularly drink excessively;
- High percentage of women who admitted to drinking alcohol while pregnant;
- 60% of respondents stated having used drugs in the year previous to the survey;
- 43% of all reported injuries were transportation related;
- 54% of adults reported having experienced one or more forms of physical violence;
- 49% of women indicated having been victims of sexual assault or attempts to commit sexual assault when they were a minor;

[63] Ullivik Go – Specialist request management system, Data extracted March 2017

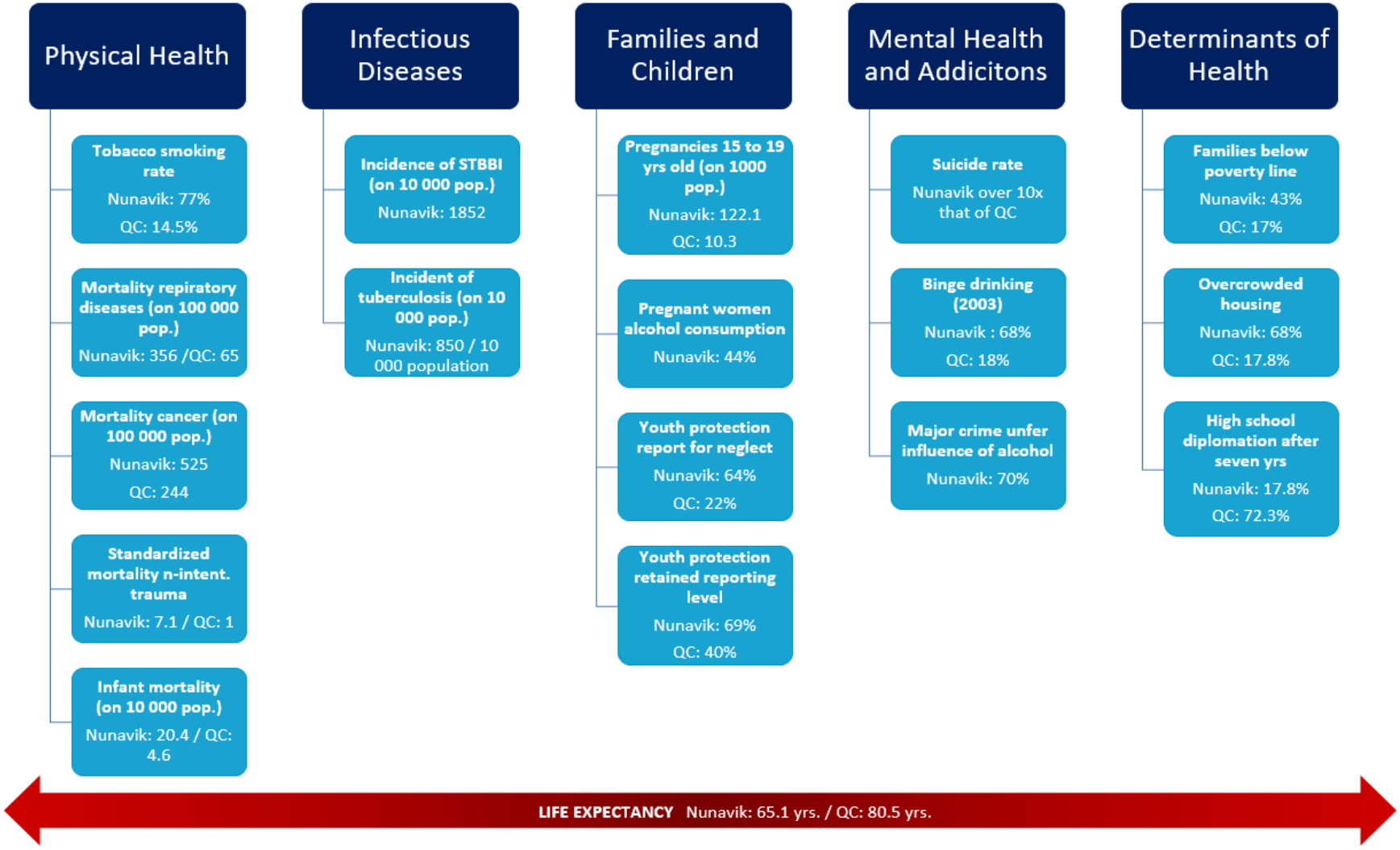
[64] Anctil, M. (prepared by) (2008). Survey Highlights. *Nunavik Inuit Health Survey 2004, Qanuippitaa? How are we?* Quebec: Institut national de santé publique du Québec (INSPQ) & Nunavik Regional Board of Health and Social Services (NRBHSS). Retrieved from https://www.inspq.qc.ca/pdf/publications/774_ESISurveyHighlights.pdf

- 13% of the population with a high level of psychological distress and considered likely to become depressed or develop mental health problems.

In 2011, the MSSS, jointly with partners, released a health profile for Quebec, which includes data demonstrating the effects of Inuit lifestyle on their health. The 2004 Qanuippitaa survey also covered psychosocial health and raised several issues including psychological distress, suicide, violence and rape. In the Quebec health profile, only one indicator is included for Nunavik, reflecting the population's psychosocial health: the adjusted mortality rate due to suicide, which was 99.6/100 000 for Nunavik and 15.4/100 000 for the province. Using adjusted mortality rates, it is possible to demonstrate the difference between Nunavik's health indicators and the rest of Quebec. Figure 12 on the next page illustrates the situation.

In 2017, a new health survey, Qanuilirpitaa (How are we now?) (See Annex 9.3) was conducted across the region. Continuity with the previous health survey of 2004 was ensured, in order to allow for the assessment of the evolution of certain trends. The analysis of this new data has not yet been completed. Publication of the data is expected in the fall of 2018 and the winter of 2019. Once this new data is available, this document will be updated.

Figure 16 Nunavummiut Health Indicators[65][66]



[65] Idem

[66] Nunavik Regional Board of Health and Social Services with the collaboration of Institut national de santé publique du Québec (2011). *Health Profile of Nunavik 2011: Demographic and Socioeconomic Conditions, Government of Québec*, 32 pages and appendices. Retrieved from https://www.inspq.qc.ca/pdf/publications/1589_PortraitSanteNunavik2011_ConditionsDemoSocioecono_VA.pdf

4. HEALTH PRIORITIES

4.1 Identification of Priorities

The NRBHSS's priorities of action stem from various sources, the Ilusilirniqmi Pigutjiutni Qimirrnuniq process, the Parnasimautik consultations, the Regional Public Health Action Plan and the Strategic Regional Plan.

Ilusiliriniqmi Pigutjiutini Qimirruniq (IPQ)

In 2004, the MSSS asked all the regions of Quebec to revise and improve services to ensure they respond more adequately to the needs of their respective populations. This process was called the Clinical Project. In Nunavik, the process was launched in 2009 and was called Ilusiliriniqmi Pigutjiutini Qimirruniq (IPQ). It "aims at revising and improving social and health services so that they respond more adequately to the needs of the population of Nunavik"[67].

In 2009, both health centres identified the focus of that process in the region for the coming years: youths in difficulty, addictions and mental health service programs. In 2010, during the Orientation Committee of the Partners for Health and Well-Being in Nunavik, regional cross-sector partners, Inuit associations and community organizations identified nine services to be strengthened or developed as regional priorities regarding the three aforementioned topics.

Starting in 2010, several committees were created to conduct research, consultations and analysis in order to draft recommendations regarding the services to improve and develop as priorities. Since then, several recommendations were completed, approved by the partners, adopted by the NRBHSS's board of directors and funded by the provincial government.

This process marked a major change in the philosophy of the Nunavik Health and Social Services Network. The orientation of the system's development originated from a consultative and partnership process at whose core were the needs and desires of Nunavimmiut.

The IPQ brings together more than 40 different regional users, bodies and organizations, and more than 150 individuals have been actively involved in the process over the past years. The IPQ is at the very base of the process of regional strategic planning. The recommendations adopted beforehand by the various authorities were integrated and serve as a source for the annual plans of action and for capital planning. For more information, please visit the IPQ Website[68].

[67] Ilusiliriniqmi Pigutjiutini Qimirruniq. (2014). Ilusiliriniqmi Pigutjiutini Qimirruniq. Retrieved from http://ipqnunavik.com/home/
[68] www.ipqnunavik.com

Parnasimautik Consultations

Parnasimautik was a regional consultation process that aimed at creating a comprehensive vision for the development of the region. The final report was presented to provincial government officials in 2015 as a reply to the Province's plan for the development of Nunavik *(Plan Nord)*.

The Parnasimautik report, "is a portrait of Who We Are, Our Communities and Our Region. It defines a vision of the future that includes greater control of planning and governance for Nunavik Inuit in every aspect of our lives, our communities and our region."[69] It provides a community-based vision of topics such as family, education, health and social services, justice, cost of living and housing, local development and employment.

Under the health and social services component, youth in difficulty and support for parents, addictions, mental health and suicide were identified as the main concerns of the population. The full report is available on the website[70].

Regional Public Health Action Plan

The Regional Action Plan for Public Health in Nunavik, 2016–2020 follows up on Quebec's *Programme national de santé publique*. It presents the public health activities, and services to be offered in the region. This plan was established based on the results of the IPQ process and the Parnasimautik consultations and is an integral part of the Strategic Regional Plan. The narrowing of the gap between Nunavik and the rest of Quebec along with the promotion of health equity are priority objectives under this plan. It serves as a framework document for many of the federally funded programs.

Strategic Regional Plan (SRP)

The NRBHSS produces a strategic regional plan (SRP) based on its population's needs and the orientations and priorities defined by the above-mentioned processes. The SRP aims at building a plan, which provides a level of health and social services that ensures the well-being of the population. The strategic plan also provides a funding framework that includes the development required for Nunavik's health network. The latest SRP submitted to the MSSS covers the period of 2018 to 2025.

Both health centres are directly implicated in the planning process. The development of the Nunavik health and social services network is based on a global and integrated approach to the population's needs. This requires, among other things:

- An approach centred on preventive services, front-line services and community involvement;
- A model for integrated provision of health and social services;
- Services provided at the community level whenever feasible;
- Services provided sub regionally (i.e., on each coast—Ungava and Hudson) whenever efficient in terms of costs and services according to the needs;

[69] Makivik Corporation, Kativik Regional Government, Kativik School Board, Nunavik Landholding Association, NRBHSSS, Youth Association of Nunavik. (2014, November 14). *Parnasimautik Consultation report*. Retrieved from https://www.cerp.gouv.qc.ca/fileadmin/Fichiers_clients/Documents_deposes_a_la_Commission/P-202.pdf, p. 11

[70] http://parnasimautik.com/

- Services provided regionally (i.e., on the Nunavik Territory) whenever efficient in terms of costs and services according to the needs;
- Development of immovable, housing and equipment at a pace that matches service development;
- Development of technical-support systems, including information technologies, communications and management systems.

4.2 Regional Health Priorities

Regional Health Priorities[71]	
Mental Health	• Enhanced and improved suicide prevention services • Enhanced services for crisis traumas and mental illnesses – For individuals and families • Enhanced and improved healing services in every community
Addictions	• Enhance local service offer (e.g.: access to professional addiction services in every community) • Improve family oriented services • Invest in prevention, detection, professional community-based support and specialized treatment • Change social norm surrounding binge drinking and drinking during pregnancy • Social and cultural relevant treatment, offered in the region
Youth in Difficulty	• Prevent parental neglect by supporting parents in their role and personal development • Enhance child development services and education • Review youth protection services to better reflect northern reality, by including community involvement mechanisms • Implement early detection programs for delayed development and provide the needed support services for the child • Concerted actions (daycares, schools, health centres, CLSCs, etc.) • Increase multidisciplinary actions • Increase the number of Inuit workers intervening with children and families • Enhance and increase family resources, such as family houses or wellness centres
Public Health	• Mobilize communities as partners in their health and wellness • Promote the adoption of healthy lifestyles • Coordinate the development of a regional food security policy • Prevention and control of infectious diseases • Increase support to children, families and pregnant women
Physical Health	• Increase general services to respond to continuous population growth • Increase availability of screening services (e.g.: intellectual disability, hearing, pervasive development disorders) • Optimize health trajectory • Develop and expand service agreements • Patriate services

[71] Nunavik Regional Board of Health and Social Services. (2018). *Strategic Regional Plan 2018-2025*.(N.D.)

Regional Health Priorities[71]	
Loss of Autonomy	• Enhance access to services in each community • Support individuals and families • Foster maintaining individual in environment of choice
Health and Social Network	• Renew and renovate aging equipment and infrastructure • Increase employee stability • Increase number of Inuit resources • Patriate services

5. FEDERAL HEALTH PROGRAMS

As of April 1, 2019, the Regional Board of Health and Social Services (NRBHSS) hopes to sign a new contribution agreement with Indigenous Services Canada for a ten-year term (2019-2029), under block funding.

In order to obtain this type of multi-year agreement, the NRBHSS has developed a multi-year health plan to implement the programs and initiatives funded by Indigenous Services Canada, in line with provincial priorities and services. Rather than undertake a planning process and then engaging in program delivery, NRBHSS continues to manage existing programs while planning and setting health priorities in collaboration with partners.

Using a block funding approach will allow for greater autonomy and flexibility within the health programs and services delivered in the region and thereby promote a better impact on the health of the population. This will also allow greater flexibility in decision-making on program objectives and the allocation of financial and material resources to programs.

The current contribution agreement with Indigenous Services Canada should include funding for approximately $ 10 million a year under a variety of health prevention and promotion programs and initiatives. In the coming years, the NRBHSS will continue to implement the health plan and update it to reflect the current health needs of the people of Nunavik.

In the following section, the information is organized in accordance with Indigenous Services Canada program authorities. The health status of the population is described under each functional area group (healthy child development, mental wellness, etc.). Each program or initiative for which the NRBHSS receives funding is detailed according to the delivery of services, the goals, the program planning, the evaluation and the budget.

The program planning is presented on a five-year basis. A summary evaluation of the results should be carried out after the first five years of the agreement in order to ensure the continuous improvement of the program planning. In addition, as the NRBHSS does not deliver direct health services, but rather supports the organization of health and social services in the region, the objectives stated in the program planning in the following sections are often more process oriented, rather than health oriented.

5.1 Healthy Child Development

5.1.1 Health Status and Context

Pregnant women and young families are a prioritized sub-population group in Nunavik. Varieties of services are provided to pregnant women, newborns and their families in the region. "Although the health of Inuit children did improve in the past years, several health indicators still reveal substantial disparities when compared to the population of Quebec as a whole. […] The combination of adverse determinants — poverty, low education levels, and overcrowded housing — compound the vulnerability of young parents and their children. […] The living conditions of Inuit women inevitably have repercussions on the health of young children from the first moments of life."[72]

The fertility rate in the region is higher than the rest of the province. For the period of 2004 to 2008, Nunavik women had an average of 3.22 children whereas women in the rest of the province had 1.62 children.[73] In addition, for the period of 2006 to 2010, the fertility rate of Nunavik women aged 15 to 19 was also much higher than for the women of the same age in the rest of the province. Respectively 125 per 1000 women compared to 10 per 1000 women.[74]

Considering the high number of births, healthy pregnancies are an important issue. Alcohol abuse and notably, binge drinking is a problem within Inuit communities, especially among young people. This leads public health authorities to be concerned for the potential of Fetal Alcohol Spectrum Disorder (FASD) cases. This permanent condition affects the physical, emotional, psychological, and behavioural development of individuals. The primary disabilities associated with FASD are directly linked to the underlying neurological damage caused by prenatal alcohol exposure. These can include, but are not limited to, poor memory, impaired language and communication skills, poor impulse control and social and emotional deficits. This disorder is frequently undetected. Many behaviours of FASD may appear as delinquent or antisocial, and can result in individuals being misunderstood and vulnerable to additional long-term secondary disabilities. If prevention, diagnosis, and intervention do not take place, the problems become pervasive and the adverse effects on the individual and family impinge on the entire community including education, health care, social services and the judicial system.

According to the health survey *Qanuippitaa, How are we?*, conducted in 2004, with respect to tobacco use and alcohol consumption during pregnancy, 65% smoked daily and 44% reported having drunk alcohol during their last pregnancy. In Nunavik in 2004, the proportion of drinkers was 77%, which is lower than the rate observed in Canada and in Quebec. However, "Close to seven women in ten reported heavy drinking episodes on a monthly basis. This pattern seems particularly frequent among women aged 18-29, who are also the most likely to become pregnant."[75]

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[72] NRBHSS, in collaboration with INSPQ (2015). *Nunavik Health Profile 2014: Young Children and Their Families.* Government of Québec. Retrieved from http://nrbhss.gouv.qc.ca/sites/default/files/Profile_Enfants_Famille_EN.pdf, p. 39,

[73] Chaire de recherche du Canada sur la condition autochtone comparée – Université Laval. (2015). *Le Nunavik en chiffre 2015*. Retrieved from http://www.chaireconditionautochtone.fss.ulaval.ca/documents/pdf/Nunavik-en-chiffres-vf-fr.pdf, p. 14

[74] NRBHSS, in collaboration with INSPQ (2015). *Nunavik Health Profile 2014: Young Children and Their Families.* Government of Québec. Retrieved from http://nrbhss.gouv.qc.ca/sites/default/files/Profile_Enfants_Famille_EN.pdf, p. 12

[75] Ibid, p. 22

A study from 2011 on alcohol, smoking and drug use among Inuit women of childbearing age and during pregnancy demonstrated that 61% of the women drank alcohol during their pregnancy and "62% of these women reported at least one episode of binge drinking, which corresponds to 38% of the whole sample"[76]. Conclusions show that alcohol is a major risk factor to maternal and child health in the Inuit population, underscoring the need for culturally relevant and effective prevention programs.

Furthermore, anecdotal evidence leads some front-line workers to believe that the number of Inuit living with FASD may be higher than the national average. Even though only very few medical experts can make a diagnosis, the above concerns, combined with a very young and quickly growing population, reinforces the need for proactive, culturally safe FASD activities for the region, as for support for pregnant women.

Another important issue faced by Inuit communities that directly affect pregnant women and children is food insecurity. "Food insecurity refers to situations when the food purchased does not last and there is not enough money to buy more food, balanced meals are unaffordable, or household members cut the size of their meals or skip meals because there is not enough money for sufficient food."[77] According to the aboriginal Peoples Survey of 2012, the proportion of individuals aged 25 and over who experienced food insecurity in the 12 months preceding the survey was of 55% in Nunavik.[78] In a recent cohort study in the region, "half of the children (49.7%, n=145) were food insecure, while one third were iron depleted, 12.6% had anemia, and 8.7% had iron deficiency anemia".[79]

Not having access to healthy store bought foods also means children are consuming more products containing refined sugar, and refined sugar is considered to be one of the main contributors to tooth decay. In 2004, only 3% of children in Nunavik were cavity-free at age six. In other words, almost all the children in Nunavik suffer from tooth decay.[80] Other important factors linked to oral health are dental hygiene and access to services. The latter often proves challenging in the region.

Throughout the difficulties faced by families, women and children, the Nunavik region is also working to restore traditional practices, which contributes to the empowerment of the population, and positively influences their health. The development of midwifery services in Nunavik spans from a need to reclaim pregnancy, labour and birth from a cultural point of view. These moments were once a major event for the family and the community, which strengthened family ties through the attachment to the child being born. Evacuation policies for pregnant women, particularly in the 1960s and 1970s, contributed to the breakdown of family ties and precipitated the loss of cultural knowledge Inuit women previously shared. In contrast, since the end of the 1980s, the gradual re-appropriation of pregnancy, labour and birth has been very successful, thanks to the establishment of midwifery services in Nunavik. Currently, there are four midwives working on the Ungava Coast and twelve midwives on the Hudson Coast.

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[76] Muckle, G., Laflamme, D., Gagnon, J., Jacobsen, J.L., Jacobsen, S.W. (2011, June) Alcohol, Smoking and Drug Use among Inuit Women of Childbearing Age during Pregnancy and the Risk to Children, *Pub Med Central*, 35(6), 1081-1091, Doi: 10.1111/j.1530-0277.2011.01441.x. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3097283/

[77] Arriagada, P. (2017). *Food insecurity among Inuit living in Inuit Nunangat*. Retrieved from http://www.nunivaat.org/documents/Publication/Food-insecurity-among-Inuit.pdf, p.2

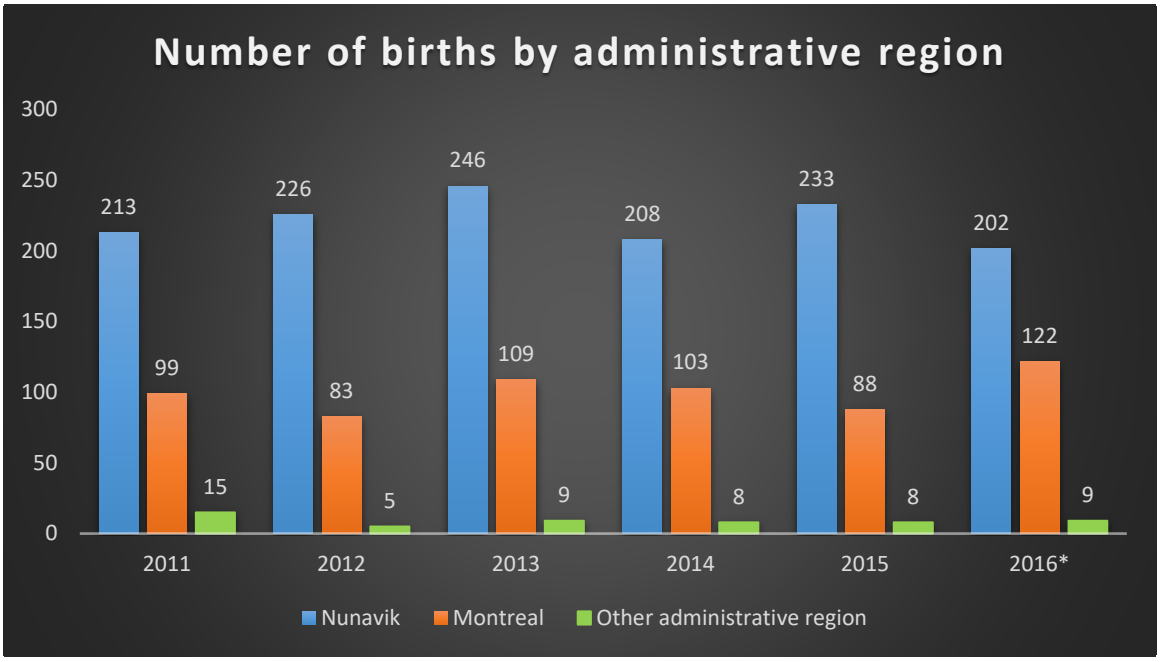
[78] Ibid, p.3

[79] Pirkle, C.M., Lucas, M., Dallaire, R., Ayotte, P., Jacobsen, J.L., Jacobsen, S.W., Dewailly, E., Muckle, G. (2014). Food insecurity and nutritional biomarkers in relation to stature in Inuit children from Nunavik, *Canadian Public Health Association*, 105(4), 233-238, Doi: 10.17269. Retrieved from http://journal.cpha.ca/index.php/cjph/article/view/4520

[80] NRBHSS, in collaboration with INSPQ (2015). *Nunavik Health Profile 2014: Young Children and Their Families.* Government of Québec. Retrieved from http://nrbhss.gouv.qc.ca/sites/default/files/Profile_Enfants_Famille_EN.pdf, p. 33

Despite the efforts in place to reclaim the birthing process through the midwifery initiative, many births are still taking place outside of Nunavik. Over the period of 2011-2016, 1,986 births were registered with an annual average of 331. Out of those births, 33% occurred outside of Nunavik. Most out-of-region births take place in Montreal.[81] Considering a third of Nunavimmiut children are born in Montreal, which in most cases implies one or many stays at Ullivik by the mother, and the high rate of risky behaviours observed among pregnant women and women of childbearing age during their stay, there is a need for more prenatal prevention at Ullivik. (See section 2.1.3 under Inuulitsivik Health centre for more information about Ullivik)

Figure 17 Number of birth by administrative region per year, Nunavik, 2011-2016*[82]



*Provisional data

A report from ITK based on the 2006 Aboriginal Children's Survey from Statistics Canada analyzes the results surrounding breastfeeding. According to the report, 76% of Nunavik mothers initiated breastfeeding, 54% breastfed for six months or less and 34% breastfed for twelve months or less.[83] The national initiation rate was higher than Nunavik's; at 90%, but the sustained breastfeeding rate at six months was the same for Nunavik mothers and other mothers in Canada.[84]

The following sections present the service delivery, program planning and budget for all healthy child development related federal funding.

[81] Ministère de la Santé et des Services Sociaux. Fichier des naissances vivantes, 2011-2015 fermé, 2016 provisoires. Compilation Direction de la Santé Publique du Nunavik, 6 septembre 2018.
[82] Idem
[83] Asuri, S., Ryan, A.C., Arbour, L. (2011). *Early Inuit Child Health in Canada – Report 2: Breastfeeding among Inuit in Canada.* Retreived from https://www.itk.ca/wp-content/uploads/2016/07/2011-Report-Breastfeeding-among-Inuit-in-Canada.pdf, p.6
[84] Ibid, p. 7

5.1.2 Maternal and Child Health

5.1.2.1 Service Delivery

The NRBHSS has a child and family team within the department of Public Health. The team's tasks are to support and organize promotion and prevention activities to ensure the health and well-being of children and their families as well as contribute to the development of children and favourable environments. The team also works towards defining strategies for preventive intervention adapted to the needs of Nunavik families.[85]

Another mandate of the children and family team is to adapt and deliver, in collaboration with regional partners, the *Services intégrés en périnatalité et pour la petite enfance* (SIPPE) program from the MSSS. In Nunavik, the provincial program is named Ilagiilluta. It is adapted to the Inuit reality and incorporates federal health programs for children and families, such as FASD and CPNP.

In the region, different programs and organizations support families and children, such as the health centres, the CLSCs, the DYP, the family houses, the schools, the daycare centres, etc. Varieties of services are provided, but there needs to be better collaboration between actors in order to provide children and families with an effective continuum of services.

The federal Maternal and Child Health (MCH) program is new for the NRBHSS. This new funding provides an opportunity for the region to develop a better continuum of services for pregnant women, children and families. For the time being there is no full-time resource dedicated to the MCH program, but the children and family team will use the funds to pursue its work in regards to the continuum of services. In addition, the funding will also be used to contribute to the objectives and activities of the Regional public health action plan related to breastfeeding.

5.1.2.2 Goals

- Improve the health of young children by implementing an integrated continuum of services;
- Improve the development of young children by working upstream on protective factors, such as breastfeeding.

5.1.2.3 Health Program Planning

[85] Nunavik Regional Board of Health and Social Services. (2018). Public Health – Prevention and Promotion – Children and Families. Retrieved from https://nrbhss.ca/en/departments/public-health/prevention-and-health-promotion/children-and-families

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Maternal and Child Health (MCH)								
Goals: 1- Improve the health of young children by implementing an integrated continuum of services.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1.1- By 2025, pregnant women and young families will have access to a variety of integrated services covering the continuum of health.	1.1.1- Develop a working group with NRBHSS representatives, the health centres, local organizations and community-based representatives to build a regional strategy based on the continuum of health.	Pregnant women, their partners and young families	Coordinator for Prevention and health promotion (Véronique Dion-Roy)	Other NRBHSS representatives(Geneviève Pellerin's team, Elena Labranche's team, etc.) Health centre representatives Ullivik Local organizations (e.g..: family houses) KRG - Daycare Centres	2019-2020	Working group created Continuum of health detailed Strategy developed	Services for pregnant women and young families are identified across the continuum of health. Service gaps are identified and filled. Services for pregnant women and young families are better integrated.	Regional action plan, evaluation of working group once a year. Evaluation process to be identified.
	1.1.2- Develop and implement a regional action plan based on the strategy.				Ongoing as of 2019-2020	Action plan developed Actions implemented		
	1.1.3- Develop and implement an evaluation process in accordance with action plan.				Ongoing as of 2019-2021	Evaluation process developed Evaluation steps implemented		

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Maternal and Child Health (MCH)								
Buts/Goals: 2- Improve the development of young children by working upstream on protective factors, such as breastfeeding.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2.1- As part of the strategy (See activity 1.1.1), increase breastfeeding initiation and duration. (1-4)	2.1.1- Collaborate with working group (See activity 1.1.1) to implement regional BFI training from Kanesatake.	Professionals and paraprofessionals working with pregnant women across the region (nurses, midwives, SIPPE workers, etc.)	Prevention and health promotion officer (Amélie Bouchard)	Working group (See 1.1.1) Health centres	2019-2020	Training implemented Nb of participants	Trainees are comfortable with content of training	Post training evaluation
	2.1.2- Following training, collaborate with working group to identify the priorities of action to support breastfeeding in the region. (Social marketing campaign, breastfeeding support network, breastfeeding sponsors, home visits, workshops in schools and family houses, breastfeeding friendly public spaces, etc.)	Pregnant women, their partner and young families	Prevention and health promotion officer (Amélie Bouchard)	Working group (See 1.1.1) Health centres	2019-2020	Priorities of action identified. Work plan for implementation of actions developed	Integrated and coherent approach to implementing actions	Work plan
	2.1.3- Develop and/or regional tools with members of the working group for identified actions.	Pregnant women, their partner and young families	Prevention and health promotion officer (Amélie Bouchard)	Working group (See 1.1.1) Health centres	2020-2021	Tools developed	Adapted tools available for culturally relevant interventions	List of tools available
	2.1.4- Implement the identified actions in at least 1 health centre.	Pregnant women, their partner and young families	Health centre(s)	Prevention and health promotion officer (Amélie Bouchard) Working group (See 1.1.1)	Ongoing as of 2020-2021	Nb of actions implemented Nb of individuals reached	Nb of women initiating breastfeeding Duration of breastfeeding	Work plan Data from health centre(s)
	2.1.5- Work with the health centre to gradually expand identified actions to a number of communities.	Pregnant women, their partner and young families	Health centre(s)	Prevention and health promotion officer (Amélie Bouchard)	Ongoing as of 2022-2023	Communities to participate are identified Nb of communities Work plans with communities developed	Actions implemented in new communities Nb of women initiating breastfeeding Duration of breastfeeding	Work plans with communities Data from health centre(s)/CSLCs

5.1.2.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

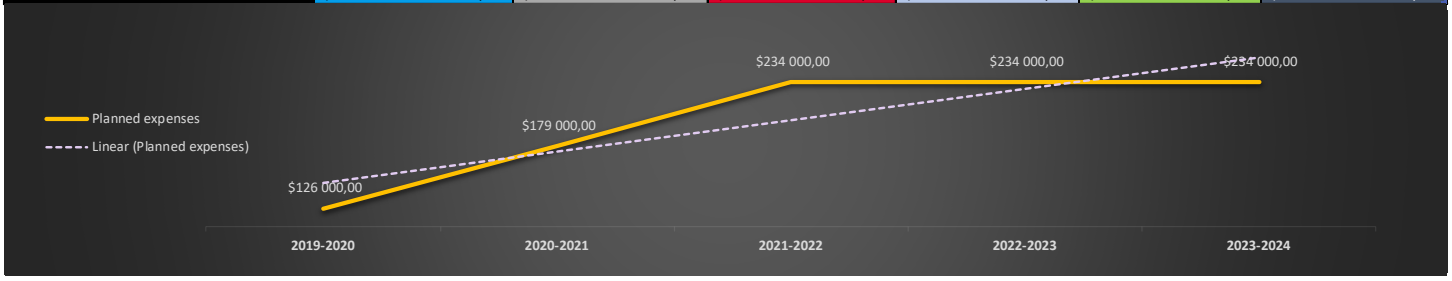
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics included in the survey are sociocultural determinants of health, family and physical health. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.1.2.5 Budget

Although funding for MCH has only been confirmed up to 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Maternal and Child Health					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Activities: - Breastfeeding initiative (meetings - travel, training, transfer to Health centres)	$ 123 480,00	$ 175 420,00	$ 229 320,00	$ 229 320,00	$ 229 320,00	$ 986 860,00
Administration fees	$ 2 520,00	$ 3 580,00	$ 4 680,00	$ 4 680,00	$ 4 680,00	$ 20 140,00
TOTAL	$ 126 000,00	$ 179 000,00	$ 234 000,00	$ 234 000,00	$ 234 000,00	$ 1 007 000,00



5.1.3 Fetal Alcohol Spectrum Disorder

5.1.3.1 Service Delivery

The NRBHSS coordinates the FASD program, which is offered in complementarity with other programs targeting children and families, such as the Canada Prenatal Nutrition Program (CPNP), the Ilagiilluta services as well as addiction-related programs. Ilagiilluta services are also referred to as the provincial initiative *Services Intégrés en Périnatalité et en Petite Enfance* (SIPPE). Ilagiilluta services aim to support l maternal and child health initiatives, including FASD prevention and education. This initiative also supports individual counselling or referral services for pregnant women struggling with alcohol-related issues and coordinates public awareness campaigns. Although Ilagiilluta services are mainly funded under the provincial government, the NRBHSS supports existing services with some federal funds in order to offer a more integrated and complete variety of services. Prevention efforts start prior to birth and intend to promote healthy and alcohol-free pregnancies as well as reduce harm caused by alcohol consumption during pregnancy.

Prevention efforts of the region are outlined by four prevention levels recommended in a 2008 publication of the Public Health Agency of Canada entitled - Fetal Alcohol Spectrum Disorder (FASD): Canadian Perspectives[86]. Please note that the attached program planning is for levels 1 and 2. The federal funding received is used for promotion and prevention. Levels 3 and 4 are related to provincial funding. Additional information on projects supporting levels 3 and 4 can be provided upon request.

Level 1 – Broad awareness, community education and large-scale health promotion efforts addressed to the general population. This level aims to raise public awareness around the subject through communication campaigns and health promotion activities. Engagement and involvement of a broad range of people at the community level is the key to advancing social support and social change. Positive and respectful messages that avoid placing the responsibility only on the mother and not cause undue anxiety on women who have consumed small amount of alcohol during their pregnancy is also essential to avoid negative stigma. (Public health team of the NRBHSS)

Level 2 – On the second prevention level, the target population is narrowed down to women of childbearing age, their support networks and health-care providers, in order to discuss alcohol consumption during pregnancy and the risks associated. Interventions at this level also include the promotion of birth control to enhance pregnancy planning. (Public health team of the NRBHSS)

Level 3 – The third level of prevention is more specific and is targeted at pregnant women with alcohol-related issues. At this level, specialized and culturally adapted recovery and support services are made available. (Addictions team of the NRBHSS)

Level 4 – The last level aims at supporting mothers to maintain the healthy changes they were able to make during their pregnancies. An important element is also providing assistance to those who were unable to make significant changes in their lifestyles and supporting them to improve their health as well as the health

[86] Public Health Agency of Canada. (2008). *Fetal Alcohol Spectrum Disorder (FASD) Prevention: Canadian Perspectives*. Retrieved from http://www.phac-aspc.gc.ca/hp-ps/dca-dea/prog-ini/fasd-etcaf/publications/cp-pc/pdf/cp-pc-eng.pdf, p. 3

of their children. In addition, early intervention for children who potentially have FASD is also important at this stage. (Addictions team of the NRBHSS)

There is one person responsible for the FASD file at the NRBHSS under the department of Public Health. This person ensures that the program is well integrated within the maternal and child health services and supports the health centres FASD workers, by creating better service trajectories, providing adapted educational material and organizing regional events (training, conferences) to name a few. Direct services are provided in the communities. Hence, most of the funding is transferred to the two health centres on the Ungava and Hudson coasts, where FASD workers:

- Support local community employees and partners regarding FASD prevention and education;
- Provide individual counselling or referral services for pregnant women struggling with alcohol-related issues;
- Coordinate public awareness campaigns on FASD prevention in all communities on their coast.

FASD team - Inuulitsivik Health Centre:

There are two FASD community workers based in Puvirnituq for the seven communities of the Hudson Coast. One position is funded through Indigenous Services Canada, and the other one is funded through the MSSS.

FASD team – Ungava Tulattavik Health Centre:

There is one FASD Coordinator in Kuujjuaq for the seven communities of the Ungava Coast. The FASD worker is part of the SIPPE (Ilagiilluta) team and serves as a consulting resource for communities. The position is funded through Indigenous Services Canada. Work has been done to allow the services to be implemented in smaller communities as well. FASD prevention is a priority for the Inuit on Ungava Coast and it has become a big part of the services offered to the pregnant women and young families.

Various interveners that work with pregnant women have raised the issue of alcohol consumption during the stay of women in Montreal. A higher rate of at-risk behaviours in pregnant women and women of childbearing age while staying at Ullivik (smoking, alcohol & drug intake, sleep deprivation, etc.) has been observed. In order to counter these behaviours, the NRBHSS, the IHC and the SIPPE (Ilagiilluta) services work in collaboration with Ullivik to establish a better service trajectory, thus ensuring a continuum of services and support for the women travelling to Montreal.

5.1.3.2 Goals

- Reduce the prevalence of FASD in future generations in Nunavik;
- Build strong collaborations between all stakeholders to ensure a continuum of services in prevention of FASD and promotion of healthy pregnancies.

5.1.3.3 Health Program Planning

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

FASD

Goals:

Reduce the prevalence of fetal alcohol spectrum disorders (FASD) in the future generations in Nunavik

Build strong collaborations between all stakeholders to ensure a continuum of services in prevention of FASD and promotion of healthy pregnancies

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- Create environments conducive to healthy pregnancies.	1.1- Collaborate with other NRBHSS departments on healthy child development in order to implement a coherent and integrated action plan.	All Nunavimmiuts	Public health nurse, child and family team (Dominique Lavallée)	Other NRBHSS programs: e.g.: medical affairs, addicitons, family, children and youth	2019-2020	Nb of work group meetings Also see MCH 1.1.1	Action plan completed Also see MCH 1.1.1	Annual report from Public health nurse, children and family team Meeting minutes Also see MCH 1.1.1
	1.2- Create and implement a communication campaign aimed at: - Informing the population regarding the impacts of drug and alcohol during pregnancy; - Empowering family members regarding their supportive role towards the mother and unborn child; - Destigmatizing the mothers who might have consummed alcohol/drugs during their pregnancy; -Provinding information regarding available resources (at all levels).	All Nunavimmiuts		Communications team	Ongoing as of 2021-2022	Communication plan developed Nb of communication strategies implemented	Nb of women who received alcohol or drug related counselling during their pregnancy. Nb of women who reported drinking during their pregnancy	Annual report from Public health nurse, children and family team Annual reports from Health centres
	1.3- Support and fund community based activities aimed at raising awareness on the dangers of consumming alcohol and drugs while pregnant and promote healthy pregnancies (eg. FASD awareness day, etc.).	All Nunavimmiuts		Community organizations / members organizing activity	Ongoing as of 2019-2020	Nb of activities funded Nb of participants	Nb of women who received alcohol or drug related counselling during their pregnancy. Nb of women who reported drinking during their pregnancy	Annual report from Public health nurse, children and family team Annual reports from Health centres
	1.4- Support and fund community based activities aimed at developing strong sober networks around pregnant women.	All Nunavimmiuts		Community organizations / members organizing activity	Ongoing as of 2019-2021	Nb of activities funded Nb of participants	Nb of women who received alcohol or drug related counselling during their pregnancy.	Annual report from Public health nurse, children and family team Annual reports from Health centres
	1.5- Build strong collaborations between all stakeholders to ensure a continuum of services in prevention of FASD and promotion of healthy pregnancies (Ullivik, Hospitals in Montreal, etc.)	Pregnant women New mothers Partners		Other NRBHSS programs, Health centres, CLSCs, Ullivik, Hospitals, etc.	Ongoing as of 2021-2022	Nb of meetings Nb of institutions involved Nb of collaborations / partenrships developed Also see MCH 1.1.1	Coherent approach to FASD prevention accross the health and social services network. Also see MCH 1.1.1	Annual report from Public health nurse, children and family team Meeting minutes Also see MCH 1.1.1

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

FASD

Goals:

Reduce the prevalence of fetal alcohol spectrum disorders (FASD) in the future generations in Nunavik

Build strong collaborations between all stakeholders to ensure a continuum of services in prevention of FASD and promotion of healthy pregnancies

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2- Promote family planning and early detection of pregnancies to reduce alcohol exposure during prenatal period.	2.1- Provide culturaly-safe information on birth control and options in case of failures of a contraceptive method, unprotected sexual relation or unplanned pregnancies. (See 1.2)	Women of child bearing age and their partner	Public health nurse, children and family team (Dominique Lavallée)	CLSCs / Health centres Schools Community organizations	Ongoing as of 2020-2021	Nb of people reached Nb of information sessions/materials	Nb and type of birth control methods distributed	Annual report from Public health nurse, children and family team Annual reports from Health centres Report from pharmacy Report from participating schools
	2.2- Give safe and easy access to contraceptive methods and emergency contraception.	Women of child bearing age and their partner		Local pharmacies CLSCs / Health centres Schools	Ongoing as of 2020-2021	Nb and type of birth control methods distributed Location where birth control was provided	Nb of unplanned pregnancies Nb of VTPs	Annual reports from Health centres Report from pharmacy Report from participating schools
	2.3- Give easy and safe access to pregnancy tests without nursing or medical consultation.	Women of child bearing age and their partner		Local pharmacies CLSCs / Health centres Schools	Ongoing as of 2020-2021	Nb of pregnancy tests distributed Location where pregnancy tests were provided	Nb of women gainig early knowledge of their pregnancy Nb of women who adopt healthier lifestyles earlier their pregnancy	Annual reports from Health centres Report from pharmacy Report from participating schools
	2.4- Provide school resource (eg: nurse, student counsellors) with training to offer pregnancy tests, individual counseling and group activities concerning family planning, sexual education, parenthood, prevention of FASD, healthy use of alcohol and referal to CLSC's.	High school students		School resource	Ongoing as of 2020-2021	Nb of school resources trained	Nb of schools offering these activities	Annual report from Public health nurse, children and family team Report from participating schools

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

FASD

Goals:

Reduce the prevalence of fetal alcohol spectrum disorders (FASD) in the future generations in Nunavik

Build strong collaborations between all stakeholders to ensure a continuum of services in prevention of FASD and promotion of healthy pregnancies

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
3- Create stronger supportive networks for pregnant women and their family.	3.1- Collaborate with the Ilagiilluta program (SIPPE) to support it's expansion accross the region.	Pregnant women and their family	Public health nurse, child and family team (Dominique Lavallée)	NRBHSS Child and family team	Ongoing as of 2019-2020	Nb of active Ilagiilluta teams accross the region Nb of Ilagiilluta teams including FASD as an intervention component	Nb of women who received alcohol or drug related counselling during their pregnancy. Nb of women who reported drinking during their pregnancy	Annual report from Public health nurse, children and family team Annual reports from Health centres
	3.2- Support and fund community-based activities aimed at supportive interventions (eg. Baby showers, etc.)	Pregnant women and their family		NRBHSS Child and family team Community organizations / members organizing activity	Ongoing as of 2019-2021	Nb of activities funded Nb of participants	Nb of women who received alcohol or drug related counselling during their pregnancy. Nb of women who reported drinking during their pregnancy	Annual report from Public health nurse, children and family team Annual reports from Health centres
	3.3- Train and support local resources to inlcude counselling to women and their partner on the risks of alcohol and drug consumption during pregnancy in prenatal follow-ups.	Pregnant women and their partner		NRBHSS Child and family team Local resources	Ongoing as of 2021-2022	Nb of resources trained	Nb of pregnant women and their partners receiving counselling as part of the prenatal follow-ups.	Annual report from Public health nurse, children and family team Annual reports from Health centres
	3.4- Provide personalized support to FASD coordinators.	FASD coordinators		NRBHSS Child and family team	Ongoing as of 2019-2020	Nb of trainings / meetings / support sessions offered	FASD coordinators feel conformatable in their role	Annual report from Public health nurse, children and family team Annual reports from Health centres

5.1.3.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

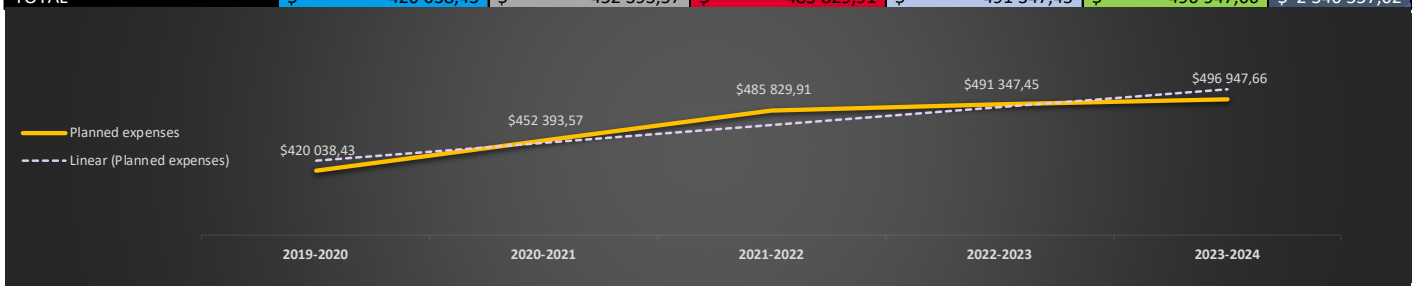
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics included in the survey are substance abuse, as well as the family related determinants of health. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.1.3.5 Budget

Although part of the FASD funding has only been confirmed up to 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Fetal Alcohol Spectrum Disorder					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	anned expenses
Hudson (55% of the population)	$ 135 265,71	$ 152 705,13	$ 170 727,32	$ 173 701,28	$ 176 719,79	$ 809 119,23
Ungava (45% of the population)	$ 110 671,95	$ 124 940,56	$ 139 685,99	$ 142 119,23	$ 144 588,92	$ 662 006,65
Salary	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 828 500,00
Administration fees	$ 8 400,77	$ 9 047,87	$ 9 716,60	$ 9 826,95	$ 9 938,95	$ 46 931,14
TOTAL	$ 420 038,43	$ 452 393,57	$ 485 829,91	$ 491 347,45	$ 496 947,66	$ 2 346 557,02



5.1.4 Canada Prenatal Nutrition Program

5.1.4.1 Service Delivery

Of the various actions in place within the broader regional public health action plan, the Canada prenatal nutrition program (CPNP) aims at improving access to healthy foods for pregnant women and new mothers up until the child is 1 year old. Combined with other federal and provincial funds, the CPNP program provides services to families and children in complementarity with programs such as FASD and Ilagiilluta services (SIPPE).

Main local and regional stakeholders recognize food insecurity as a priority issue in the region. With high rates of poverty and the high cost of food, the CPNP Program alleviates the consequences of food insecurity by providing nutritious food for the pregnant women and new mothers, up until the child is 1 year old, through the distribution of store-bought food coupons. Coupons are distributed as part of prenatal and postnatal follow-ups. The follow-ups provide an opportunity for pregnant women to learn about various health topics including the selection of healthy store-bought food, breastfeeding, FASD prevention and the adoption of healthy lifestyles. While this program targets nutritious store-bought food, the need to ensure access to traditional food in Nunavik has been repeatedly voiced within the population. The development of new partnerships with hunters and key organizations will also be explored in the coming years to increase access to traditional food during pregnancy.

A significant part of the funds is transferred to the two regional Health centres, who serve seven remote communities each. Both, UTHC and IHC provide a variety of services to pregnant women, newborns and their families (Midwifery, FASD prevention, SIPPE, etc.). A worker coordinates the CPNP file at the NRBHSS, as part of the Public Health department. This ensures the integration of the program with the other maternal and child health initiatives. The person at the NRBHSS also coordinates regional initiatives for the program, such as program evaluations, training and the development of adapted tools.

5.1.4.2 Goals

- Improve access to nutritious food for pregnant women and new mothers, up until the child is 1 year old, while promoting healthy lifestyles conducive to the overall health optimal development of unborn and newborn children.

5.1.4.3 Health Program Planning

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
CPNP								
Goals: Improve access to healthy store-bought food for pregnant women and new mothers, up until the child is 1 year old, while promoting healthy lifestyles conducive to the overall health optimal development of unborn and newborn children.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- By 2024, 75% of the woman taking part in the coupon program will participate in at least one SIPPE or prenatal activity.	1.1- Work with NRBHSS SIPPE agent and Health centres to ensure implementation of this approach.	Pregnant women Mothers (up until child is 1 year old)	Prevention and health promotion officer (Léa Laflamme)	NRBHSS SIPPE agent Health centres Maternity wards	Ongoing	Nb of women participating in SIPPE/prenatal activities	Integrated approach to maternal and child health	Annual reports from Health centres
	1.2- Distribution of food coupons to pregnant women and new mothers.				Ongoing	Nb of participants in coupon program	Develop a more trusting relationship between professionals and target population	Annual reports from Health centres Receipts from Health centres
2- By 2024, every woman taking part in the coupon program will receive information and counselling (if needed) regarding the following topics: FASD, Breastfeeding, Nutrition, Oral health.	2.1- Work with Health centres to provide resources (tools, teaching materials, etc.).	Pregnant women Mothers (up until child is 1 year old)	Prevention and health promotion officer (Léa Laflamme)	Health centres Maternity wards	Ongoing	Nb of participants having received information and/or counselling on one or more of the identified topics Nb of tools and teaching resources distributed	Integrated approach to maternal and child health	Annual reports from Health centres NRBHSS inventory of distributed resources
3- By 2021, improve CPNP program in accordance with evaluation results.	3.1- Joint evaluation of SIPPE and CPNP programs by external evaluator.	NRBHSS Health centres	Prevention and health promotion officer (Léa Laflamme) and SIPPE agent (T.B.D.)	Health centres Maternity wards	2019-2020	Evaluation report	Improved CPNP program Integrated approach to maternal and child health	Evaluation report
	3.2- Prioritize evaluation recommendations and implement prioritized actions.	Pregnant women Mothers (up until child is 1 year old)			Ongoing as of 2019-2020	Prioritized evaluation recommendations Action plan to implement recommendations	Improved CPNP program Integrated approach to maternal and child health	Evaluation report Action plan

5.1.4.4 Evaluation

A program evaluation is planned with an external evaluator in 2019-2020. This evaluation will contribute to the continuous improvement of the program, by describing:

- How the program contributes to food security;
- How the program affects the access to other services offered to pregnant women and young families (e.g. SIPPE, FASD prevention);
- Identify how it could be improved.

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

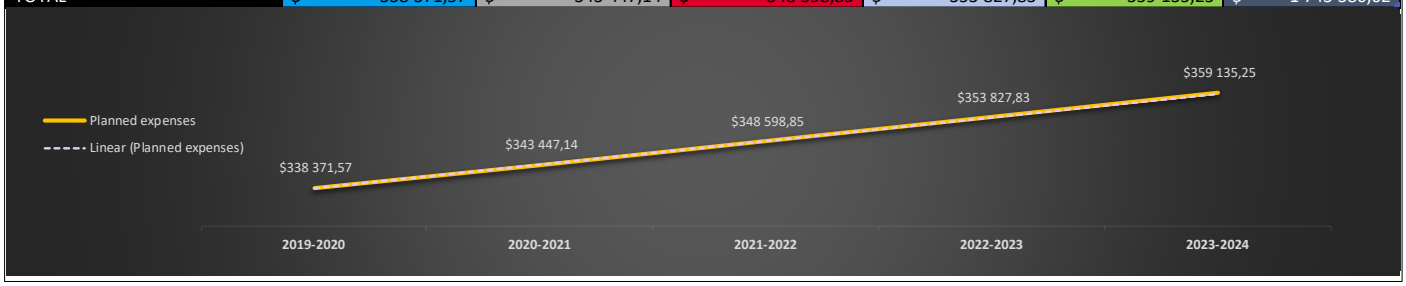
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics included in the survey are food security and nutrition. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.1.4.5 Budget

A conservative indexation of 1.5% was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Canada Prenatal Nutrition Program					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Hudson (55% of the population)	$ 91 247,27	$ 93 983,01	$ 96 759,78	$ 99 578,20	$ 102 438,90	$ 484 007,16
Ungava (45% of the population)	$ 74 656,86	$ 76 895,19	$ 79 167,09	$ 81 473,07	$ 83 813,64	$ 396 005,85
Salary	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 828 500,00
Administration fees	$ 6 767,43	$ 6 868,94	$ 6 971,98	$ 7 076,56	$ 7 182,70	$ 34 867,61
TOTAL	$ 338 371,57	$ 343 447,14	$ 348 598,85	$ 353 827,83	$ 359 135,25	$ 1 743 380,62



5.1.5 Midwifery

5.1.5.1 Service Delivery

There are four birthing centres in Nunavik. Three are on the Hudson Coast, located in Inukjuak, Puvirnituq and Salluit, and one on the Ungava Coast, located in Kuujjuaq. The NRBHSS is trying to expand the services into more communities. The midwives fly to the 10 other communities in order to do follow-ups with the pregnant women there.

The midwifery program's core competencies used as a basis for midwife education and qualification in Nunavik are adapted to practise in the region, but are equivalent to those of the *Ordre des sages-femmes du Québec (OSFQ)* and the Association of Ontario Midwives (AOM). The community midwife's scope of practice is focused on normal pregnancy, birth and postpartum. The Nunavik midwife acts as a team leader in both normal and abnormal situations and, in emergency care. The midwife works in collaboration with other members of the health-care team. The scope of competency for a Nunavik midwife in these areas often extends beyond that of the *OSFQ* and the AOM, due to the nature of practice in a remote region. This program currently has a dozen Inuit graduates.

The birth centres are a midwifery-led collaborative model of care that involves effective teamwork between midwives, physicians, and nurses working in the remote villages and at the sub-regional Health centres. Midwifery education is a key component of the birth centres, and training community members as midwives have both sustained the program and been one of its key elements of success. Currently, there are four midwives working on the Ungava Coast and twelve midwives on the Hudson Coast.

The Department of Inuit Values and Practices is responsible for the midwifery file and the regional framework for the implementation of a regional network of birthing centres within the region, and on the clinical plan for Kuujjuaq's birthing centre. The framework is available at Annex 9.4.

There is no federal funding for midwifery for the time being, hence why there is no program planning included in this document for this specific program. Nonetheless, funding could be transferred to the midwifery initiative should a need arise and unused funding be available.

In addition, should federal funding become available under midwifery, the NRBHSS wishes to be considered for it, as there are ever-growing needs to expand and improve this initiative in the region.

5.1.6 Children's Oral Health Initiative

5.1.6.1 Service Delivery

Preventive and curative dental services are available in the Nunavik region. The Health centres employ dental hygienists who travel across their respective coasts to provide oral health promotion and prevention activities to schools, daycares and CLSCs. Each Health centre also employs dentists who travel across the region to provide care and treatment to patients.

There are seven dentists permanently based in the region (Kuujjuarapik, Inukjuak, Puvirnituq, Salluit, Kangiqsualujjuaq, Kangiqsujuaq and Kuujjuaq). These dentists provide curative care in the village where they are based, but also travel along the coast to provide services to the other villages on a monthly basis. A denturist also visits the villages four times a year and dental surgery is performed in Puvirnituq and Kuujjuaq.

Although these services are available, oral health in Nunavik is alarmingly poor. As mentioned previously, in 2004, 97% of children six and under had at least one cavity.[87] With such a state of health, there needs to be more efforts invested in the promotion of healthy oral habits and primary prevention at an early age. The new funding for the Children's Oral Health Initiative provides the region with this opportunity.

In order to be able to offer better quality services to the children and young families of the region, a new resource will be hired at the NRBHSS. With the support of this new resource, a comprehensive review of services provided in the region, as well as services that are missing or need to be strengthened, will be completed before the end of 2018-2019. Following this review, an action plan will be built in order to fill the gaps identified and reinforce the elements that work best in the current dental services offered.

5.1.6.2 Goals

- Diminish the number of children with tooth decay, by fostering the adoption of good oral health practices in Nunavik children, including healthy nutrition.
- Improve access to preventive care and activities.

5.1.6.3 Health Program Planning

[87] NRBHSS, in collaboration with INSPQ (2015). *Nunavik Health Profile 2014: Young Children and Their Families.* Government of Québec. Retrieved from http://nrbhss.gouv.qc.ca/sites/default/files/Profile_Enfants_Famille_EN.pdf, p. 33

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

Children's Oral Health Initiative (COHI)

Goals:

Diminish the number of children with tooth decay, by fostering the adoption of good oral health practices in Nunavik children, including healthy nutrition.

Improve acces to preventive care and activities.

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- Provide oral health promotion activities accross the region.	1.1- Based on the portrait of available services, develop a regional action plan which includes the activities mentionned below.	Dental health profesionals and paraprofesionals Children	Dental health profesional at NRBHSS (T.B.D.)	Health centres Dental Hygenists (from health centres) KI - Schools KRG - Daycare centres	2019-2020	Action plan	Integrated approach to children's orla health	Action plan Portrait of available services
	1.2- Collaborate with the midwives of the region to ensure the integration of oral health component in prenatal follow-ups.	Pregnant women	Dental health profesional at NRBHSS (T.B.D.)	NRBHSS - IVP Department Midwives	Ongoing as of 2020-2021	Nb of midwives including oral health in their prenatal follow-ups Nb of pregnant women receiving oral information during prenatal follow-ups	Nb of pregnant women adopting good oral health behaviours	Prenatal follow up reports from midwives.
	1.3- Collaborate with Ilagiilluta (SIPPE) teams to ensure integration of oral health component in the interventions with pregnant women and young families.	Pregnant women and young families	Dental health profesional at NRBHSS (T.B.D.)	NRBHSS - SIPPE officer (T.B.D.) Local SIPPE teams	Ongoing as of 2020-2021	Nb of Ilagiilluta teams including oral health in their interventions Nb of pregnant women and young families receiving oral information	Nb of pregnant women adopting good oral health behaviours Number of children with tooth decay	Annual SIPPE reports
	1.3- Support dental hygenists in their school visits (twice a year), by provding training material.	School aged children	Dental health profesional at NRBHSS (T.B.D.)	Dental Hygenists (from health centres)	Ongoing	Number of tools and training material developed and deployed Nb of schools visited Nb of students met	Number of children with tooth decay	Annual reports from Dental hygenists. Inventory of tools and training materials.
	1.4- Support dental hygenists in their daycare visits (twice a year) by providing tools and training material.	Children at daycare	Dental health profesional at NRBHSS (T.B.D.)	Dental Hygenists (from health centres)	Ongoing	Number of tools and training material developed and deployed Nb of daycares visited Nb of children met	Number of children with tooth decay	Annual reports from Dental hygenists. Inventory of tools and training materials.

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

Children's Oral Health Initiative (COHI)

Goals:

Diminish the number of children with tooth decay, by fostering the adoption of good oral health practices in Nunavik children, including healthy nutrition.

Improve acces to preventive care and activities.

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2- All children in Nunavik will have access preventive oral health care.	2.1- Work with health centres to implement a screening process for all elligible children once a year, which includes the application of fluoride varnish.	All children 0 to 7 years old	Dental health profesional at NRBHSS (T.B.D.)	Health centres Dental Hygenists (from health centres)	Ongoing as of 2021-2022	Nb of villages visited Nb of children screened	Number of children with tooth decay	Screening process established. Annual reports from Dental hygenists.
	2.2- Work with health centres to implement a preventive measures clinic twice yearly for application of pit and fissure sealants and alternative restoration treatment.	All children 0 to 7 in need of preventive treatment	Dental health profesional at NRBHSS (T.B.D.)	Health centres Dental Hygenists (from health centres)	Ongoing as of 2021-2023	NB of villages visited Nb of children who received preventive treatments	Number of children with tooth decay	Preventive measures clinic work plan. Annual reports from Dental hygenists.

5.1.6.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

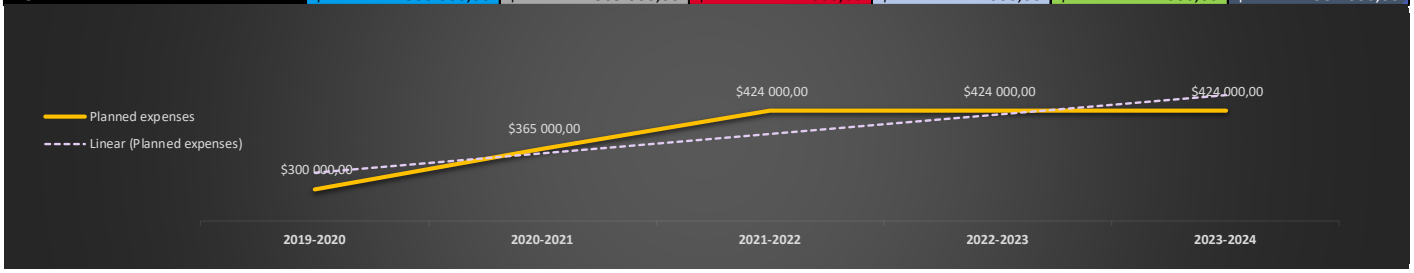
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. One of the health topics included in the survey is oral health. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.1.6.5 Budget

Although funding for COHI has only been confirmed up to 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Children's Oral Health Initiative					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Activities: - Travel fees, salaries, training	$ 294 000,00	$ 357 700,00	$ 415 520,00	$ 415 520,00	$ 415 520,00	$ 1 898 260,00
Administration fees	$ 6 000,00	$ 7 300,00	$ 8 480,00	$ 8 480,00	$ 8 480,00	$ 38 740,00
TOTAL	$ 300 000,00	$ 365 000,00	$ 424 000,00	$ 424 000,00	$ 424 000,00	$ 1 937 000,00



5.2 Mental Wellness

5.2.1 Health Status and Context

On June 11, 2008, Prime Minister Stephen Harper apologized on behalf of all Canadians for "the policy of assimilation" and the terrible pain and suffering endured by aboriginal peoples, including Inuit, who attended Indian residential schools. The apology came after years of hard work, by aboriginal organizations, including Makivik.

In recent years, there have been growing public accounts of abuse at residential schools all across Canada, and increasing numbers of lawsuits and class action suits launched in the courts on behalf of former students. Approximately 80,000 people alive today[88] resided at residential schools operated by the Government of Canada. Of those survivors, 350 are Nunavimmiut.

A major issue affecting Nunavimmiut's well-being is the impact of colonization and the numerous collective traumatic events and societal changes it has instigated. These events have affected the social, family and community structure of all Nunavimmiut, and have initiated a wide array of psychosocial issues.

A large portion of the population is carrying over repeated traumas and losses that lead, in many cases, to post-traumatic stress. If these traumas are not addressed, their effects will continue for generations to come. Intergenerational traumas culminate in various mental health problems, substance abuse issues, behavioural problems, instances of violence and suicide. Systemic factors such as the overcrowding of residential housing, low family income, food insecurity, poor education and loss of culture combined with the difficulty of mental health and addiction services to respond adequately to the current needs also contributes to the prevalence of addictions and various social issues listed above.

According to the 2004 Qanuippitaa health survey[89], alcohol is the most often used substance among both women and men. A proportion of 86.9% of the survey participants stated that they drank alcohol regularly. That consumption was not necessarily daily but it was abusive (more than six drinks per session). What differentiates Nunavik from the rest of Quebec is the way alcohol is consumed. What clearly characterizes alcohol consumption in Nunavik is the high number of binge-drinking episodes, that is, five or more drinks on the same occasion. In 2004, close to one quarter (24%) of the individuals who reported having consumed alcohol during the past year, had engaged in binge drinking at least once a week.[90]

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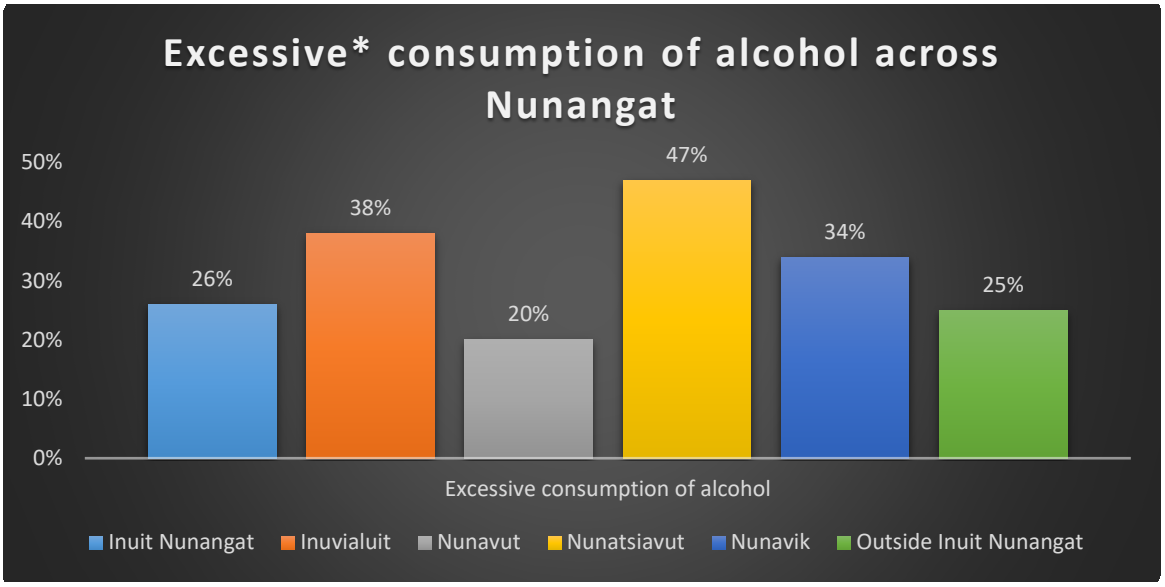
[88] Indigenous and Northern Affairs Canada. (2008, June 11). Statement of apology to former students of Indian Residential Schools. Retrieved from http://www.aadnc-aandc.gc.ca/eng/1100100015644/1100100015649

[89] Institut National de Santé Publique du Québec. (2018). *Nunavik Inuit Health Survey 2004*. Retrieved from https://www.inspq.qc.ca/en/expertise/aboriginal-health/nunavik-inuit-health-survey-2004

[90] Muckle, G., Boucher, O., Laflamme, D. (2007*). Qanuippitaa? How are we? Alcohol, drug use and gambling among the Inuit of Nunavik: Epidemiological profile*. Retrieved from https://www.inspq.qc.ca/pdf/publications/657_esi_alcool_drogues_gambling.pdf, p. 6

Figure 18 Prevalence of excessive alcohol consumption, Nunangat population 15 and older[91]



*Excessive refers to five drinks or more on a single occasion

Also important to note is that alcohol consumption seems to be on the rise. The proportion of occasional and regular alcohol consumers rose to 77% in the population aged 15 years and older in 2004, which represents an increase of close to 17% since 1992. [92]

In this regard, Nunavik posts a high rate of crime perpetrated under the influence of alcohol. According to Kativik regional Police Force, between 2010 and 2013, 70% of assaults were perpetrated under the influence of alcohol. For the same period, 45% of sexual assaults were perpetrated under the influence of alcohol.[93]

Another repercussion of alcohol abuse is the high rate of suspected fetal alcohol spectrum disorder (FASD) cases. Even though only very few medical experts can make a FASD diagnosis, 44% of women reported having drunk alcohol during their last pregnancy in the 2004 health survey.[94]

Whereas drugs are concerned, there is a high rate of cannabis consumption. In 2004, 60% of the respondents indicated having used drugs during the previous year, a proportion four times higher than that observed in the rest of Canada. In 2004, cannabis was the drug most often used (60%), followed by cocaine (7.5%), solvents (5.9%), hallucinogenic (2.7%) and injectable drugs (2.0%).[95]

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[91] Wallace, S. (2014, August). *Inuit Health: Selected findings from the 2012 Aboriginal Peoples Survey*. Retrieved from https://www150.statcan.gc.ca/n1/pub/89-653-x/89-653-x2014003-eng.htm

[92] Idem

[93] Kativik Regional Police Force. (2013). *Annual Report, 2013*, N.D.

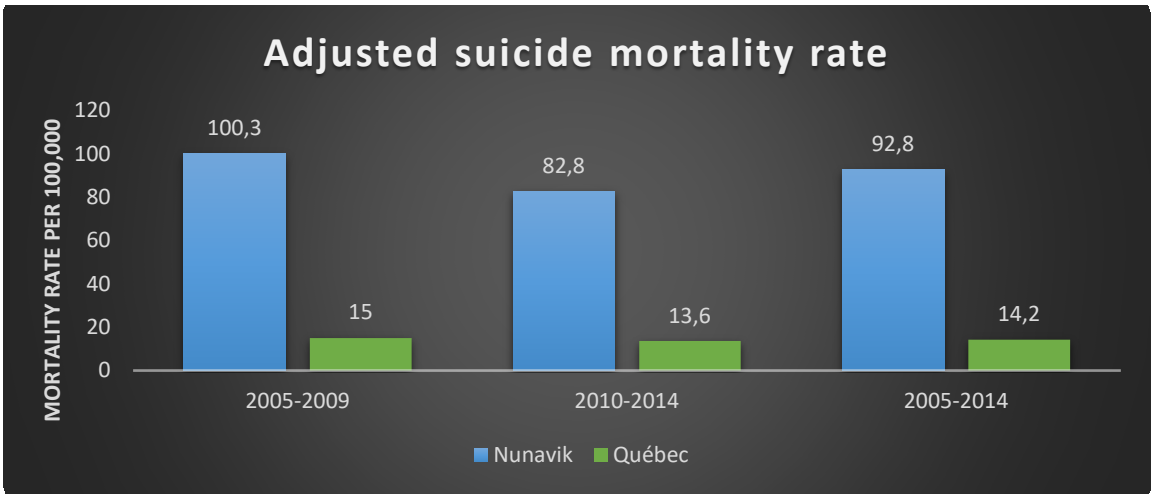
[94] Dodin, S., Blanchet, C. (2007). *Qanuippitaa? How are we? Women's health and preventive sexual behavior among men and women*. Retrieved from https://www.inspq.qc.ca/pdf/publications/665_esi_women_health_sexual_health.pdf, p. 7

[95] Muckle, G., Boucher, O., Laflamme, D. (2007*). Qanuippitaa? How are we? Alcohol, drug use and gambling among the Inuit of Nunavik: Epidemiological profile*. Retrieved from https://www.inspq.qc.ca/pdf/publications/657_esi_alcool_drogues_gambling.pdf, p. 5

Cannabis is by far the most widely used drug in Nunavik, and its consumption is on the rise. Between 1992 and 2004, rates went from 38.3% to 60.2% for the overall population and from 37.5% to 77.7% for those aged 15 to 19.[96] Regular use of cannabis by youths whose brain is still developing increases risk of psychosis and long-term mental problems. The comorbidity of mental health, cannabis use, violent behaviours and legal issues combined with the misunderstanding of mental illness and stigma associated with asking for help, cause late detection of mental illness, difficulties in the treatment and chronic symptoms. An increase of 50% in cocaine use was observed between the two surveys and 100% increase in the use of solvents over the same period.[97] There is serious concern regarding the legalization of cannabis, the impact it will have on the population and how it will be addressed in Nunavik.

Another impact of intergenerational traumas, change of lifestyle, economic and political marginalization, and cultural changes, is the high prevalence of suicide. The incidence of suicide, which could be considered a symptom of the state of mental health, is of great concern in Nunavik. For the period of 2005-2015, the suicide rate was seven times higher than the rate found elsewhere in the province.[98] Suicide also affects young men four times more than women, in fact, men accounted for 77% of suicides in the period covering 2005 to 2016.[99]

Figure 19 Adjusted suicide mortality rate, Nunavik 2005-2014[100]



With such high rates of suicide, all inhabitants of Nunavik have somewhat been affected by suicide in the course of their lifetime. Furthermore, a large percentage of Nunavimmiut have had suicidal thoughts or attempted suicide. "One third of respondents (to the 2004 health survey) reported having had suicidal ideation during their lifetime and one in five had made a suicide attempt."[101] Statistics show that 6.7% made

[96] Ibid, p. 6

[97] Idem

[98] Ministère de la santé et des services sociaux. Fichier des décès 2005-2014 fermé, 2015-2016 provisoires. Compilation Direction de santé publique Nunavik, 6 septembre 2018.

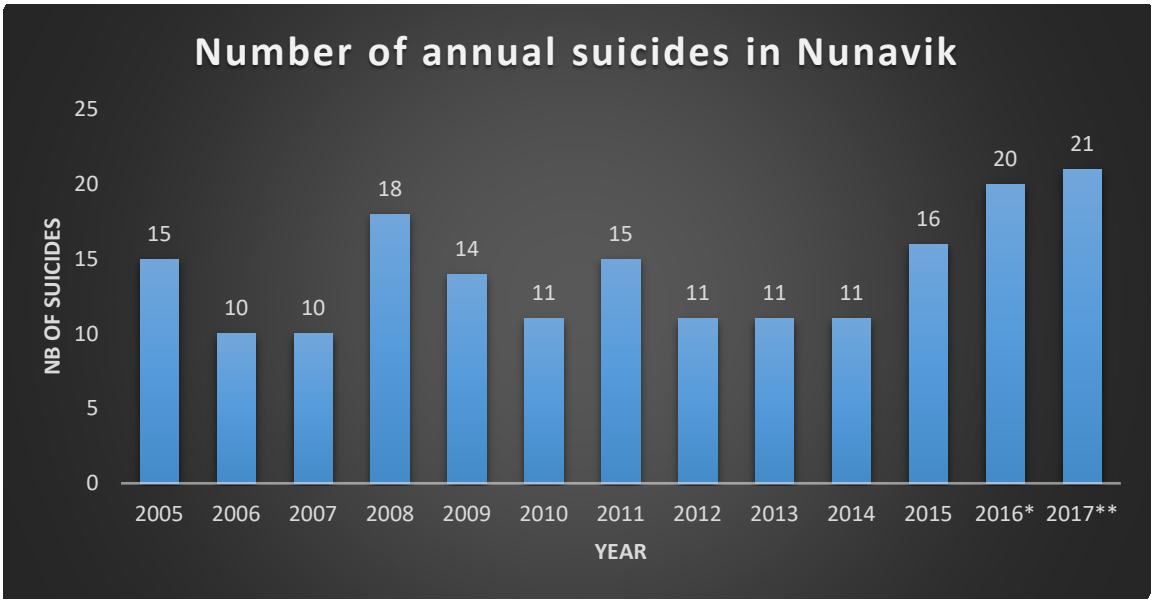
[99] Idem

[100] Idem

[101] Kimayer, L.J., Paul, K. W., (2007*). Qanuippitaa? How are we? Mental health social support and community wellness*. Retrieved from https://www.inspq.qc.ca/pdf/publications/666_esi_mental_health.pdf, p. 9

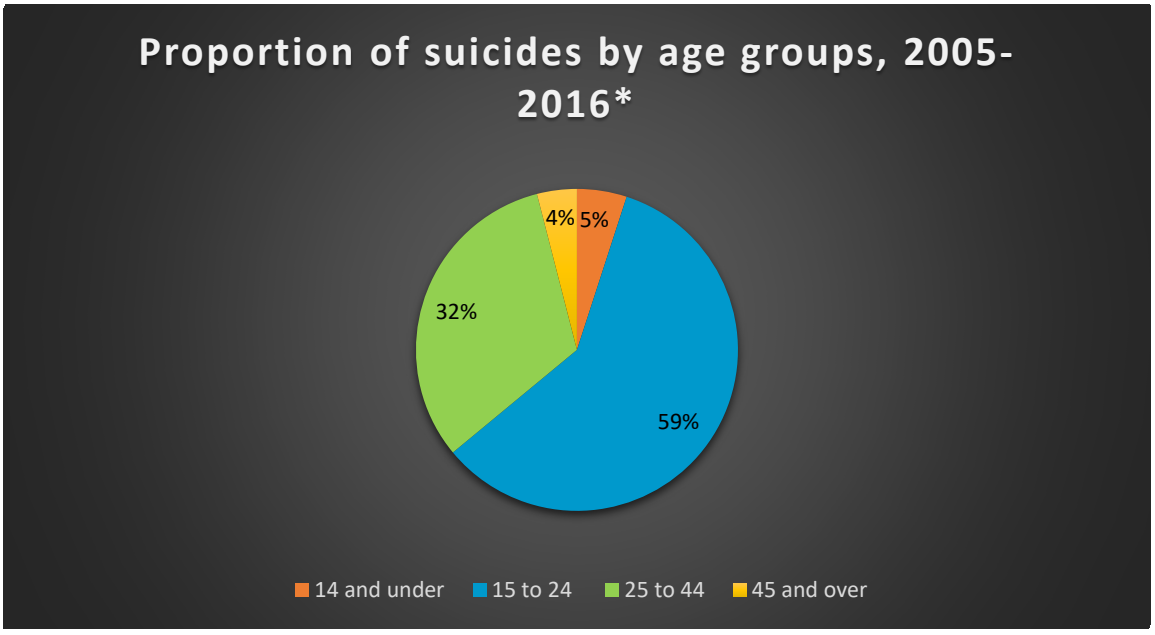
an attempt during the 12 months preceding the survey.[102] Over the past 30 years, rates of suicidal behaviour have risen dramatically in Nunavik.

Figure 20 Number of annual suicides in Nunavik[103]



*&** Provisional data

Figure 21 Proportion of suicides by age group, 2005-2016*[104]



*Provisional data

[102] Idem
[103] Ministère de la santé et des services sociaux. Fichier des décès 2005-2014 fermé, 2015-2016 provisoires. Compilation Direction de santé publique Nunavik, 6 septembre 2018.
[104] Idem

In the 2004 Nunavik health survey, 13% of the population reported experiencing a high level of psychological distress and was considered more likely to become depressed or develop other mental-health problems. Women, youths (aged 15 to 29 years) and individuals with low income reported the highest levels of psychological distress. This distress appears to be linked to the consumption of alcohol and drugs as well as a history of sexual violence and exposure to physical violence in a family or conjugal context.[105]

Therefore, understanding the sources of mental health, resilience and well-being is of crucial importance to public health efforts in Nunavik. According to the Nunavik Inuit Health Survey of 2004 on mental health and well-being almost 3 out of 4 people in Nunavik were satisfied or very satisfied with their life. As for social support, only 1 in 3 people reported they had someone to turn to when they needed help. Women reported higher levels of social support than men did. However, women, youth (aged 15-29) and those with lower incomes reported higher levels of emotional distress. Emotional distress is also associated with alcohol and substance use, a history of sexual abuse, and exposure to domestic violence.

The concept of health and wellness is holistic. It encompasses various elements that contribute to a healthy and well-balanced individual all the while grounding said individual in the broader context of his community. "Research summarized by Health Canada (2005) indicates the following factors are supports to positive mental health: family and community support; sense of belonging; positive self-esteem; skills in problem solving; cultural values and religious beliefs; positive attitude toward school; early identification and appropriate treatment of psychiatric illness; and easy access to a variety of medical and psychological services."[106]

In order to foster positive mental health, focus also needs to be on supporting factors, such as family and culture. As an example, Nunavimmiut women generally give birth for the first time at an early age and have a much higher birth rate than the provincial average. Nunavik's population has a very large proportion of young people. As mentioned in the demographic profile of this document, 34% of the inhabitants are under 15 years and the average age is 26[107], a little less than half that of the province as a whole (41,9)[108]. Considering the social and mental issues faced young families, it is important to provide them with support so that they can develop their parenting abilities and begin to make changes to limit the effects of substance abuse or mental health issues on their own lives and those of their children.

The following sections present the service delivery, program planning and budget for all mental wellness related federal funding.

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[105] Kimayer, L.J., Paul, K. W., (2007*). Qanuippitaa? How are we? Mental health social support and community wellness*. Retrieved from https://www.inspq.qc.ca/pdf/publications/666_esi_mental_health.pdf, p. 9

[106] Inuit Tapiriit Kanatami. (2014, September). *Social determinants of Inuit health in Canada*. Retrieved from https://www.itk.ca/wp-content/uploads/2016/07/ITK_Social_Determinants_Report.pdf, p. 34

[107] Idem

[108] Statistics Canada. (2018, May 30). Age and sex Highlight Tables, 2016 Census. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/as/Table.cfm?Lang=E&T=31

5.2.2 Indian Residential School

5.2.2.1 Service Delivery

The Indian Residential Schools Resolution Health Support Program (IRS-RHSP) provides mental-health and emotional-support services to eligible former Indian residential-school students and their families throughout all phases of the Indian Residential School Settlement Agreement, including: Common Experience Payments (CEP), Independent Assessment Process (IAP), Truth and Reconciliation Commission (TRC) and commemorative activities. Services under the Resolution Health-Support Program are safe, confidential, respectful and non-judgmental.

The Department of Inuit Values and Practices (IVP) of the NRBHSS is in charge of the Indian residential school file. The emotional-health support team of IVP visits the communities to organize healing sessions for former students and their families affected by the legacy of residential schools.

The emotional-health support team has a set schedule to visit at least five communities per year where they offer workshops on different topics. They provide training to health support workers in communities, on issues that affect former students, community wellness, job-related skills, etc. The team also works in collaboration with the suicide prevention workers and the Good touch and Bad Touch Program (sexual abuse prevention program). Local support workers offer emotional support to former students of residential schools and their families. The team also visits communities that need support for crisis or trauma upon request.

5.2.2.2 Goals

- Promoting healing and reconciliation among youth and intergenerational survivors;
- Helping Nunavimmiut, understand the impacts that the legacy of Indian residential schools has had on them and the communities in order to promote the development of new partnerships for the future;
- Support former students and their families.

5.2.2.3 Health Program Planning

Indigenous Services Canada provided a template for the work plan. Because the Indian residential school initiative is not permanent, the federal government is unable to guaranty the renewal, for this initiative beyond 2019-2020. In this context, an exhaustive planning was not developed. Below is the work plan that was developed by the NRBHSS and approved by Indigenous Services Canada, for the period of April 1, 2018, to March 31, 2020.

IRS 2018-2019/2019-2020				
Objective	**Tasks/Activities**	**Explain how your organization has or will complete each task**	**Number of anticipated Participants**	**Date activity is expected to be completed**
Hire the appropriate number of RHSWs and CSPs to support former IRS students and their families who are eligible for the services offered by your IRS RHSP.	• Assess the number of former IRS students who are eligible to use the services offered by your organization.	Keep track of people we met and continue to record the number of former students. Record number of family members met.	350	April 2018-March 2019 April 2019-March 2020
	• Ensure that eligible former IRS Students can safely address a broad spectrum of wellness issues related to the disclosure of childhood abuse(s).	• Provide counselling and follow-up weekly; • FM Information session; • Provide on the land healing so that former students or family members can safely do their work.	5000	April 2018-March 2019 April 2019-March 2020
	• Hire CSP who are recognized by their communities as respected elders and who are comfortable delivering their services under this program.	We have 4 part-time workers mainly for cultural support. They are also available to be RHSW. We will be using 2 culture support during our community healing at a time (Elisapie Tookkalak, Louisa Cookie, Lolly Annahatak, new worker Qialak Nappaluk from Kangirsujuuaq). Hire two new trainees. Mentor natural helpers (youth) who can support community youth. We will hire 2 youth workers- part time.		April 2018-March 2019 April 2019-March 2020
	• Ensure that all health supports workers have completed a criminal check prior to beginning work.	A security check will be performed on new employees.	All employees	April 2018-March 2019 April 2019-March 2020

IRS 2018-2019/2019-2020				
Objective	**Tasks/Activities**	**Explain how your organization has or will complete each task**	**Number of anticipated Participants**	**Date activity is expected to be completed**
	• Ensure health support workers have access to regular clinical supervision and support which includes debriefing.	We have our regular meeting every Monday's, with a prayer and a regular update of new progress in our program. Meet with individual workers weekly or every second week at the latest. Debriefing is an important part of the mutual support. Debriefing done by everyone.	All employees	April 2018-March 2019 April 2019-March 2020
	• Ensure client files are up to date, confidential, and kept in a secure place.	Files are locked in a cabinet. Only the workers have access.		April 2018-March 2019 April 2019-March 2020
	• Assist each health support worker in the development of his or her self-care plan and to monitor its status on a regular basis.	Workers are aware of the importance of balance and self-care. Self-care plans need to be revisited and made stronger. (Have new employees and plans will be updated if needed.)		April 2018-March 2019 April 2019-March 2020
	• Provide training to health support workers on issues concerning former students, communities, wellness, and job-related skills. Promote participation of health supports at IRS RHSP training opportunities.	Training is always offered to the workers. Training plans will be developed accordingly. We are researching the possibility of using the Crisis and Trauma Resource Institute, Inc. to do an enhanced version of working with clients who have experienced multiple trauma work. This presentation would be delivered on each coast (Ungava and Hudson), one in the Ungava Coast and another in the Hudson Coast depending on the needs.	25 workers on each coast	April 2018-March 2019 April 2019-March 2020
Former students and their families are informed of the program.	Provide IRS RHSP information sessions to communities	We have 4 full-time workers and each will be given a workshop on different topics.	**(2018)** Akulivik	April 2018- March 2019 April 2019- March 2020

IRS 2018-2019/2019-2020				
Objective	**Tasks/Activities**	**Explain how your organization has or will complete each task**	**Number of anticipated Participants**	**Date activity is expected to be completed**
	We plan on going to 5-7 communities to do workshops, information session and healing workshop.	We will work in partnership with the social worker and the family centre – mini healing workshops in communities. These two years we will be focusing more on the effect of intergenerational trauma on youth and look more into healing with men's group. This would be the 4th year we will be focusing on Trauma and Grieving.	Kuujjuarapik Umiujaq Inukjuak Kuujjuaq Tasiujaq **(Also 2019):** Salluit, Ivujivik, Kangirsuk, Kangirsualujjua, Inukjuak and Kuujjuarapik	
	Provide IRS RHSP information sessions to partners.	Present at the Mayor's meeting. (once or twice a year); Present at the NRBHSS AGM (once a year); Present to CLSCs in each community we visit; Present to other programs at NRBHSS (once a year); Present to Police teams (once a year); Present during each treatment session to participants; Present to teachers in communities where we visit;	As per partner schedules	April 2018- March 2019 April 2019- March 2020

IRS 2018-2019/2019-2020				
Objective	**Tasks/Activities**	**Explain how your organization has or will complete each task**	**Number of anticipated Participants**	**Date activity is expected to be completed**
	Work with partners to respond to needs of former students and their families. Attend to the holistic needs of the clients in partnership with other services (emotional, physical, mental, and spiritual)	Inform clients of their right to all services and assist them in accessing these services.	All clients	April 2018- March 2019 April 2019- March 2020
Coordinate services to former students and their families	Respond to requests for **services** for former students or family members from Quebec Regional office, former students (and family) or other persons. Respond to requests for services within the shortest delay. All the RHSP are expected to report to the coordinator to make sure follow up are respected and professional.	Priorities are important to our clients and the response should be done confidentially and be respectful to all clients. Calls for service need to be within 24 hours.	All workers All clients	April 2018- March 2019 April 2019- March 2020
	RHSW and CSP provide health support services to eligible former students and their families before, during and following each component of the Settlement Agreement: • Common Experience Payment (CEP) • Independent Assessment Process (IAP) • Persons of Interest (POI)	Although the Settlement Agreement is winding down, our work with individuals, families and communities is increasing. Symptoms of the legacy of residential schools (suicides, addiction, MMIWG, violence) are becoming better understood as to their beginnings.	4,000 to 5,000 former students and family members	April 2018- March 2019 April 2019- March 2020
	Promote the gathering of former students in each community to honour their history.	Many activities are already organized via other programs (Brighter Futures) and organizations within the communities for the elders		April 2018- March 2019 April 2019- March 2020

IRS 2018-2019/2019-2020				
Objective	**Tasks/Activities**	**Explain how your organization has or will complete each task**	**Number of anticipated Participants**	**Date activity is expected to be completed**
		and former students. The goal here is to promote wellness within the communities.		
	Ensure that former students are aware of updates to the Settlement Agreement.	Use FM radio, phone contact and newsletters. Radio works very well.	All communities	April 2018- March 2019 April 2019- March 2020
Former students are aware of the resources available to them	Identify regional partners and keep an up-to-date list.	Keep maintaining the list up to date.		April 2018- March 2019 April 2019- March 2020
	Develop and maintain a list of resources available to former students	Keep maintaining the list up to date.		April 2018- March 2019 April 2019- March 2020
	Review information and regular updates on the following websites: • Indigenous Services Canada (ISC), FNIHB, IRS RHSP • Aboriginal Affairs and Northern Development IRSSA (ADR, CEP, IAP) • www.nibtrust.ca	Reviewing when necessary.		April 2018- March 2019 April 2019- March 2020
Reports for ISC are submitted as per the schedule	Respond to IRS RHSP, Quebec Region, ISC reporting requirements. RHSP and the Coordinator is expected to do the reporting with her boss to make sure it is done for the reporting period.	RHSP workers are expected to do their monthly stats on time and keep file updated of their clients.	All workers	Every 3 months April 2018- March 2019 April 2019- March 2020

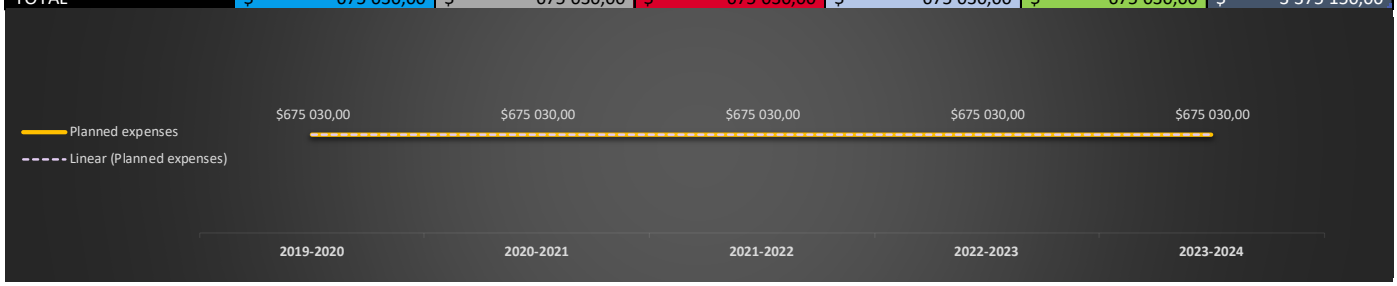
5.2.2.4 Evaluation

Data is collected in order to report 4 times per year to Indigenous Services Canada. This data is compiled at the end of the year in the annual activity report. There is no long-term evaluation process planned for this initiative.

5.2.2.5 Budget

Although funding for IRS has only been confirmed up to 2019-2020, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Indian Residential School					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses
Emotional-health support team workshops on different topics	$ 495 829,40	$ 495 829,40	$ 495 829,40	$ 495 829,40	$ 495 829,40	$ 2 479 147,00
Salary	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 828 500,00
Administration fees	$ 13 500,60	$ 13 500,60	$ 13 500,60	$ 13 500,60	$ 13 500,60	$ 67 503,00
TOTAL	$ 675 030,00	$ 675 030,00	$ 675 030,00	$ 675 030,00	$ 675 030,00	$ 3 375 150,00



5.2.3 Mental Wellness Teams

5.2.3.1 Service Delivery

The Mental Wellness Teams (MWT) funding is a new initiative for Nunavik, which provides the region with an opportunity to work closely with communities and develop an approach which will increase local services and fulfill certain gaps.

At the NRBHSS, the IVP department leads this new initiative. The department plans on hiring a resource to coordinate the MWT file. As part of their mandate, the new resource will work with Health centres, community representatives and the Community Wellness Committees, to help identify natural helpers. Natural helpers will become part of a formal network supported and coordinated by IVP. They will also become part of their local mental health/wellness network and provide culturally-safe and community-based mental wellness services. In order to achieve this, the IVP department will work with the Health centres to build a framework for the work of the natural helpers and establish clear partnerships.

In order to deploy a solid program, the implementation will be done in phases, allowing for the evaluation and continuous improvement of the program. The first year, the program will be implemented in two communities, the year after, it will be expanded to include four new communities and eventually reach all fourteen communities.

5.2.3.2 Goals

- Increase local mental wellness services by creating and supporting a Natural helper's network.

5.2.3.3 Health Program Planning

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

Mental Wellness Teams

Goals: Increase local mental wellness services by creating and supporting a Natural helper's network.

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- Build and implement a Mental Wellness Team (MWT) framework.	1.1- Hire a resource to coordinate MWT file.		IVP Director (Elena Labranche)	NRBHSS Administrative department	2018-2019	Resource hired		
	1.2- With the collaboration of regional partners, develop a framework for MWTs (Natural helpers).	All Nunavimmiut	Planning and programming officer (T.B.D.)	Health centres / CLSCs Community Wellness Committees Community Wellness Coordinators NRBHSS Mental health agent	2019-2020	Framework developed Nb of partners involved	Creation of partnerships	Meeting minutes Formal agreements with partners
	1.3- With the collaboration of regional partners, identify and recruit Natural helpers. 1.3.1- In Kuujjuaq and Puvirnituq 1.3.2- In 4 additional communities 1.3.3- In all remaining communities	Natural helpers			Ongoing as of 2019-2020	Nb of Natural helpers identified - by community and age group Nb of Natural helpers recruited - by community and age group		List of Natural helpers recruited
	1.4- Build an evaluation component that could include tools such as reporting templates for Natural helpers, surveys and evaluation forms.	Natural helpers Planning and programming officer			2019-2020	List of tools developed	Continuous improvement	Results of established evaluation process
	1.5- Deploy MWT (Natural helpers) framework in Kuujjuaq and Puvirnituq.	All Nunavimmiut			Ongoing as of 2021-2022	Nb of communities in which framework is deployed Nb of local partnerships	Nb of interventions Nb individuals referred by Natural helpers	Reports from partners and Natural helpers in accordance with evaluation process (1.4) Report from Planning and programming officer
	1.6- Deploy MWT (Natural helpers) framework in 4 additional communities.	All Nunavimmiut			Ongoing as of 2022-2023	Nb of communities in which framework is deployed Nb of local partnerships	Nb of interventions Nb individuals referred by Natural helpers	Reports from partners and Natural helpers in accordance with evaluation process (1.4) Report from Planning and programming officer
	1.7- Deploy MWT (Natural helpers) framework in remaining communities.	All Nunavimmiut			Ongoing as of 2023-2024	Nb of communities in which framework is deployed Nb of local partnerships	Nb of interventions Nb individuals referred by Natural helpers	Reports from partners and Natural helpers in accordance with evaluation process (1.4) Report from Planning and programming officer

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Mental Wellness Teams								
Goals: Increase local mental wellness services by creating and supporting a Natural helper's network.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2- Empower Natural helpers to provide high quality mental wellness services in collaboration with local partners/network.	2.1- Provide one on one support to Natural helpers over the phone and in person.	Natural helpers	Planning and programming officer (T.B.D.)	Health centres / CLSCs Community Wellness Committees Community Wellness Coordinators NRBHSS Mental health agent	Ongoing as of 2021-2022	Nb of one on one support sessions provided List of topics covered	Natural helpers are confident in their role Turnover rate	Report from Planning and programming officer
	2.2- Support the network of Natural helpers by holding a monthly call with the group.	Natural helpers			Ongoing as of 2021-2022	Nb of calls held Nb of participants List of topics covered	Natural helpers are confident in their role Turnover rate	Report from Planning and programming officer Meeting minutes

5.2.3.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

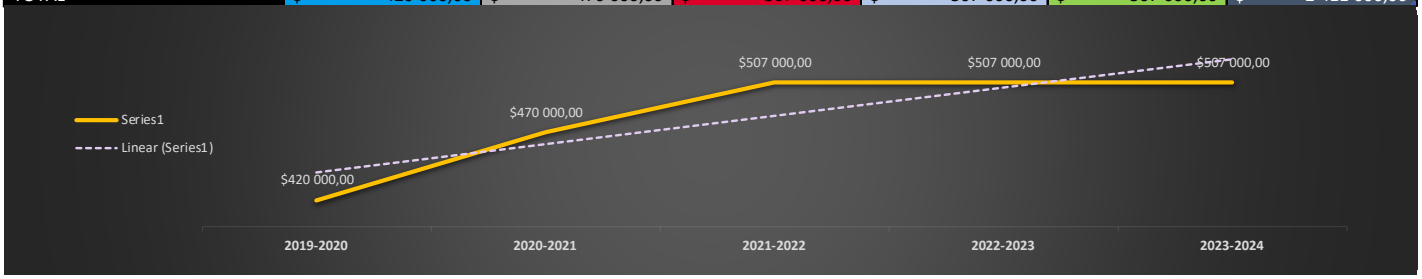
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics that were included in the survey are mental health and resilience, as well as the sociocultural determinants of health. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.2.3.5 Budget

Although funding for MWT has only been confirmed up to 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Mental Wellness Teams					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses
NRBHSS Salary	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 828 500,00
Transfer to Health centers	$ 235 900,00	$ 274 900,00	$ 306 160,00	$ 306 160,00	$ 306 160,00	$ 1 429 280,00
Training	$ 10 000,00	$ 20 000,00	$ 25 000,00	$ 25 000,00	$ 25 000,00	$ 105 000,00
Administration fees	$ 8 400,00	$ 9 400,00	$ 10 140,00	$ 10 140,00	$ 10 140,00	$ 48 220,00
TOTAL	$ 420 000,00	$ 470 000,00	$ 507 000,00	$ 507 000,00	$ 507 000,00	$ 2 411 000,00



5.2.4 Building Healthy Communities – Community Liaison Wellness Worker

5.2.4.1 Service Delivery

To be efficient and respond to the needs of each community, local services in Nunavik must ensure community involvement. In other words, actions based on community members' involvement and on the traditional Inuit cultural system will optimize chances of success for prevention and care initiatives. A community approach requires decentralization of services.

In order to achieve this, a decentralized approach was developed for the Building healthy communities program – Community liaison wellness worker (CLWW). This program involves three levels of actors: regional, sub-regional and local.

At the regional level, the Planning and Programming Department of the NRBHSS is in charge of supporting the development of the CLWW program through an agent that specializes in mental health and ensures the implementation of the program across the region. This includes the development of community-specific activities and reporting.

At a sub-regional level, two Community Wellness Coordinators (CWCs), one per coast, under the Department of Community Services of each health centre, are responsible for hiring and supporting CLWWs in their role. The CWC for the Hudson Coast manages 10 CLWW positions and the CWC for the Ungava Coast manages 7 CLWW positions. The coordinators are also responsible for identifying sub-regional (by Coast) priorities and training needs with the CLWWs. They strongly support the development of community-specific activities and programming.

At a local level, the role of the CLWW is to help improve the delivery and quality of health and social services in their community. The CLWW must therefore build links with CLSC professionals, the local Community Wellness Committee, other community organizations, and individuals of their community.

The CLWW also has the mandate to:

- Establish priorities for action in his community, in partnership with his collaborators;
- Promote, develop and participate in activities aiming to improve the population's health and well-being;
- Promote the CLSC's services within the community;
- Facilitate collaborative ties between the various local organizations and government programs and;
- Promote partners' comprehension of Inuit culture, practices, and traditions.

Each community has a Community Wellness Committee, for which the CLWW acts as a secretary. Members of the committee include representatives of the Health centre Board of Directors, members of municipal council and community members who are interested and want to make a difference in the well-being of their community. This wellness committee is the main support network for CLWWs at a local level.

The Building healthy communities program funding comes from various sources. Indigenous Services Canada provides funding for the salaries of the CWCs and the CLWWs. Funding for community activities is provided by the provincial government, as well as through funding requests addressed to NRBHSS programs and other regional or

local organizations. The Public Health department of the NRBHSS has also developed linkages and partnerships with CWCs and CLWWs by providing support for various prevention and promotion activities and programs.

5.2.4.2 Goals

- Increase wellness in the population through awareness and prevention.
- Provide a structured framework to Community Liaison Wellness Workers (CLWWs) and work with the Nunavik Regional Board of Health and Social Services (NRBHSS) to support the implementation of the program.
- Provide a structured framework to Community Liaison Wellness Workers (CLWWs) and Community Wellness Coordinators (CWCs) to support them in their work.

5.2.4.3 Health Program Planning

The following Health Program Planning was developed in collaboration with several actors of each level. The Health program Planning aims to strengthen the program in general, secure funding from Indigenous Services Canada and increase the overall wellness of the population.

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Building Healthy Communities - CLWW								
Goals: 1- Increase wellness in population through awareness and prevention.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1.1- By 2024, every Community Liaison Wellness Worker (CLWW) will have generated a form of community engagement surrounding the priorities.	1.1.1- Establish dialogue with community members on sub-regional priorities (over radio, local Facebook page, face-to-face exchange, etc.)	Community members of 14 communities	CLWWs	CWCs Wellness Committees	Ongoing	Nb of exchanges/dialogues Nb of participants	Improvement of community awareness regarding the CLWWs role	Feedback from community members (activities evaluation forms) and Feedback from CLWWs during annual meeting (minutes and evaluation forms)
	1.1.2- Organize public awareness/education activities based on priorities.	Community members of 14 communities	CLWWs	CWCs Wellness Committees	Ongoing	Nb of activities per priority Nb of participants	Improvement of community awareness	Feedback from community members (activities evaluation forms) and Feedback from CLWWs during annual meeting (minutes and evaluation forms)
1.2- By 2024, every CLWW will have strengthened and/or created links with local organizations and the CLSC.	1.2.1- Pursue the development and the implication of the Wellness Committees.	Wellness Committees	CLWWs	CWCs	Ongoing	Nb of Wellness Committees held Nb of committee members participating in activities	Greater implication of the Wellness Committee members in CLWW led initiatives	Excel reporting file/document
	1.2.2- Build links with local men organizations to develop projects/activities implicating men.	Inuit men and organizations/groups of the 14 communities	CLWW	Wellness Committees	Ongoing	Nb of projects/activities developed in collaboration. Nb of participants in the activities.	Better service offer for men	Excel reporting file/document
	1.2.3- Where possible, create a local prevention working committee to implicate various actors in the prevention actions led by the CLWW.	Active community members who want to get involve	CLWWs	Wellness Committees	Ongoing	Creation of committee Nb of members Nb of meetings	Greater community engagement. CLWWs feel supported	Feedback from CLWWs during annual meeting (minutes and evaluation forms) Excel reporting file/document
	1.2.4- Create better links with the CLSC employees and programs in order to better collaborate on various projects.	Community members of the 14 communities and CLSC staff	CLWWs	CLSC staff	Ongoing	Nb of projects/activities developed in collaboration Adaptation of CLSC services to Inuit culture	Greater engagement from partners (CLSCs and community org.) CLWWs feel supported	Feedback from CLWWs during annual meeting (minutes and evaluation forms) Excel reporting file/document

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Building Healthy Communities - CLWW								
Goals: 1- Increase wellness in population through awareness and prevention.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1.3- By 2024, organize prevention activities based on the identified priorities.	1.3.1- Develop and promote a prevention activities calendar based on priorities.	All community members	CLWWs	CWCs Wellness Committees CLSC staff	Ongoing as of 2019-2020	Calendar developed Calendar promoted (identify way it was promoted)	CLWWs feel better equipped and organized	Feedback from CLWWs during annual meeting (minutes and evaluation forms) Excel reporting file/document
	1.3.2- As included in activities calendar, develop and organize at least 2 regular prevention activities twice a month.	All community members	CLWWs	CWCs Wellness Committees CLSC staff	Ongoing as of 2019-2020	Nb of activities Nb of participants Nb of priorities addressed	A core group is mobilized, trusting relationships are built and more sensitive subjects can be addressed. Increased awareness and wellness for community members.	Feedback from community members (activities evaluation forms) and Feedback from CLWWs during annual meeting (minutes and evaluation forms) Excel reporting file/document
	1.3.3- Develop and organize occasional prevention activities throughout the year, as included in the activities calendar	All community members	CLWWs	CWCs Wellness Committees CLSC staff	Ongoing	Nb of activities Nb of participants Nb of priorities addressed	Increased awareness and wellness for community members.	Feedback from community members (activities evaluation forms) and Feedback from CLWWs during annual meeting (minutes and evaluation forms) Excel reporting file/document

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Building Healthy Communities - CLWW								
Goals: 2- Provide a structured framework to Community Liaison Wellness Workers (CLWWs) and work with the Nunavik Regional Board of Health and Social Services (NRBHSS) to support the implementation of the program.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2.1- Improve structure of the program.	2.1.1- In collaboration with CLWWs, update sub-regional priorities every 2 years.	CLWWs and the 14 communities	Community Wellness Workers (CWCs)	CLWWs	Next update 2020-2021	Updated priorities	CLWWs feel they have clear orientations for their work	Feedback from CLWWs during annual meeting (minutes and evaluation forms)
	2.1.2- In collaboration with the regional and local levels, structure the reporting and evaluation process to ensure a consistent approach.	CLWWs	CWCs	NRBHSS Mental health agent (Laurence Millette) CLWWs	2019-2020	Excel reporting file/document developed Nb of CLWWs using the tool	Better quality data is collected	Excel reporting file/document
	2.1.3- Improve and facilitate access to funding for local projects by working with the Health centres and the regional level (NRBHSS) (See activity 3.2.1)	CLWWs and the 14 communities	CWCs	NRBHSS Mental health agent (Laurence Millette) Federal agreement officer (Julie Duquette) NRBHSS Healthy living coordinator (Véronique Dion-Roy)	2019-2020	Streamlined access to funding Process to access funding is know and used	CLWWs are concentrating on projects rather than securing funding.	Feedback from CLWWs during annual meeting (minutes and evaluation forms)
2.2- Improve ongoing support to CLWWs and increase retention of workers.	2.2.1- Hold regular team meetings (calls, videoconferences and possibly one face to face) with CLWWs to provide coaching, information and encourage exchanges on best practices on program management and sub-regional priorities.	CLWWs	CWCs	NRBHSS Mental health agent (Laurence Millette)	Ongoing, starting fall 2019	Nb of meetings Nb of participants	CLWW turnover rate Overall satisfaction of CLWW Nb of CLWWs that feel supported and equipped to do their job	Feedback from CLWWs during annual meeting (minutes and evaluation forms) Staff turnover rate
	2.2.2- Provide new CLWWs with a binder of information to help guide them in their new position.	CLWWs	CWCs	NRBHSS Mental health agent (Laurence Millette)	Inuulitsivik Health centre: Ongoing Ungava Tulattavik Health centre: ongoing as of 2020-2021	Nb of binders given to new employees	CLWW turnover rate Overall satisfaction of CLWW Nb of CLWWs that feel supported and equipped to do their job	Feedback from CLWWs during annual meeting (minutes and evaluation forms) Staff turnover rate
	2.2.3- Identify training needs with CLWWs (based on priorities) and organize 1 local and sub-regional trainings per year.	CLWWs	CWCs	NRBHSS Mental health agent (Laurence Millette)	Ongoing as of 2019-2020	List of training needs Nb of trainings organized	CLWW turnover rate Overall satisfaction of CLWW Nb of CLWWs that feel supported and equipped to do their job	Feedback from CLWWs during annual meeting (minutes and evaluation forms) Staff turnover rate

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

Building Healthy Communities - CLWW

Goals: 3- Provide a structured framework to Community Liaison Wellness Workers (CLWWs) and Community Wellness Coordinators (CWCs) to support them in their work.

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
3.1- Support CLWWS and CWCs in their work by providing clear guidelines and planning framework based on sub-regional priorities.	3.1.1- Build program development plan and structure on a 2 year basis, based on identified priorities.	CWCs CLWWs	NRBHSS Mental health agent (Laurence Millette)	CWCs	2019-2020	Program plan developed	CLWW and CWC have clear directions and timeframe/planning	Program plan document
	3.1.2- Develop training plan based on priorities and identified needs, which includes a regional and sub-regional component.	CWCs CLWWs	NRBHSS Mental health agent (Laurence Millette)	CWCs	2019-2020	Training plan developed	Regional and sub-regional trainings are planned in advance and are in line with priorities and need.	Training plan
	3.1.3- Organize 1 regional training per year, based on training plan (3.1.2).	CWCs CLWWs	NRBHSS Mental health agent (Laurence Millette)	CWCs	Ongoing	Nb of regional trainings organized Nb of participants	CLWWS and CWCS feel better equipped to do their work.	Training evaluation forms
	3.1.4- Create a communication strategy aimed at the health and social services network to help partners understand the program and encourage a better use of human resources (CLWWs).	Health and social services network partners	NRBHSS Mental health agent (Laurence Millette)	NRBHSS Communication team CWCs	2020-2021	Communication strategy developed Communication strategy deployed (Nb of communication activities)	Communication, understanding and partnerships take place more smoothly.	Feedback from CLWWs and NRBHSS agents during annual meeting (minutes and evaluation forms)
	3.1.5- Create linkages with other programs at the NRBHSS level in order to create a coherent approach to the CLWW program and a better use of human resources (CLWWs).	CWCs CLWWs	NRBHSS Mental health agent (Laurence Millette)	CWCs Other NRBHSS departments	Ongoing	Nb of partnerships developed or sustained	Communication, understanding and partnership take place more smoothly.	Feedback from CLWWs and NRBHSS agents during annual meeting (minutes and evaluation forms)

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Building Healthy Communities - CLWW								
Goals: 3- Provide a structured framework to Community Liaison Wellness Workers (CLWWs) and Community Wellness Coordinators (CWCs) to support them in their work.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
3.2- Improve ongoing funding access for the CLWWs.	3.2.1- Work at the Health centre and NRBHSS levels to develop streamlined access to funding for CLWWs.	CWCs CLWWs	NRBHSS Mental health agent (Laurence Millette) Federal agreement officer (Julie Duquette)	Health centres NRBHSS Healthy living coordinator (Véronique Dion-Roy)	2019-2020	Streamlined access to funding Process to access funding is known and used	CLWWs are concentrating on projects rather than securing funding.	Feedback from CLWWs and CWCs during annual meeting (minutes and evaluation forms) Budget plans in place for each Health centre (CWCs)
3.3- Support CWC and CLWWs.	3.3.1- Host an annual regional meeting with all CLWWs, CWCs and regional partners (other programs, associations, etc.).	CWCs CLWWs	NRBHSS Mental health agent (Laurence Millette)		February of each year	Meeting held Nb of participants	Continuous improvement of the program and CLWWs and CWCs concerns and recommendations are taken into account	Feedback from CLWWs and NRBHSS agents during annual meeting (minutes and evaluation forms)
	3.3.2- Organize 2 to 4 managers meetings a year with CWCs.	CWCs	NRBHSS Mental health agent (Laurence Millette)		Every 3 months	Nb of meetings Nb of participants	CWCs feel supported in their work.	Feedback from CWCs and NRBHSS agents during annual meeting (minutes and evaluation forms)
	3.3.3- Explore possibility of creating a web-based support tool for CLWWs to share and exchange.	CWCs CLWWs	NRBHSS Mental health agent (Laurence Millette)		2021-2022	Potential web-based platforms identified Web based platform created	Alternative support network reinforces CLWWs capacities and creates collegiality	Monitor usage of web-based platform

5.2.4.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

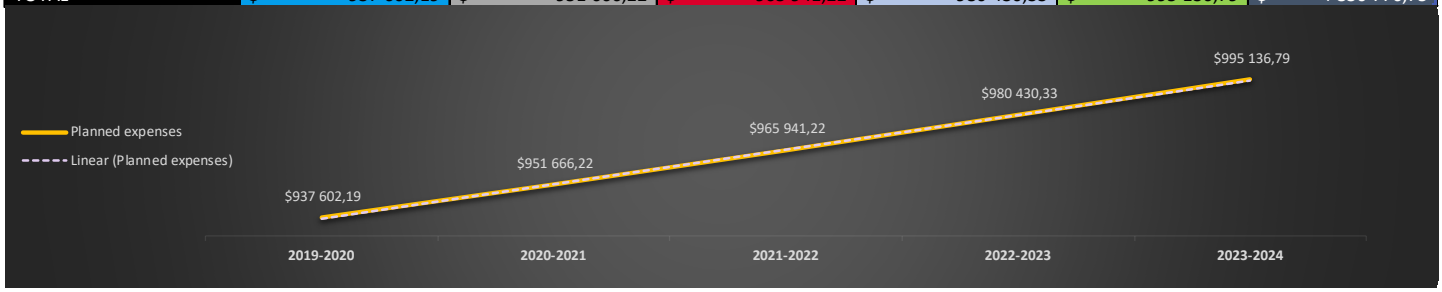
In addition, the 2017 Qanuilirpitaa health survey (see Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics that were included in the survey are mental health and resilience, as well as the sociocultural determinants of health. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.2.4.5 Budget

A conservative indexation of 1.5% was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Building Healthy Communities – Community Liaison Wellness Worker					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Coordinators Salaries	$ 320 000,00	$ 320 000,00	$ 320 000,00	$ 320 000,00	$ 320 000,00	$ 1 600 000,00
CLWW Salaries (14 communities)	$ 598 850,15	$ 612 632,90	$ 626 622,39	$ 640 821,73	$ 655 234,05	$ 3 134 161,22
Regional projects	$ 18 752,04	$ 19 033,32	$ 19 318,82	$ 19 608,61	$ 19 902,74	$ 96 615,54
TOTAL	$ 937 602,19	$ 951 666,22	$ 965 941,22	$ 980 430,33	$ 995 136,79	$ 4 830 776,75



5.2.5 Brighter Futures

5.2.5.1 Service Delivery

The objective of the Brighter Futures Program is to support Inuit traditional approaches to mental wellness through learning-related activities that strive to increase awareness, change attitudes, build knowledge and enhance skills. The five components of the program are mental health, child development, parental skills, healthy babies and injury prevention. The ability to provide joint services covering these five elements contributes in part to answer the complex psychological and social issues at play in Nunavik.

Community involvement in the development and delivery of services is a key element to ensure the relevance and success of the activities. In other words, actions based on community members' involvement and on traditional Inuit culture will optimize the well-being of the communities. The Inuit Practice and Values department of the NRBHSS administers the Brighter Futures program.

In order to provide communities with the opportunity to identify their needs and determine how best to answer them, funding is available to the 14 Nunavik communities through a call for proposal process. To receive funding, the project manager needs to send a proposal with a resolution from the Secretary Treasurer of the local Northern Village (NV), supporting the project. Communities can submit projects throughout the fiscal year. An internal committee reviews the submitted proposals and ensures the projects are eligible and meet the program priorities.

To ensure equitable access to all communities, maximum amounts are calculated per community based on population. Although the goal is for all communities to benefit from Brighter Futures funding, some communities do not apply or reach the maximum amount available to them. The balance is redistributed according to projects received. Projects funded by Brighter Futures often also receive funding from multiple sources, such as Kativik School Board, Kativik Regional Government, Makivik and other NRBHSS programs.

5.2.5.2 Goals

- Increase the well-being of all Nunavimmiut in the different spheres of life (mental, spiritual, physical and cultural) by supporting community-based and led initiatives.

5.2.5.3 Health Program Planning

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Brighter Futures								
Goals: Increase the well-being of all Nunavimmiut in the different spheres of life (mental, spiritual, physical and cultural) by supporting community-based and led initiatives.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- Every community in the region will access Brighter Futures (BF) funding in order to implement projects aimed at one or more of the 5 components of the program (Mental health, child development, parental skills, healthy babies and Injury prevention).	1.1- Inform community organizations regarding the BF funding.	All Nunavimmiut	Planning and programming officer BF (Diane Snowball)	Community Wellness Committees Municipalities Health centres/CLSCs Radio stations	Ongoing as of 2019-2020	Nb of projects implemented per year. Nb of population reached by project. NB of projects per program component	Timely funding of projects More BF projects	BF program tracking tool Report from planning and programming officer
	1.2 - Contact the communities that are not using the BF program to promote the initiative.	All Nunavimmiut		Community Wellness Committees Municipalities Health centres/CLSCs	Ongoing as of 2019-2021	Nb of new communities sending proposals Nb of communities participating in BF program	More communities benefiting from the BF program	BF program tracking tool Report from planning and programming officer
2.1 - Sound governance practices will continue to be integrated in the management of the program.	2.1 - Pursue the reinforcement of capacities by supporting projects in the development of their proposals.	Local workers (that submit projects)	Planning and programming officer BF (Diane Snowball)	PP Officers - Federal gov. (Julie Duquette and Karine Boulanger-Cadieux)	Ongoing as of 2019-2021	Nb of projects supported per year	Improvement of quality of proposals received	BF program tracking tool Report from planning and programming officer
	2.2 - Develop and implement an evaluation tool in accordance with reporting template that is easy for projects to use and will help improve their projects from year to year.	Local workers (that submit projects)		PP Officers - Federal gov. (Julie Duquette and Karine Boulanger-Cadieux)	Ongoing as of 2019-2022	Tool developed Nb of projects who use the tool	More thorough evaluation of BF projects Local capacity development	Reports and evaluations received from projects BF program tracking tool Report from planning and programming officer
	2.3 - Continue to provide last installment upon reception of final report in order to insure reports are sent in on time.	Local workers (that submit projects)				Nb of reports received on time	Local capacity development	Reports and evaluations received from projects BF program tracking tool Report from planning and programming officer

5.2.5.4 Evaluation

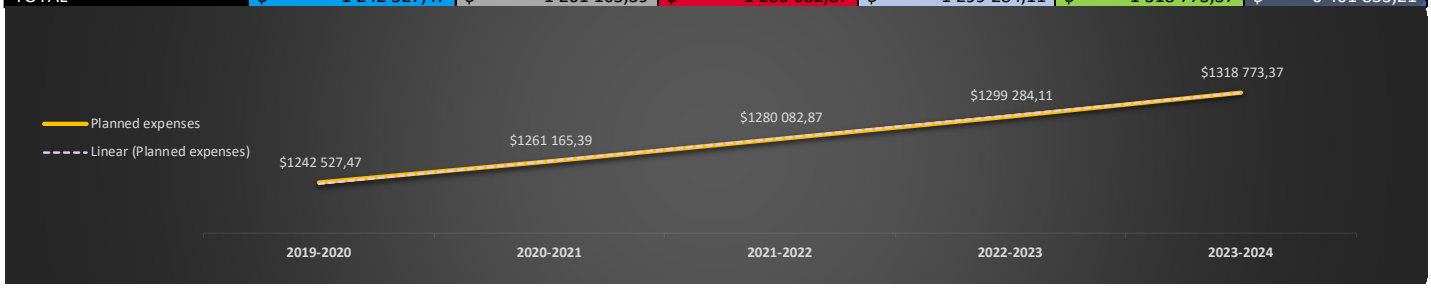
Every year, an annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

Furthermore, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics that were included in the survey are mental health and resilience, as well as the sociocultural determinants of health. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

5.2.5.5 Budget

A conservative indexation of 1.5% was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Brighter future					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Akulivik (projects)	$ 42 131,83	$ 43 008,06	$ 43 897,42	$ 44 800,13	$ 45 716,38	$ 219 553,81
Aupaluk (projects)	$ 13 936,41	$ 14 226,25	$ 14 520,43	$ 14 819,03	$ 15 122,11	$ 72 624,23
Inukjuak (projects)	$ 117 040,04	$ 119 474,14	$ 121 944,75	$ 124 452,42	$ 126 997,71	$ 609 909,06
Ivujivik (projects)	$ 27 550,22	$ 28 123,18	$ 28 704,75	$ 29 295,03	$ 29 894,17	$ 143 567,35
Kangiqsualujjuaq (projects)	$ 62 713,85	$ 64 018,12	$ 65 341,95	$ 66 685,64	$ 68 049,49	$ 326 809,05
Kangiqsujuaq (projects)	$ 49 938,80	$ 50 977,39	$ 52 031,55	$ 53 101,53	$ 54 187,56	$ 260 236,83
Kangirsuk (projects)	$ 37 744,44	$ 38 529,42	$ 39 326,17	$ 40 134,88	$ 40 955,71	$ 196 690,63
Kuujjuaq (projects)	$ 183 431,55	$ 187 246,40	$ 191 118,48	$ 195 048,65	$ 199 037,76	$ 955 882,84
Kuujjuaraapik (projects)	$ 45 680,46	$ 46 630,48	$ 47 594,75	$ 48 573,49	$ 49 566,91	$ 238 046,10
Puvirnituq (projects)	$ 118 459,49	$ 120 923,11	$ 123 423,69	$ 125 961,77	$ 128 537,93	$ 617 305,98
Quaqtaq (projects)	$ 26 840,49	$ 27 398,70	$ 27 965,28	$ 28 540,36	$ 29 124,06	$ 139 868,89
Salluit (projects)	$ 98 780,76	$ 100 835,12	$ 102 920,30	$ 105 036,75	$ 107 184,95	$ 514 757,87
Tasiujaq (projects)	$ 24 582,28	$ 25 093,52	$ 25 612,43	$ 26 139,13	$ 26 673,72	$ 128 101,08
Umiujaq (projects)	$ 29 421,31	$ 30 033,19	$ 30 654,25	$ 31 284,62	$ 31 924,45	$ 153 317,82
Lodging	$ 82 425,00	$ 82 425,00	$ 82 425,00	$ 82 425,00	$ 82 425,00	$ 412 125,00
Salaries	$ 257 000,00	$ 257 000,00	$ 257 000,00	$ 257 000,00	$ 257 000,00	$ 1 285 000,00
Administration fees	$ 24 850,55	$ 25 223,31	$ 25 601,66	$ 25 985,68	$ 26 375,47	$ 128 036,66
TOTAL	$ 1 242 527,47	$ 1 261 165,39	$ 1 280 082,87	$ 1 299 284,11	$ 1 318 773,37	$ 6 401 833,21



5.2.6 Missing and Murdered Indigenous Women and Girls

5.2.6.1 Service Delivery

In 2018-2019 Indigenous Services Canada deployed a new initiative: Missing and Murdered Indigenous women and Girls (MMIWG). Considering the resemblance of MMIWG with the Indian residential school initiative, it was decided that the IVP department of the NRBHSS would be responsible for this new file.

For the time being it is unclear how long this initiative will last and what funding will be made available in the future. A summary plan was developed in order to secure funding for 2018-2019 and will be used for the period of 2019-2020. The plan will be updated in accordance with the availability of funding.

5.2.6.2 Goals

- Ensure that survivors, family members and those affected by the issue of MMIWG have access to an appropriate level of mental wellness support services; and
- Ensure that survivors, family members and those affected by the issue of MMIWG can safely address mental wellness issues related to the impacts of MMIWG.

5.2.6.3 Health Program Planning

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

Missing and Murdered Indigenous Women and Girls (MMIWG)

Goals:

- **Ensure that survivors, family members and those affected by the issue of MMIWG have access to an appropriate level of mental wellness support services; and**
- **Ensure that survivors, family members and those affected by the issue of MMIWG can safely address mental wellness issues related to the impacts of MMIWG.**

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1. Address the mental health problems affecting survivors, family members and those affected by the issue of MMIWG in a community-based, holistic and integrated manner.	1.1- Inform community members about available support, including other victim support services and eligibility criteria.	Survivors Family members Others affected by MMIWG	Planning and programming officer for the MMIWG file (T.B.D.)	Health Centres/CLSCs NRBHSS - Mental Health team	Ongoing as of 2018-2019	Nb of radio shows/advertisement Nb of posters/flyers Facebook posts	Community members know about the support available. Requests for activities and support are received.	Annual report from PP officer
	1.2- Organize workshops and support groups in 3 communities per year.	Survivors Family members Others affected by MMIWG		Health Centres/CLSCs NRBHSS - Mental Health team	Ongoing as of 2018-2019	Nb of community visited Nb of events (workshops and support groups) held Nb of participants	Individuals and families facing issues linked to MMIWG feel supported and know where to turn to for support.	Annual report from PP officer Participants evaluation forms
	1.3- Provide training opportunities to community worker(s) on topics relevant to MMIWG.	Community worker(s)		Health Centres/CLSCs NRBHSS - Mental Health team	Ongoing as of 2018-2019	Nb of trainings received	Community worker feels comfortable in his/her role	Annual report from PP officer Participants evaluation forms
	1.4- Support the delivery of health and cultural support services at National inquiry-sanctioned events.	Survivors Family members Others affected by MMIWG		Health Centres/CLSCs NRBHSS - Mental Health team	Ongoing as of 2018-2019	Nb of requests for support Nb of events Nb of participants from Nunavik in event	Participants from Nunavik receive the appropriate support.	Annual report from PP officer Participants evaluation forms

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Missing and Murdered Indigenous Women and Girls (MMIWG)								
Goals: • Ensure that survivors, family members and those affected by the issue of MMIWG have access to an appropriate level of mental wellness support services; and • Ensure that survivors, family members and those affected by the issue of MMIWG can safely address mental wellness issues related to the impacts of MMIWG.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2. Ensure integrated and coordinated care for survivors, family members and those affected by the issue of MMIWG by coordinating human and service sectors.	2.1- Inform partners of the Nunavik health and social services network regarding the MMIWG initiative.	Health centres Community Liaison Wellness Workers Social Services Women's Association etc.	Planning and programming officer for the MMIWG file (T.B.D.)	Health Centres/CLSCs NRBHSS - Mental Health team	Ongoing as of 2018-2019	Nb of partners informed Nb of referrals received	Development of partnerships	Annual report from PP officer
	2.2- Develop linkages with relevant partners in order to ensure a continuum of services for survivors and family members.	Partners Survivors Family members		Health Centres/CLSCs NRBHSS - Mental Health team	Ongoing as of 2018-2019	Linkages developed Continuum of services established	Individuals in need receive required services within the continuum of services established.	Annual report from PP officer

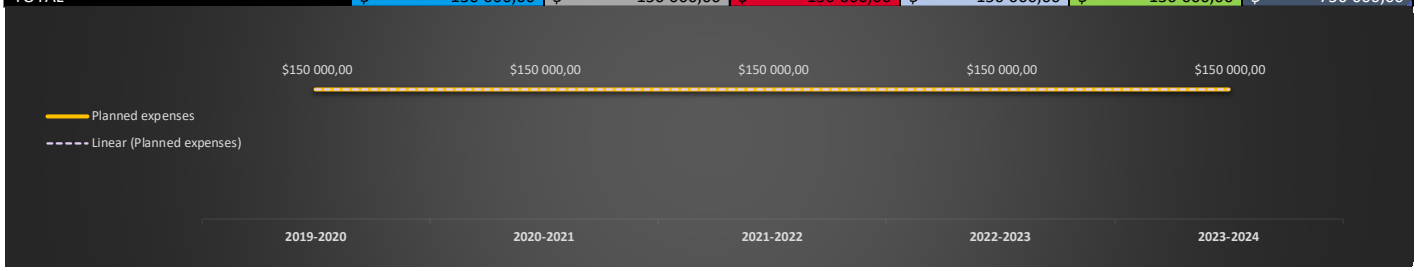
5.2.6.4 Evaluation

As requested by Indigenous Services Canada, quarterly reports will be produced. Additionally, an annual financial report and an annual activity report including the implementation and result indicators mentioned in the program planning will be produced.

5.2.6.5 Budget

Although funding for MMIWG has not been confirmed beyond 2018-2019, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Missing and Murdered Indigenous Women and Girls					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Salaries	$ 120 000,00	$ 120 000,00	$ 120 000,00	$ 120 000,00	$ 120 000,00	$ 600 000,00
Travel	$ 17 000,00	$ 17 000,00	$ 17 000,00	$ 17 000,00	$ 17 000,00	$ 85 000,00
Material for activities and promotion	$ 5 000,00	$ 5 000,00	$ 5 000,00	$ 5 000,00	$ 5 000,00	$ 25 000,00
Training	$ 3 000,00	$ 3 000,00	$ 3 000,00	$ 3 000,00	$ 3 000,00	$ 15 000,00
Administration fees	$ 5 000,00	$ 5 000,00	$ 5 000,00	$ 5 000,00	$ 5 000,00	$ 25 000,00
TOTAL	$ 150 000,00	$ 150 000,00	$ 150 000,00	$ 150 000,00	$ 150 000,00	$ 750 000,00



5.2.7 National Aboriginal Youth Suicide Prevention Strategy

5.2.7.1 Service Delivery

Locally adapted and delivered services are important components that contribute to the efficiency of an initiative. The service delivery model for Suicide prevention takes this into consideration. Through provincial funding, varieties of specialized services are made available to Nunavimmiut in the two regional Health centres and in every community CLSC. At the NRBHSS level, the Planning and Programming Department is in charge of supporting the development of the suicide prevention program through two positions that ensure the implementation of the program across the region and the development of adapted tools. The Suicide prevention officer at the NRBHSS is responsible for regional suicide prevention training, coordinating the Regional Suicide Prevention Committee (RSPC), supporting the Suicide Prevention Liaison Workers (SPLW) and the Community Wellness Coordinators. The suicide prevention communication tools officer at the NRBHSS is responsible for the development of tools, communication strategies and regional suicide prevention conferences.

For the region, there are four SPLW positions, two for each coast. These workers are under the management of the Community Wellness Coordinator and are based at the Health centres. The SPLWs have the responsibility to build links with the department of IVP, CLSC professionals, the CLWWs, the local Community Wellness Committees and other community organizations on their respective coast.

As mentioned in the section on the Building healthy communities program, The Community Wellness Coordinator is under the responsibility of the Community Services Department of each Health centre. In regards to suicide prevention, the coordinator's main responsibility is to hire and support SPLWs in their role. Recruitment of SPLWs is an ongoing issue. There are currently only 2 filled positions, one for each coast.

As part of the Ilusiliriniqmi Pigutjiutini Qimirruniq (Clinical Project IPQ) process, partners in the Nunavik health and social services network identified suicide prevention in 2010 as a regional priority. In 2012, a regional Inuit-led committee, the Regional suicide prevention committee (RSPC), representing various local and regional organizations, was mandated to develop recommendations to reduce the number of suicides in the region. The Board of Directors of NRBHSS adopted all of the recommendations developed by the working committee in December 2013.

The recommendations, as approved by the NRBHSS Board of Directors, are as follows:

- Establish a permanent regional suicide prevention committee;
- Create two permanent positions (sub regional) of suicide prevention coordinator;
- Increase programs and activities that promote wellness (cultural activities, model recognition program);
- Launch prevention and awareness campaign (testimonies, day of mourning, ASIST training, regional conference in Nunavik);
- Provide crisis intervention in communities (mental health team, intervention protocol);
- Provide support services (helpline, websites, men's services, caregiver support groups);
- Create a regional healing team;
- Establish a regional system for monitoring suicide mortality and attempted suicide.

The RSPC has put forward a number of initiatives based on the approved recommendations:

- REACH OUT Nunavik Facebook page: to support everyone who needs help by sharing information about resources available in the region.
- The elaboration of the Nunavik Crisis-response work plan which involves collaboration between various partners.
- Front line worker training on best practices pertaining to suicide intervention in Nunavik, in partnership with *l'Association québécoise en prévention du suicide* and *le Centre intégré universitaire de santé et de services sociaux de l'Estrie – Centre hospitalier universitaire de Sherbrooke*.
- In parallel to the development of training on best practices in suicide intervention, the regional system for monitoring suicide mortality and attempted suicide was developed, validated and tested with front-line workers. Interveners will be able to use it, once they have completed the best practices in suicide prevention training.
- Community mobilization workshops on suicide prevention (mapping of resources). The objectives of the workshops are to mobilize the community around suicide prevention and create a local committee to coordinate efforts in suicide prevention, intervention and postvention.
- Participating in research: a) Pathway – Canadian Institutes of Health Research, b) Death by suicide Study – University McGill & Monique Séguin.
- Applied Suicide Intervention Skills Training from Living Works (ASIST), a two-day interactive workshop on suicide first aid. The RSPC recommended, as a matter of priority, increasing the capacity of communities to prevent suicide and to intensify ASIST training activities in all communities in Nunavik.
- Dialogue for life, hosted by the First Nations and Inuit Suicide Prevention Association of Quebec and Labrador, offers a space for frontline workers, families and individuals to receive both healing and training in dealing with losing loved ones to suicide.
- Inspired by Dialogue for Life, the creation of Puttautiit annual conference was recommended through the IPQ (IPQ, www.ipqnunavik.com). Nunavimmiut have wanted to see such an event in the region for a very long time, a conference for them, based on their specific needs and culture.

<u>While the bulk of suicide prevention services are provided through MSSS funding, Indigenous Services Canada provides funding to support three projects: Regional training, Dialogue for life Conference and the Puttautiit Conference.</u>

<u>Regional training:</u>

The ASIST program of Living Works (www.livingworks.net) prepares community interveners (whether through their jobs, their community status or their kinship bonds) to offer psychosocial first aid to individuals at risk of suicide. ASIST proposes an intervention model that enables community members to ensure a first response to suicidal individuals. The two-day ASIST training program in Nunavik enables individuals to identify those at risk, reach out to them and lead them to consult the appropriate services. To ensure that the individuals referred receive the appropriate help, it is also important to offer specialized training in crisis intervention to the various health professionals.

ASIST is recognized as a crucial element of the regional plan of action in suicide prevention. The intensification of ASIST activities and suicide-prevention activities in general demonstrates a growing mobilization in Nunavik regarding this issue.

We expect the number of training activities and projects related to suicide prevention to undergo sustained growth over the coming years. With the goal of supporting this heightened effort in suicide prevention, the training of new ASIST trainers and the multiplication of training sessions in communities are planned over the upcoming years.

Although the ASIST training is well known throughout the region, it does not answer everyone's need and comfort level. The NRBHSS plans to explore other training options for community members, paraprofessionals and professionals.

Dialogue for life:

Dialogue for Life is an annual conference organized by the First Nations and Inuit Suicide Prevention Association of Quebec and Labrador (FNISPAQL). It brings together over 700 participants from various aboriginal groups. Workshops organized by Inuit and First Nations representatives and attended by professionals working with those populations are presented, providing an aboriginal point of view and aboriginal suicide-prevention strategies. Healing workshops, training and specific programming for youths are also organized within the conference.

The project thus aims to enable participants from Nunavik to attend the conference. In addition, the professionals identified by the Nunavik Health centres can attend the conference to gain a better understanding of the issues related to suicide prevention among the Inuit and First Nations, and to become familiar with traditional intervention techniques. The conference is held once a year in November.

Puttautiit:

Puttautiit is an annual regional conference that has been taking place since 2015-2016. The location of the conference changes from year to year. So far, the conference has taken place in Puvirnituq, Kuujjuaq and Inukjuaq. The conference offers workshops on developing skills to intervene with someone at risk of suicide, on gaining understanding of the ways in which traumatic experiences in history have affected Inuit, and provides access to tools and a space for healing. A well-being network exhibition held on the last day of the event and open to the community, gives access to those who attend an opportunity to learn more about wellness initiatives in the region. More specifically, Inuit (elders, traditional healers, community helpers, etc.) and professional consultants are invited to provide information, training and workshops including:

- Family healing for suicide; homicide and sudden death survivors;
- Applied Suicide Intervention Skills Training (ASIST);
- Men and women healing cycles;
- Historical collective trauma effects;
- Cultural identity; heritage; spirituality; practices, etc.;
- Addiction counselling;
- FASD prevention workshops;
- Inuit traditional healing workshops;
- Strengths and celebration of life.

Nunavik land-based healing program:

Although this project is not directly funded with Indigenous Services Canada funds, surpluses could be allocated to this initiative. In 2016, Inuit Tapiriit Kanatami (ITK) developed the National Inuit Suicide Prevention Strategy, with the help of the four Inuit regions of Canada (Inuvialuit Settlement Region in the Northwest Territories, Nunavut, Nunavik in Northern Quebec, and Nunatsiavut in Northern Labrador). The specific objectives and actions ITK and the regions decided to take fall within six priority areas: creating social equity, creating cultural continuity, nurturing healthy Inuit children from birth, ensuring access to a continuum of mental wellness services for Inuit, healing unresolved trauma and grief, and mobilizing Inuit knowledge for resilience and suicide prevention. In line with this strategy, the NRBHSS sent a project proposal to ITK to secure funding for the Nunavik Land-Based Healing Program, which was approved for a 3-year period (2016-2019).

Community involvement in the development and delivery of services is a key element to ensure the relevance and success of the activities. In other words, actions based on community members' involvement and on traditional Inuit culture will optimize the well-being of the communities. The On the land project stems from a request from community members following a crisis. Members of the community suggested giving access to the land to families who cannot afford it. This would be a good opportunity for them to connect with the land, but also work on their issues with a counsellor, that would be accompanying them.

The project provides families dealing with various issues, an opportunity to go out on the land and carry out workshops as well as individual counselling with natural helpers and professionals. This holistic approach allows families to reconnect, improve communication, share traditional knowledge and recognize their cultural identity. Overall, the project works to strengthen protective factors against suicide.

5.2.7.2 Goals

- As part of the regional suicide prevention strategy, develop culturally appropriate regional expertise on suicide prevention through capacity development of community-based workers and community members.

5.2.7.3 Health Program Planning

The NRBHSS is currently working on developing a regional Suicide prevention action plan with the support of ITK. Once this plan is established, it could influence the planning submitted below. An update will be provided if that is the case.

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Suicide Prevention								
Goals: 1- As part of the regional suicide prevention strategy, develop culturally appropriate regional expertise on suicide prevention through capacity development of community-based workers and community members - Training.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1.1- By 2024 increase the number of individuals who can respond to suicidal behavior (listening, detecting, referring), by providing training.	1.1.1- Provide ASIST training opportunity once a year.	Professionals, paraprofessionals, interveners, community members, etc.	Coordinator for Suicide prevention (Véronique Paradis)	Health Centers	Ongoing	Nb of trainings Nb of participants Nb of new certified ASIST trainers	Nb of referrals by ASIST participants Nb of consultations with health professionals following referral	Training evaluation forms List of suicide prevention interventions by health professionals (Health Centers)
	1.1.2- Identify alternative training (to ASIST) to respond to suicidal behavior.				2019-2020	List of alternative trainings and target audience	N/A	N/A
	1.1.3- Provide alternative training (to ASIST) to respond to suicidal behavior.			Health Centers	Ongoing as of 2020-2021	Nb of trainings Nb of participants	Nb of individuals feeling better equipped to respond to suicidal behavior Nb of referrals by participants Nb of consultations with health professionals following referral	Training evaluation forms List of suicide prevention interventions by health professionals (Health Centers)
1.2- By 2024, enhance support in post-care services.	1.2.1- Identify post-care trainings.	Professionals, paraprofessionals, interveners, community members, etc.	Coordinator for Suicide prevention (Véronique Paradis)	Health Centers	2019-2020	List of trainings and target audience	N/A	N/A
	1.2.2- Provide post-care training.			Health Centers	Ongoing as of 2020-2021	Nb of trainings Nb of participants	Nb participants feeling better equipped to respond following a suicide attempt Nb of health professionals implementing post-care services.	Training evaluation forms Health Center reports

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Suicide Prevention								
Goals: 2- As part of the regional suicide prevention strategy, develop culturally appropriate regional expertise on suicide prevention through capacity development of community-based workers and community members - Regional Conference Puttautiit								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2.1- By 2024 increase the number of individuals who can respond to suicidal behavior (listening, detecting, referring), by engaging community members in a regional dialogue.	2.1.1- Organize annual 5 day-long suicide prevention conference (Puttautiit) in a Nunavik village. Conference includes workshops, healing and information regarding suicide related services.	Local community members Local and regional organizations	Coordinator for Suicide prevention (Véronique Paradis)	NRBHSS IVP department CLWWs Health centers Community where the conference is held (Municipality) Local and regional organizations	Annually in October	Nb of participants Nb of communities represented Nb of participants completing training (ASIST or other)	Nb of referrals Nb of consultations with health professionals Nb of participants feeling better equipped to face suicide related situations	Evaluation form Tool monitoring suicide attempts and deaths (implemented 2017)
	2.1.2- Annually evaluate the event in order to continuously improve conference and adapt to the changing needs of the population.	Participants Organizers			Annually following the conference	Nb of evaluation forms completed Post conference meeting with organizers	Improve conference content and outreach	Evaluation form Minutes from post conference meetings

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Suicide Prevention								
Goals: 3- As part of the regional suicide prevention strategy, develop culturally appropriate regional expertise on suicide prevention through capacity development of community-based workers and community members - Dialogue for Life.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
3.1- Community members in need will have an opportunity to receive training, tools and healing services.	3.1.1- Fund participation of 10 community members annually to the Dialogue for Life Conference.	Community members in need of healing Community members who wish to develop capacities	Coordinator for Suicide prevention (Véronique Paradis)	Health Centers	Ongoing annually	Nb of participants Nb of villages represented	Nb of referrals Nb of consultations with health professionals Nb of participants feeling better equipped to face suicide related situations	Evaluation form
	3.1.2- Develop and implement an evaluation form for the participants.	Community members who took part in conference			Ongoing as of 2019-2020	Nb of evaluation forms completed	Information regarding the impact of participation.	Evaluation form
3.2- Professionals and paraprofessionals will have an opportunity to receive training, tools and ensure their interventions are culturally adapted.	3.2.1- Fund participation of 6 professionals and/or paraprofessionals annually to the Dialogue for Life Conference.	Professionals and paraprofessionals	Coordinator for Suicide prevention (Véronique Paradis)	Health Centers	Ongoing annually	Nb of participants Nb of villages represented	Nb of participants sensitized about culturally adapting their interventions Nb of participants feeling better equipped for their interventions	Evaluation form
	3.2.2- Develop and implement an evaluation form for the participants.	Professionals and paraprofessionals who took part in conference			Ongoing as of 2019-2020	Nb of evaluation forms completed	Information regarding the impact of participation.	Evaluation form

5.2.7.4 Evaluation

Every year, an annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities. Regarding the Land-based healing project, there is a planned evaluation process with ITK, who will hire a consulting firm to develop an evaluation framework and tools.

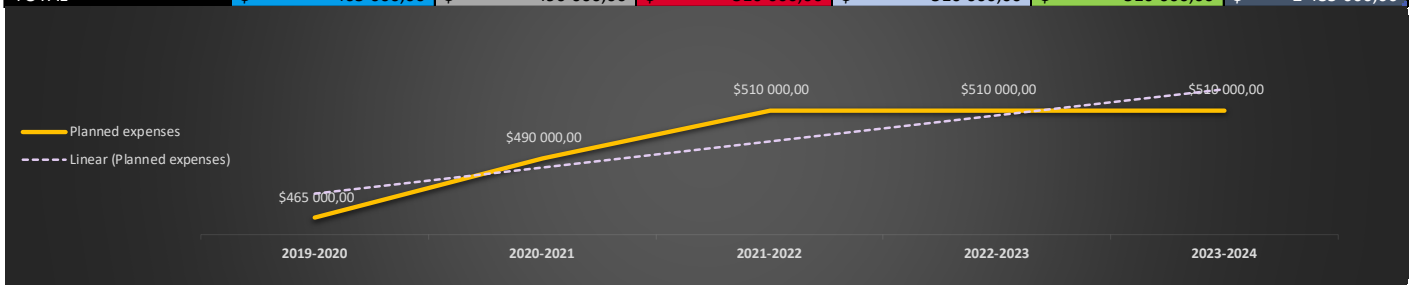
Furthermore, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics that were included in the survey are mental health and resilience, as well as the sociocultural determinants of health. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

5.2.7.5 Budget

As mentioned previously, the NRBHSS is currently working on developing a regional suicide prevention action plan. Once this plan is established, it could influence the planning submitted as well as the budget below. An update will be provided if that is the case.

Although part of the Suicide prevention funding has only been confirmed up to 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned National Aboriginal Youth Suicide Prevention Strategy					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses
Asist training	$ 106 600,00	$ 118 850,00	$ 128 650,00	$ 128 650,00	$ 128 650,00	$ 611 400,00
Puttautit	$ 70 356,00	$ 78 441,00	$ 84 909,00	$ 84 909,00	$ 84 909,00	$ 403 524,00
Dialogue for life	$ 36 244,00	$ 40 409,00	$ 43 741,00	$ 43 741,00	$ 43 741,00	$ 207 876,00
Salaries	$ 242 500,00	$ 242 500,00	$ 242 500,00	$ 242 500,00	$ 242 500,00	$ 1 212 500,00
Administration fees	$ 9 300,00	$ 9 800,00	$ 10 200,00	$ 10 200,00	$ 10 200,00	$ 49 700,00
TOTAL	$ 465 000,00	$ 490 000,00	$ 510 000,00	$ 510 000,00	$ 510 000,00	$ 2 485 000,00



5.2.8 Substance Abuse and Addictions Prevention

5.2.8.1 Service Delivery

There are two addictions officer positions under the Planning and Programming department of the NRBHSS. The workers work closely with the Health centres and community workers to support local initiatives and develop training pertinent to their work. The workers also collaborate with other programs at the NRBHSS like for example FASD. This collaboration allows for concerted interventions and training.

Three levels of services are offered in the region: Prevention services, referral services and aftercare services. These services are offered in partnership with the two Health centres and regional organizations. Each Health centre has a pivot addiction intervener, tasked with supporting the interveners in each community and under each activity sector.

Prevention:
The Inuit association Nunalituguait Ikajuqatigiitut (NI) organizes various information activities in the region's communities and schools. The CLSC employees and the community liaison wellness workers (CLWWs) periodically participate in or organize prevention and awareness activities in the communities, notably in relation to FASD or with regards to the schedules for prevention activities and campaigns against addictions.

Referral:
Youths and adults struggling with an addiction can consult the CLSC interveners (assistance, advice, referral to treatment services). A training program, translated and adapted to Nunavik's specific needs, has been designed. Training sessions are offered by two instructors at the communities' request, with the objectives of enabling the interveners and community members to identify individuals with addiction problems and offer them support in their search for help or in referral for treatment.

Treatment:
In Nunavik, only one community organization—the Isuarsivik Treatment Centre—offers treatment services for addictions (See next section for details). Its 42-day program has been adapted to the Inuit culture and is offered in alternating sessions to women and men. If a treatment service is requested, the Inuit of Nunavik are referred to the regional treatment centre (Isuarsivik), sometimes another treatment centre in Quebec (offering services in English) or a centre outside the province funded by Indigenous Services Canada's NNADAP.

After-Care:
The interveners of the CLSC points of service are the primary sources of support for clients returning to their community. Certain initiatives led by the communities or the churches have led to the emergence of support groups. For example, an AA group is active in Kuujjuaq and the pivot addiction counsellor at the IHC manages two support groups (in Inukjuak and Puvirnituq).

Training:
To be effective, addiction services must be culturally relevant, available in Inuktitut and delivered in the Nunavik region. To achieve this, varieties of training programs are available for Nunavik workers. The Nechi Institute delivers a certified training program for addiction workers. After 13 weeks (320 hours) of training and a placement of at least 200 hours at Isuarsivik Recovery Centre in Kuujjuaq, participants are certified as Community Addiction Counsellors.

The training is for individuals who wish to expand their knowledge surrounding addictions and better serve their clients. It is also aimed at individuals who wish to be employed by Isuarsivik or the Saqijuq initiative. The training registration and process is coordinated by the NRBHSS in collaboration with the Nechi Institute and Isuarsivik. The training is composed of two tiers:

Tier 1: Community addiction training: 8 modules: Communication & Ethics, Addictions, Family Disease, Personal Growth, Assessment, Intervention, Aftercare and Prevention.

Tier 2: Advanced Counselling Skills: 5 modules: One on One Counselling, Family Dynamics, Group Dynamics, Suicide Prevention & Grieving and Culture & Traditional Values

Another training available to Nunavik workers is a two-day Frontline Addictions Training for CLSC workers, youth protection workers, nurses, police officers, teachers, community organizations, etc. This training has four modules:

- **Module 1: Self-Inquiry: Attitudes to develop when intervening in addictions.**
  To recognize the importance of adopting appropriate attitudes when working with people affected by addiction.
- **Module 2: Towards a common language: Basic concepts for identification and early intervention.**
  To identify the basic concepts required for identification and early intervention with people with an addiction or at risk of becoming addicted.
- **Module 3: Identification of cases.**
  To identify users who have or are at risk of developing an addiction.
- **Module 4a: Brief motivational intervention.**
  To intervene with someone with or at risk of developing an addiction, based on the main elements of "brief motivational intervention" (BMI).
- **Module 4b: Brief motivational intervention.**
  To intervene with someone with or at risk of developing an addiction problem, based on elements of "brief motivational intervention" (BMI), in the social and cultural context of Nunavik.

Most addiction prevention services are provided through MSSS funding. Indigenous Services Canada provides funding to the Inuit association NI through the National Native Alcohol and Drug Abuse Program for prevention services. Hence, there is no program planning included in this document for addiction prevention. Nonetheless, funding could be transferred to addictions and substance abuse prevention and training initiatives should a need arise and unused funding be available.

5.2.9 Substance Abuse and Addictions Treatment

5.2.9.1 Service Delivery

Under the leadership of the Northern Village of Kuujjuaq and with the support of Makivik Corporation, Isuarsivik Treatment Centre was first established in 1995 as a community organization dedicated to offering specialized substance abuse services to local clients. Concurrently, the NRBHSS was gradually recognizing the need to put in place regional services in regards to substance abuse. By the end of the 1990s, Isuarsivik accepted to open its residential treatment program for substance abuse to clients from across Nunavik.

Isuarsivik Treatment Centre has been offering a culturally relevant program since 1995. The Board of Directors felt that over the years, the adaptation of southern programs by the Inuit had mitigated results. It was decided that a new program should be developed. The Board of Directors decided in 2006 to invest in the development of a distinct approach to substance abuse rehabilitation based on the experience of a group of dedicated professionals and community based volunteers from Nunavik. The need for an Inuit program based on Inuit values, complemented by best practices in the field of addictions has resulted in the development of an Inuit trauma-informed service approach to substance abuse. This approach is now delivered through a gender-specific 42 days closed residential programs that can be offered in Inuktitut.

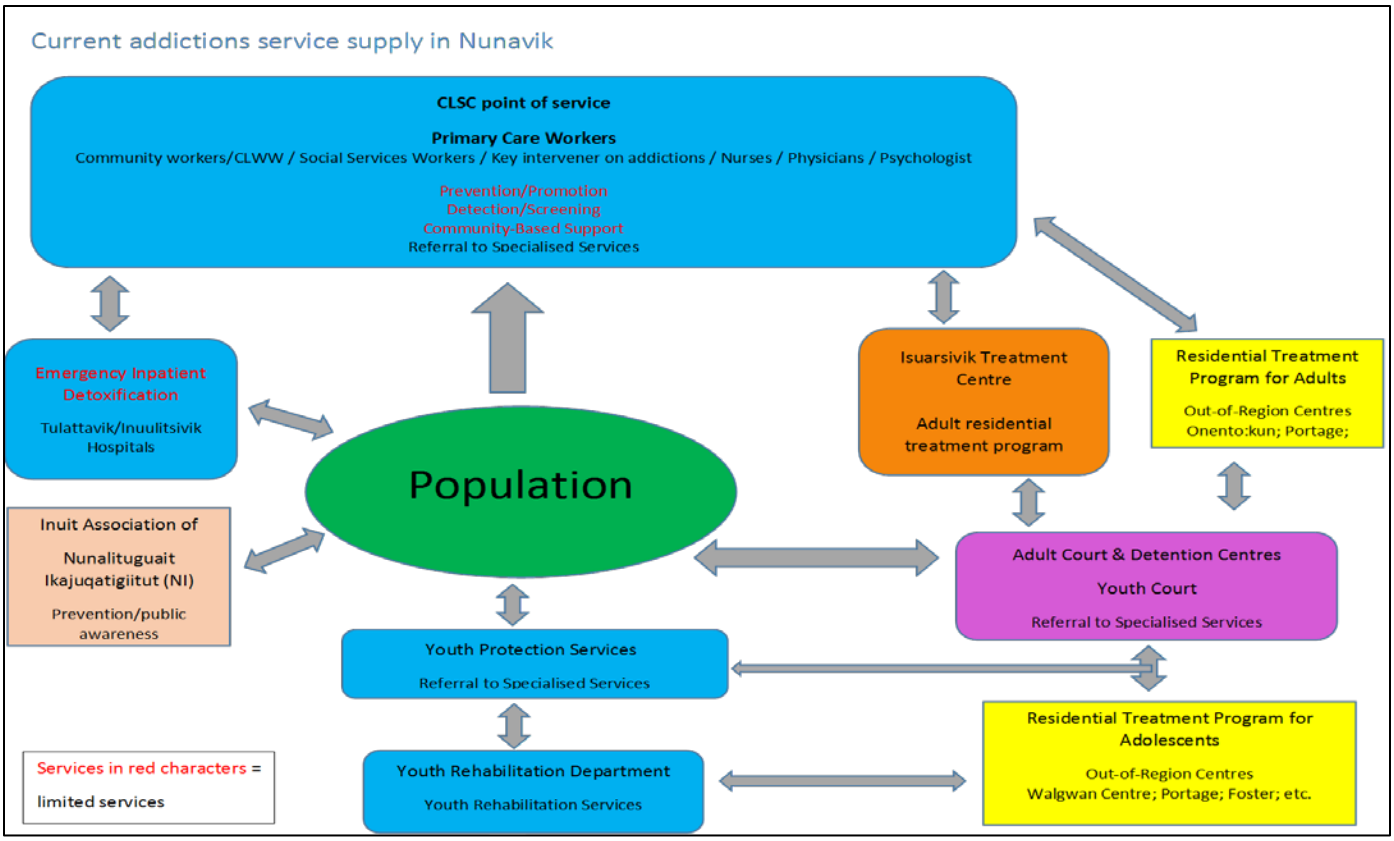
Isuarsivik offers five gender-specific cycles throughout the year. It has a capacity of nine clients per cycle. A specialized addiction counsellor supervises the treatment cycles. Part of the programming is offered in Inuktitut and includes outings on the land. It must be underlined that, since 2006, Isuarsivik significantly expanded the Minnesota-model of the treatment program from 28 to 42 days in order to include an Inuit-specific trauma component. This trauma component was developed locally, by experienced Inuit interveners and touches upon the impact of colonization at the individual, family and community level. In the last few years, a closer relationship has been developed with many cross sector partners such as Kativik Regional Police Force (KRPF), Community Services and the Department of Youth Protection. Clients are referred by both coasts' Community Services and Youth Protection departments as well as by the courts and detention centres. The centre also accepts "self-referral" clients.

In 2014, the Parnasimautik consultation process took place (see section 4. Health Priorities for more details).
During the consultations, alcohol and drug abuse was identified as a critical issue for the Nunavik region, negatively affecting individuals, families, communities and organizations. It was also stressed that the services were woefully inadequate.

Throughout the Parnasimautik consultations, Nunavik Inuit clearly requested support in two areas: **1-** Actions against violence, crime and abuse fuelled by alcohol; **2-** Strengthening the continuum of care for addictions in the following priority areas: prevention of fetal alcohol spectrum disorder (FASD), community-based addictions counselling and expansion of regional inpatient rehabilitation services to all, including families and pregnant women.

The leaders and organizations of the region have taken action and united with the relevant departments in the government of Quebec under the Saqijuq's regional action plan. The Saqijuq partners have designed a global action plan to enhance the capacity of Nunavik communities to reduce the impact of substance abuse, support its members from a grassroots approach and strengthen specialized addiction services. This project also aims to adjust the functioning of the justice system in Nunavik to encourage social regulation. One key element of Saqijuq's regional action plan is the expansion of the services offered by the current Isuarsivik Treatment Centre.

Figure 22 Current addiction services in Nunavik



Current service gaps:

The current addiction service offer presents gaps and key issues that need to be addressed in order to answer the needs identified by the population and professionals.

- Critical shortage of professional addictions counselling in each community;
- Structured detoxification program;
- Inpatient rehabilitation/treatment services;
- Inpatient rehabilitation/treatment services for youths in Nunavik;
- Inpatient rehabilitation/treatment services for adults in Nunavik;
- Aftercare support and social reintegration;
- Limited access to specialized services following treatment.

Isuarsivik development plan 2016-2036:

To be able to address the gaps identified and better respond to the needs of the Nunavik population, the Isuarsivik development plan was put in place. The existing building does not allow enough space for the development of a strong pre- and after care component, any significant treatment support services, nor an adequate integration of Inuit traditional cultural activities. The space available is insufficient to meet the existing demand, and does not provide any opportunity to integrate spouses and children during the treatment program, although these relatives

are considered key partners in the rehabilitation of the clients. A family approach cannot be integrated in the current program and building. Without a new centre and a family approach, pregnant women do not have access to emergency admission for culturally safe services in their region.

The opening of the new Isuarsivik Regional Recovery Centre is targeted for fall 2020. Isuarsivik plans to develop the capacity to accommodate 20 clients of both sexes at the same time. Family units will have the capacity to accommodate four families including their children.

To achieve this, the following steps need to be completed:

- Development of the family approach to treatment services;
- Securing infrastructure funding for the new centre;
- Securing operational funding for the new centre.

The issue of addictions is a priority for the region and the services from Isuarsivik are included in the organization of the services offered by the NRBHSS. Half of the funding for the construction of the new centre has been secured regionally and with the provincial government. The Federal government has yet to confirm any funding for this project.

5.2.10 Sexual Abuse

5.2.10.1Service Delivery

The NRBHSS and the Health centres consider the issue of sexual abuse towards children as a priority of action. There is recognition of the immediate need to provide ongoing treatment to child victims of sexual abuse to minimize negative consequences to the victims. There is very little professional support currently available to victims. Well-intentioned front-line workers often feel ill-equipped to support victims. Not receiving treatment or support after disclosing an abuse increases the negative consequences and impacts of this type of trauma.

The Good Touch Bad Touch (GTBT) program is appreciated for breaking the silence around sexual abuse and providing information and guidance that can lead to more disclosures, reports and help –seeking behaviours. However, the concern that many express is that people are given a safe a supportive space to open up about the traumas that they suffered, but then have nowhere to turn for treatment afterwards or are alone to try to cope with it after the counselling team leaves their community. Logistically and financially, the GTBT team is limited to a visit every one to two years.

A fly-in treatment team approach is proposed as a way to bring experienced sexual abuse counselling services to the population of Nunavik. Fly-in teams would regularly visit 3 to 4 communities each. These teams would consist of one planning and programming officer and three experienced clinical therapists. The teams would visit each community approximately once a month for a week. An important component of this project is that knowledge, skills and tools will be shared with local front-line workers to increase their capacity to intervene with victims. The services offered would be flexible, in order to meet the needs of the communities. Below is a list of potential activities:

- Individual and group therapy;
- Services for children, youth, adults and elders;
- Setting up peer support groups;
- Offering workshops for the community.

In 2018-2019, ITK agreed to contribute to the funds needed to begin to put this initiative in place. The treatment program will be deployed as a pilot project with 1 treatment team working with 3 to 4 communities. The pilot initiative will be closely monitored and evaluated. Additional funding will be necessary to add fly-in teams and reach more communities.

Although the NRBHSS does not receive funding for sexual abuse from Indigenous Services Canada, it financially supports this project. The issue of sexual abuse is a priority for the region. If needed, funding could be transferred to support the project. Furthermore, should funding supporting these types of initiatives become available through Indigenous Services Canada, the NRBHSS wishes to be considered as a beneficiary.

5.3 Healthy Living

5.3.1 Health Status and Context

Food Security:

Food security is one of the main priorities for the region. In the 2012 Aboriginal People's Survey, the prevalence of household food insecurity was 55% in Nunavik.[109] Consumption of unhealthy store-bought food is increasing, while traditional-food consumption seems to be decreasing, especially among the younger generation.[110] This situation is compromising communities' health and well-being. Food insecurity in children can have major impacts on their development and their school achievements. Food insecurity is also associated with a greater risk of suffering from chronic diseases such as diabetes.

In a recent cohort study in the region, "half of the children (49.7%, n=145) were food insecure, while one third were iron depleted, 12.6% had anemia, and 8.7% had iron deficiency anemia".[111] Food-insecure children had greater burdens of nutritional deficiencies and slower linear growth. Considering the high prevalence of food insecurity among Inuit children in Nunavik, nutritional deficiencies and adverse effects on development should be carefully monitored and actions taken rapidly.

Over the past few decades, major changes occurred in the eating habits of Inuit, particularly with the improvement of communication and transportation links with the regions to the south. Although traditional food remains significant and occupies an important place in the nutrition of Inuit, many of those foods have been replaced by store-bought food of low nutritional quality. Those changes in nutrition lead to nutritional deficiencies and the resulting consequences.

In 1992, the Health Quebec survey revealed that traditional foods represented 21% of the caloric intake among Inuit adults. By 2004, that proportion had dropped to 16%. As observed in 1992, consumption of traditional foods was higher among the older segment than among young adults, whereas store-bought food represented a higher portion of caloric intake among younger segments.

Recent socioeconomic and environmental changes of the past few decades also compromise the availability and accessibility of traditional foods as well as healthy store-bought food. The high cost of living, low income, lack of opportunities to transfer knowledge of hunting and fishing, changes in animal migration, variable availability of food in the grocery stores, lack of cooking skills and psychosocial problems are among the principal factors influencing food security in Nunavik.

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[109] Arriagada, P. (2017). *Food insecurity among Inuit living in Inuit Nunangat*. Retrieved from http://www.nunivaat.org/documents/Publication/Food-insecurity-among-Inuit.pdf

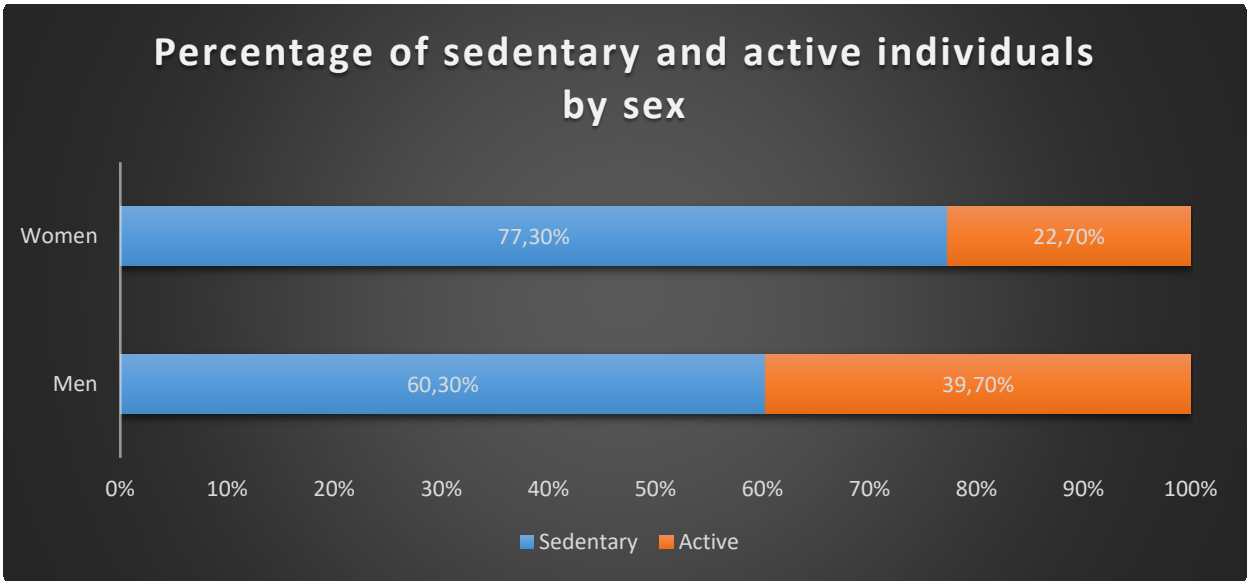
[110] Institut National de Santé Publique du Québec. (2018). *Nunavik Inuit Health Survey 2004*. Retrieved from https://www.inspq.qc.ca/en/expertise/aboriginal-health/nunavik-inuit-health-survey-2004

[111] Pirkle, C.M., Lucas, M., Dallaire, R., Ayotte, P., Jacobsen, J.L., Jacobsen, S.W., Dewailly, E., Muckle, G. (2014). Food insecurity and nutritional biomarkers in relation to stature in Inuit children from Nunavik, *Canadian Public Health Association*, 105(4), 233-238, Doi: 10.17269. Retrieved from http://journal.cpha.ca/index.php/cjph/article/view/4520

Physical activity:

In spite of the important impact of physical activity on health, little data is available on physically active lifestyles in Nunavik for the moment. The 2004 health survey[112] listed the following observations concerning leisure activities: the vast majority of the Nunavik population, particularly women, are sedentary during their free time, regardless of age (15 to 17 years: 59%; 18 years and older: 69%). Among those aged 15 to 17 years, one in seven (14%) attains the recommended level of physical activity through leisure physical activity; that proportion is one in five (18%) among those aged 18 years and older. According to the 2004 Health Survey, women were more sedentary than men were.

Figure 23 Percentage of sedentary individuals by sex, 2004[113]



Inactivity is a major issue, especially considering recent studies, which recognize inactivity as a risk factor to health as important if not more than smoking.[114] Already in 2002, the World Health Organization (WHO) stated, "sedentariness reinforces all causes of mortality, doubles the risk of cardiovascular disease, diabetes, obesity and increases the risk of colon cancer, high blood pressure, osteoporosis, lipid disorders, depression and anxiety"[115].

Diabetes:

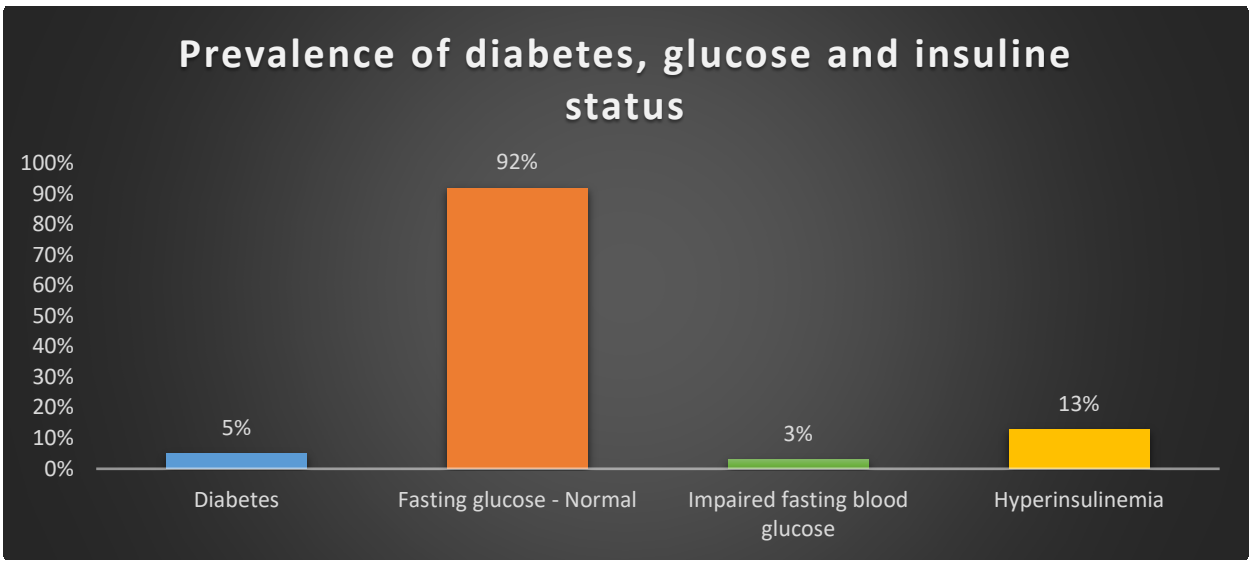
In 2004, the region's prevalence of diabetes was roughly 5%, which is comparable to levels observed among the Canadian population. However, the prevalence of risk factors for diabetes has considerably risen since 1992. "A

[112] Nolin, B., Lamontagne, P., Tremblay, A. (2007). *Qanuippitaa? How are we? Physical activity, anthropometry and perception of body weight.* Retrieved from https://www.inspq.qc.ca/pdf/publications/671_esi_physical_activity.pdf
[113] Ibid, p. 4
[114] Lee, I-M., Shiroma, E.J., Lobelo, F., Puska, P., Blair, S.N., Katzmarzyk, P.T. (2012, July 18). Effect of physical inactivity on major non-communicable diseases worldwide: an analysis of burden of disease and life expectancy, *The Lancet*, 380(9838), 219-229. Retrieved from https://doi.org/10.1016/S0140-6736(12)61031-9
[115] World Health Organization. (2002, April 4). News Release - Physical inactivity a leading cause of disease and disability, warns WHO. Retrieved from http://www.who.int/mediacentre/news/releases/release23/en/

comparative analysis of 1992 and 2004 data indicates that the prevalence of obesity and of severe obesity increased by 49% and 59% respectively. Although the prevalence of obesity was higher among women in 2004, the most significant development was among men (an increase of 73% vs. 31% among women since 1992)."[116] This is one of the reasons an increase in the rate of diabetes is expected in the region.

According to the Inuit Health: Selected Findings from the 2012 Aboriginal Peoples Survey[117], the most common chronic conditions reported by Inuit were hypertension (12%), arthritis (12%), asthma (7%) and mood disorders (7%), such as depression or bipolar disorder. Diabetes (not including gestational diabetes) was reported by 5% of Inuit. The vast majority (97%) of all diabetes cases (including gestational diabetes) were type 2.

Figure 24 Prevalence of diabetes, glucose and insulin status[118] [119]



Tobacco use:

In the last 50 years, Canada has witnessed a slow but stable decrease of its smoking prevalence, from almost 50% to less than 20%. However, this trend has not been observed among Aboriginal populations in Canada, where the smoking prevalence has remained consistently 2 or 3 times higher than that of the general population.[120]

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[116] Nolin, B., Lamontagne, P., Tremblay, A. (2007). *Qanuippitaa? How are we? Physical activity, anthropometry and perception of body weight.* Retrieved from https://www.inspq.qc.ca/pdf/publications/671_esi_physical_activity.pdf, p. 9

[117] Wallace, S. (2014, August). *Inuit Health: Selected findings from the 2012 Aboriginal Peoples Survey*. Retrieved from https://www150.statcan.gc.ca/n1/pub/89-653-x/89-653-x2014003-eng.htm

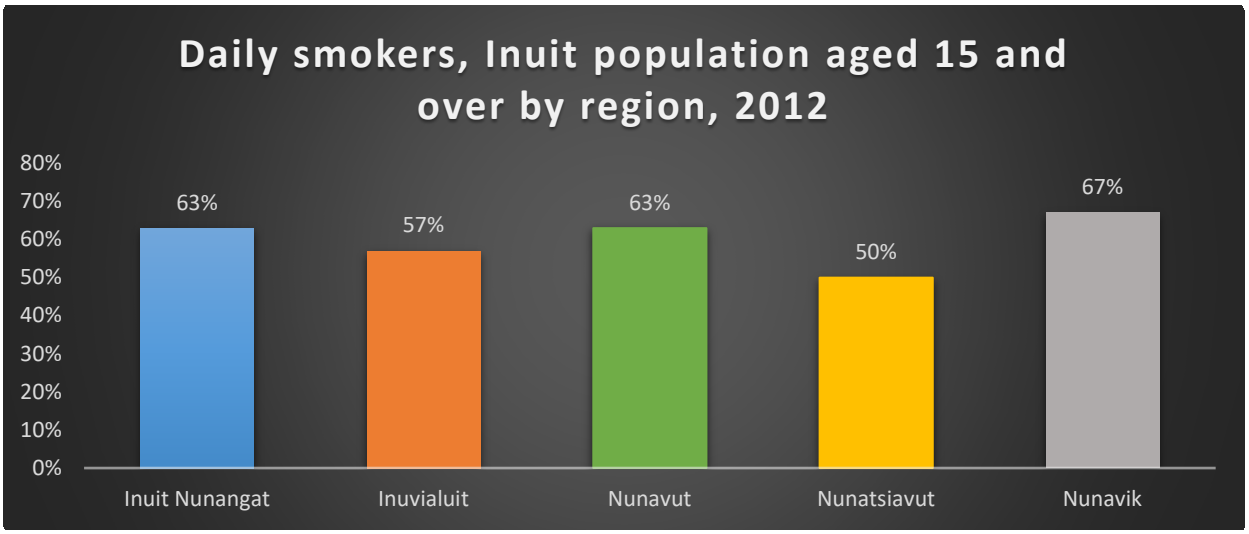
[118] Dewailly, E., Chateau-Degat, M-L., Ékoé, J-M., Ladouceur, R. (2007). *Qanuippitaa? How are we? Status of cardiovascular disease and diabetes in Nunavik*. Retrieved from https://www.inspq.qc.ca/pdf/publications/670_esi_cardiovascular_diabetes.pdf, p. 8

[119] Fasting glucose: Normal fasting blood sugar levels
Impaired fasting glucose: Above normal blood sugar levels during fasting - Prediabetes
Hyperinsulinemia: Excess levels of insulin in the blood relative to the level of glucose

[120] Kelly-Scott, K. and Smith, K. (2015, November 3). *Aboriginal peoples: Fact sheet for Canada*. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89-656-x/89-656-x2015001-eng.pdf?st=t8iAuAxM

According to the Health survey of 2004, nearly three out of four adults report smoking daily.[121] This represents one of the highest smoking prevalence in the country, even among Aboriginal groups.[122] The Aboriginal Peoples Survey of 2012 reports that 67%[123] of Inuit in Nunavik were daily smokers, which would represent somewhat of an improvement. While it is known that psychological distress and socioeconomic vulnerability factors[124] largely explain the higher rates of smoking among Aboriginal populations in general, the specific reasons for such high rates of smoking in Nunavik have never been thoroughly studied.

Figure 25 Daily smokers among Inuit 2012[125]



According to the Qanuippitaa health survey of 2004, "among non-smokers at the time of the survey, 63% declared having smoked at least 100 cigarettes in their lifetime. Among them, 90% acknowledged having smoked daily which means that 56% of present non-smokers have been regular smokers in the past."[126]

The average number of cigarettes smoked daily also increased with age: 12 cigarettes were smoked among those aged 15 to 29 and 15 cigarettes were smoked among those aged 30 and over. Close to half of the daily smokers (45%) smoked 1 to 10 cigarettes per day, 39% smoked 11 to 24 cigarettes daily and 16% smoked 25 cigarettes or more. A majority of daily smokers in Nunavik therefore declared smoking less than one pack of cigarettes per day when the survey occurred.[127]

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[121] Plaziac, C., Hamel, D. (2007). *Qanuippitaa? How are we? Tobacco use*. Retrieved from https://www.inspq.qc.ca/pdf/publications/667_esi_tobacco.pdf, p. 3

[122] Kelly-Scott, K. and Smith, K. (2015, November 3). *Aboriginal peoples: Fact sheet for Canada*. Retrieved from https://www150.statcan.gc.ca/n1/en/pub/89-656-x/89-656-x2015001-eng.pdf?st=t8iAuAxM

[123] Bougie, E. and Kohen, D. (2017, February 15). *Health Reports – Smoking prevalence among Inuit in Canada*. Retrieved from https://www150.statcan.gc.ca/n1/pub/82-003-x/2017002/article/14773/tbl/tbl01-eng.htm

[124] Cheminer sans fumer. (N.D.). Utilisation du Tabac dans les communautés autochtones (Premières Nations, Inuit/Inuk et Métis). Retrieved from https://cheminersansfumer.org/utilisation-du-tabac-dans-les-communautes-autochtones/

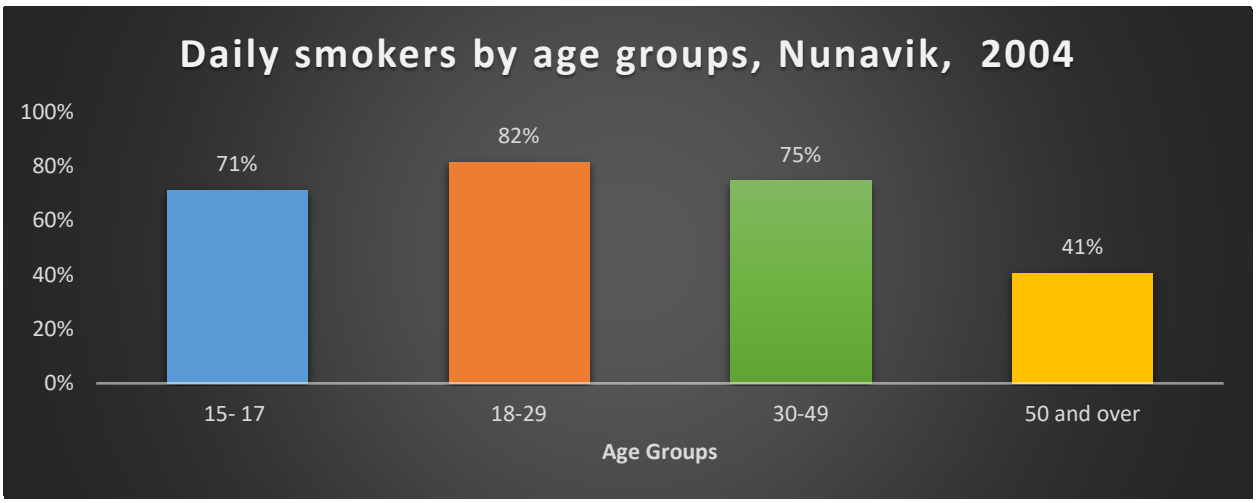
[125] Bougie, E. and Kohen, D. (2017, February 15). *Health Reports – Smoking prevalence among Inuit in Canada*. Retrieved from https://www150.statcan.gc.ca/n1/pub/82-003-x/2017002/article/14773/tbl/tbl01-eng.htm

[126] Plaziac, C., Hamel, D. (2007). *Qanuippitaa? How are we? Tobacco use*. Retrieved from https://www.inspq.qc.ca/pdf/publications/667_esi_tobacco.pdf, p. 3

[127] Ibid, p. 4

Introduction to smoking begins at a very young age: nearly half of daily smokers reported having their first full cigarette at or before the age of 14. [128] Half of daily smokers began smoking on a daily basis before the age of 16. At the time of the survey, over 80% of adolescents aged 15-17 smoked, the vast majority of them already being daily smokers (71%). The 18 to 29 age group smoked the most, at nearly 90%, whereas people aged 50 and over smoked the least (45%).

Figure 26 Daily smokers by age groups (2004)[129]



According to the Health survey of 2004, a sizeable proportion of Inuit women smoked during their last pregnancy: 65% smoked daily and 17% smoked occasionally. In comparison, in 2005, 27,6% of pregnant women in southern Quebec smoked during their pregnancy. [130]

A high proportion of smokers had tried to stop smoking in the 12 months preceding the 2004 survey: 42% of daily smokers and 65% of occasional smokers. The majority of the smokers surveyed did not use any aid to try to stop smoking. Nicotine patches and gum, which have been proven useful according to literature on quitting smoking, were used by only one in five daily smokers.

Personal health was cited as the top reason motivating ex-smokers interviewed, with more than half of individuals stating having quit for that reason. In decreasing order, the other reasons mentioned were: no particular reason, cost, tired of smoking (bad breath, disgusting), pregnancy or because of children, illness or death of a family member or friend, concern about the health of one's family, allergy or asthma and, finally, pressure from family or friends.

Data from Nunavik Inuit Health Survey 2004 revealed that smoking restrictions were present in 84% of Inuit homes. Total restriction inside the house was reported in 54% of houses, while smoking was allowed in certain rooms or under specific circumstances in 30% of households.

The following sections present the service delivery, program planning and budget for all healthy living related federal funding.

[128] Idem
[129] Ibid, p. 3
[130] Ibid, p. 6

5.3.2 Aboriginal Diabetes Initiative

5.3.2.1 Service Delivery

Programs such as the Aboriginal Diabetes Initiative (ADI) are of great importance for the promotion of healthy lifestyles, the prevention of chronic diseases and the improvement of food security. Community engagement is key to promote healthy lifestyles and prevent diabetes. Communities are progressively more engaged in health promotion activities and the NRBHSS wishes to strengthen this engagement.

Food security is also one of the priorities in public health. One of the objectives for the coming years is to reinforce partnerships to improve access and availability to healthy store-bought food and country food. Increasing the adoption of healthy lifestyles by developing knowledge and awareness is also a priority of action. To achieve this, there needs to be continued efforts towards creating favourable environments, but also in continuing to offer support for people living with diabetes.

At the NRBHSS, the Health promotion and prevention team, which falls under the Public Health department, is responsible for the ADI file. As the file is multifaceted, it requires the involvement of many members of the team, such as the mental health officer, the public health nutritionist, the food security officer and the active lifestyle officer. The regional public health action plan (See NRBHSS Website for complete action plan[131]) provides the team with orientations and approaches for the delivery of the program. The team offers support to communities for the development of the program through the elaboration of adapted tools, training and the implementation of communication strategies.

Part of the funds are transferred to the two Health centres to provide diabetes prevention services, but some funding remains at the NRBHSS and is used to fund regional and local activities. Through a call for proposal process, the program supports community-based and led, prevention and promotion initiatives in family houses (Kuujjuaraapik, Puvirnituq, Inukjuak and Kangiqsualujjuaq), schools and other local organizations. Different community members can lead projects, such as local workers (CLWWs, family house staff, nurses, social workers, local recreation coordinator, and teachers). Integration and partnerships between organizations are always encouraged. To ensure these initiatives are adapted to the needs of the population, it is of capital importance for communities to serve as leaders in the planning and carrying out of the activities. It is also essential to take into account the realities unique to each community. For that purpose, regional program management must be flexible and adaptable. Here are a few examples of community-based initiatives funded through the ADI program:

- Community kitchens and cooking activities;
- In-store nutrition promotion (mainly under NNC);
- Nutrition-education activities in schools, childcare centres or the community;
- Activities to promote or share knowledge about country food;
- Nutrition Month and Country Food Day;
- Breastfeeding Week;
- Nutrition-related activities for pregnant women and young families;
- Group sessions for people living with diabetes.

[131] NRBHSS. (2016). Regional action plan for public health 2016-2020, https://nrbhss.ca/sites/default/files/action_plan_regional_en.pdf

Services oriented towards people living with the disease are also an important element of the program. These screening and treatment services are available at Health centres and CLSCs. They include nurse and nutritionist visits, communications through tools or preventive care such as foot care and retinopathy screening. The services offered might differ from one coast to another because the two Health centres have different resources at their disposition.

The ADI program greatly contributes to various activities where food security is an issue whether through the breakfast program in schools or coupons for access to healthy food for pregnant women. Food security funding received through the ADI program also contributes to the NNC planning. In addition, to address food insecurity in Nunavik, there is an inter-sectoral working group, coordinated by the prevention and health promotion team at the NRBHSS. The regional working group was created in 2015, with the goal of designing a regional food security policy. Most of the regional organizations and associations are members (i.e.: Makivik, Kativik Regional Government, Kativik Ilisarniliriniq, health centres, a variety of associations and the *Fédération des Coopératives du Nouveau Québec*). It is expected that the policy will be completed by the end of 2018-2019. There are four issues at the heart of the policy being developed:

- Access to traditional foods;
- Access, availability and quality of food in stores;
- Promotion of healthy eating and support for individuals in a serious situation of food insecurity (e.g., skipping meals or going hungry due to lack of resources);
- Local food production.

5.3.2.2 Goals

- Support community-based and led healthy living initiatives;
- Improve access to healthy store-bought food and country food;
- Improve individual management of diabetes and diminish complications.

5.3.2.3 Health Program Planning

Health Program Planning

Timeframe: 2019-2020 to 2023-2024

ADI - Diabetes Management

Goals: 1- Improve individual management of diabetes and diminish complications.

Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1.1- By 2024, reduce the number of diabetic individuals living with complications associated to diabetes.	1.1.1- Retinopathy screening offered in every village at least once every two years.	Diabetic population	Promotion and health prevention officer (Isabelle Labelle)	Health centres	Ongoing every other year	Nb of patients screened Nb of villages visited	Nb of patients diagnosed with diabetic retinopathy Nb of patients referred to ophthalmologist	Reports from Health centres Annual report from promotion and health prevention officer
	1.1.2- Work with Health centres to ensure individual counselling is provided to diabetics. (Provide tools, teaching materials, structured approach, etc.)			Health centres	Ongoing	Nb of individuals receiving counselling Nb of counselling sessions	Nb of patients presenting complications due to their diabetes	Reports from Health centres Annual report from promotion and health prevention officer
	1.1.3- Work with Health centres to ensure group counselling is provided to diabetics. (Provide tools, teaching materials, structured approach, etc.)			Health centres	Ongoing	Nb of participants in group counselling sessions Nb of group counselling sessions	Nb of patients presenting complications due to their diabetes	Reports from Health centres Annual report from promotion and health prevention officer
	1.1.4- Work with Health centres to improve access to glucose monitoring tools and promote their use.			Health centres	Ongoing as of 2019-2020	Nb of glucometers prescribed	Nb of patients using a glucometer daily	Reports from Health centres Annual report from promotion and health prevention officer
	1.1.5- Work with Health centres to implement systematic monitoring of diabetics.			Health centres IT team	Ongoing as 2020-2021	Nb of patients referred to systematic monitoring program (pilot-project)	Nb of patients integrated to systematic monitoring program (pilot-project)	Reports from Health centres Annual report from promotion and health prevention officer
	1.1.6- Create a glycemic control and monitoring registry to help prevent complications due to diabetes.			Health centres IT team	Ongoing as of 2020-2021	Nb of glycemic results before and after program interventions (pilot-project)	Impact of interventions on glycemic regulation	Reports from Health centres Annual report from promotion and health prevention officer

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
ADI - Food Security								
Goals: 2- Based on regional food								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2.1- Coordinate the implementation of the regional food security policy.	2.1.1- Continue the coordination of the regional food security working group by holding 4 meetings per year.	Local and regional organizations Families in food insecure situations	Prevention and health promotion officer (Léa Laflamme)	Kativik Regional Government, Makivik, Kativik Ilisarniliriniq, Fédération des Coopératives du Nouveau Québec, Saturviit, elder association, Hunting, Fishing	Ongoing	Nb of meetings held Nb of participants	Foster integrated regional approach to food security	Meeting minutes
	2.1.2- Develop a policy and action plan, including an evaluation component (process and impact), with working group, based in the four regional engagement sessions conducted in 2017-18 and 2018-19.	Local and regional organizations Families in food insecure situations			2019-2020	Action plan developed	Improve access to healthy store-bought food and country food	Action plan follow-ups Evaluation/assessment of implementation
	2.1.3- Implement actions pertaining to the NRBHSS and follow up with other organizations responsible for actions through the working group.	Families in food insecure situations			Ongoing as of 2020-2021	Nb of actions implemented from action plan	Improve access to healthy store-bought food and country food	Action plan follow-ups Evaluation/assessment of implementation
2.2- By 2024, every school in the region will offer a quality breakfast program.	2.2.1- Support Kativik Ilisarniliriniq and local schools in securing funding for breakfast program (Breakfast club of Canada (BCC), KI, KRG, etc.)	Schools School-aged children	Prevention and health promotion officer (Léa Laflamme)	Schools KI (School board) KRG Breakfast Club of Canada Health centres	Ongoing as of 2019-2020	Nb of schools with BCC program Nb of schools with local breakfast program Nb of children participating / total Nb of children	Nb of schools with a quality breakfast program	Annual report from schools and Kativik Ilisarniliriniq
	2.2.2- Support schools (that do not participate in BCC) to improve nutritious quality of breakfast, by providing guidelines for breakfast programs.	Schools School-aged children		Schools KI (School board) Prevention and health promotion officer - NNC (Amélie Bouchard) Health centres	Ongoing as of 2019-2020	Nb of schools who received guidelines	Nb of schools implementing guidelines	Annual report from schools and Kativik Ilisarniliriniq

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
ADI - Physical Activity								
Goals: 3- Support community-based and led healthy living activities								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
3.1- By 2024, every community will put in place at least 2 healthy living activities per year. (NRBHSS provides funding for the following types of activities)	3.1.1- Supportive environments project (e.g.: pop free zone, access to active lifestyle facilities, etc.)	All Nunavik population	Prevention and health promotion officer (Léa Laflamme)	Health Centres Local and regional organizations	Ongoing	Nb of projects Frequency of activities Nb of participants	Supportive environments for healthy living	Reports from Health centres Annual reports from project
	3.1.2- Increase knowledge and skills regarding nutrition through activities such as cooking classes, community kitchens, grocery store kiosks, etc.	All Nunavik population			Ongoing	Nb of projects Frequency of activities Nb of participants	Increased nutrition knowledge	Reports from Health centres Annual reports from project
	3.1.3- Increase physical activity service offer (e.g.: cross-country ski clubs, fitness trainings, yoga sessions, walking clubs, etc.)	All Nunavik population			Ongoing	Nb of projects Frequency of activities Nb of participants	Increased physical activity levels	Reports from Health centres Annual reports from project
	3.1.4- Improve access to healthy store-bought food and country food.	All Nunavik population			Ongoing	Nb of projects Frequency of activities Nb of participants	Improve access to healthy store-bought food and country food	Reports from Health centres Annual reports from project
	3.1.5- Projects aimed at individuals living with diabetes (e.g.: education on diabetes management, cooking classes, etc.)	Diabetic population			Ongoing	Nb of projects Frequency of activities Nb of participants	Nb of patients presenting complications due to their diabetes	Reports from Health centres Annual reports from project
	3.1.6- Work with communities with less or no projects to support local workers and / or organizations to implement activities.	Local workers and/or organizations			Ongoing	Nb of communities with projects	More community-based and led healthy living initiatives	Prevention and promotion officer's project files (List of funded projects)

5.3.2.4 Evaluation

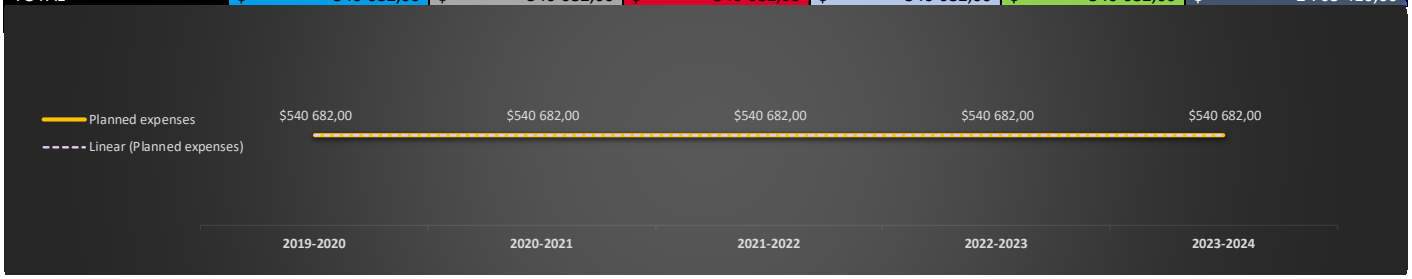
An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics that were included in the survey are diabetes and risk factors (e.g. weight, waist circumference), active lifestyle as well as food security and nutrition. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.3.2.5 Budget

	Distribution of funds and expenses planned Aboriginal Diabetes Initiative					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Projects (by call of proposal. Ex: breakfast club, community projects)	$ 364 168,36	$ 364 168,36	$ 364 168,36	$ 364 168,36	$ 364 168,36	$ 1 820 841,80
Salary	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 828 500,00
Administration fees	$ 10 813,64	$ 10 813,64	$ 10 813,64	$ 10 813,64	$ 10 813,64	$ 54 068,20
TOTAL	$ 540 682,00	$ 540 682,00	$ 540 682,00	$ 540 682,00	$ 540 682,00	$ 2 703 410,00



5.3.3 Federal Tobacco Control Strategy

5.3.3.1 Service Delivery

In 2016-2017, the Public Health Department of the NRBHSS obtained funding as part of the Federal Tobacco Control Strategy to develop and deploy a multi-component action plan on tobacco control and prevention. However, as most health-related behaviours, smoking is highly influenced by cultural and social norms; it is thus essential that interventions implemented be well adapted to the specificities of Nunavik's context.

In order to guide the development of this action plan, the NRBHSS requested the collaboration of the Aboriginal health team of the INSPQ to conduct a social marketing analysis of the determinants that influence smoking in Nunavik (See Annex 9.5). This study provides the NRBHSS with orientations for the coming years.

There are two positions dedicated to the tobacco initiative within the Health promotion and prevention team. As part of their mandate, they have the responsibility to build partnerships with key stakeholders in communities in order to implement the planning that was developed. Said planning, includes a variety of activities that cover the health promotion strategies recommended by the World Health Organization (WHO). The team, in collaboration with community stakeholders, aims at enforcing the application of provincial laws regarding smoking, rolling out a communication campaign. The communication campaign will be an important piece in the upcoming years. It is developed in collaboration with the communications team at the NRBHSS and will be assessed and adjusted throughout its deployment. Other forthcoming projects include developing and deploying a strategy for schools and strengthening community-based interventions to support tobacco cessation, either with community leaders or with health professionals. For the time being, only one position has been filled. A recruitment process is under way for the second position. A third position was added to the team in 2018-2019. A doctor now works one day a week to support the cessation treatment portion of the strategy.

5.3.3.2 Goals

Reduce prevalence of smoking in Nunavik by:

- Changing social norms/perception of smoking;
- Providing tools and support for people who want to stop smoking;
- Supporting the application of provincial laws;
- Providing cessation treatment and counselling.

5.3.3.3 Health Program Planning

A detailed planning is presented below, but for a more visual overview of the initiatives in the upcoming years, please see Annex 9.6.

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Federal Tobacco Control Strategy								
Goals: 1- Reduce prevalence of smoking in Nunavik youth by changing social norms/perception of smoking.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1.1- Contribute to reducing the number of youth that start smoking.	1.1.1- In collaboration with other public health programs and the school board, build a healthy living curriculum to be given in schools across the region throughout the school year.	School aged youth	Prevention and health promotion officer - Tobacco and Cannabis (Stéphane Anctil)	Prevention and health promotion officers of the public health team KI (School board)	2020-2021	Curriculum built	N/A	Curriculum
	1.1.2- In collaboration with KI, implement the curriculum in 2 new schools every year and provide ongoing support to schools.	School aged youth			Ongoing as of 2020-2021	Nb of schools implementing curriculum	Nb of youth that start smoking	Report from KI Annual report from prevention and health promotion officer

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Federal Tobacco Control Strategy								
Goals: 2- Reduce prevalence of smoking by providing tools and support services for people who want to stop smoking.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2.1- Contribute to the increase of individuals that quit smoking.	2.1.1- Develop a communication strategy built around the "Stay quit to win" challenge. Strategy will include: Information about the impact of smoking, the quitting process and different options available, success stories with local ambassadors, etc.	All of Nunavik population	Prevention and health promotion officer - Tobacco and Cannabis (Stéphane Anctil)	NRBHSS Communication team	2019-2020	Communication strategy and communication products (videos, etc.) produced		Communication strategy
	2.1.2- Deploy the communication strategy. Activities planned all throughout the year.	All of Nunavik population		NRBHSS Communication team Health centres and CLSCs KI (School board) Community Liaison Wellness Workers (CLWWs)	Ongoing as of 2019-2020	Nb of shares on Facebook Nb of views on videos T.B.D. in accordance with communication strategy	Nb of participants in challenge Nb of individuals who quit for prolonged periods	Follow up on communication strategy Annual report from prevention and health promotion officer
	2.1.3- Hold a "Stay quit to win challenge" annually.	Smokers		NRBHSS Communication team Health centres and CLSCs KI (School board) CLWWs	Ongoing	Nb of participants	Nb of individuals who quit (identify periods of time - 3 months, 6 months, 1 yr. etc.)	Annual report from challenge
	2.1.4- Support community-based activities by providing funding and support.	Smokers		Health centres and CLSCs KI (School board) CLWWs Other community organizations	Ongoing	Nb of activities funded / supported Nb of participants	Nb of individuals who quit Nb of individuals who quit for prolonged periods	Activity report from community
	2.1.5- Work with child and family programs of the public health team to provide tools and information regarding smoking while pregnant, breastfeeding and indoors.	Pregnant and breastfeeding mothers Families		Prevention and health promotion officers of the public health team	Ongoing as of 2019-2020	Nb of collaborations	Integrated service offer for healthy living	Annual report from prevention and health promotion officers

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Federal Tobacco Control Strategy								
Goals: 3- Reduce prevalence of smoking by supporting the application of provincial laws.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
3.1- Contribute to the application of laws regarding smoking.	3.1.1- Support regional and local organizations to implement the provincial legislation on smoke-free areas, by providing support, information and tools.	All Nunavimmiut	Prevention and health promotion officer - Tobacco and Cannabis (Stéphane Anctil)	Local and regional organizations Municipalities KI School Board	Ongoing as of 2019-2020	Nb of organizations and municipalities met/trained/supported	Nb of organizations and municipalities applying the laws Nb of individuals quitting	Nb of tools/training provided
	3.1.2- Work with local stores to support them in the application of provincial law prohibiting sales to minors.	All Nunavimmiut		Local stores	Ongoing as of 2019-2020	Nb of stores met/trained/supported	NB of stores applying the law Nb of individuals quitting	Nb of tools/training provided

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Federal Tobacco Control Strategy								
Goals: 4- Reduce prevalence of smoking by providing cessation treatment and counselling.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
4.1- Improve access to adapted cessation treatment.	4.1.1- Ensure there are group prescriptions for prescription medication to aid quitting.	Smokers who want to quit	Public health doctor specialized in smoking cessation (Dr. Simon Riendeau)	Prevention and health promotion officer - Tobacco and Cannabis (Stéphane Anctil)	2019-2020	Nb of group prescriptions (including product types)	Nb of prescriptions Nb of individuals quitting with prescription aid	Reports from Health centres
	4.1.2- Ensure nicotine replacement therapies (NRT) are available at the Health centres and CLSCs and advertised.	Smokers who want to quit			2019-2020	Nb of NRT available	Nb of NRT sold /given out Nb of individuals quitting with NRT	Reports from Health centres
	4.1.3- Organize training for health care providers on smoking cessation (universal screening, specific needs of pregnant women, counselling, etc.)	Health care professionals and paraprofessionals			Ongoing as of 2019-2020	Nb of trainings Nb of participants	Nb of professionals and paraprofessionals feeling better equipped to helps patients quit Nb of individuals quitting	Training evaluation form
	4.1.4- Support community-based activities by providing funding and support.	Smokers	Prevention and health promotion officer - Tobacco and Cannabis (Stéphane Anctil)	Health centres and CLSCs KI (School board) CLWWs Other community orgnizations	Ongoing	Nb of activities funded / supported Nb of participants	Nb of individuals who quit Nb of individuals who quit for prolonged periods	Activity report from community

5.3.3.4 Evaluation

In collaboration with the INSPQ a monitoring and evaluation plan, adapted to the context of the region was developed.

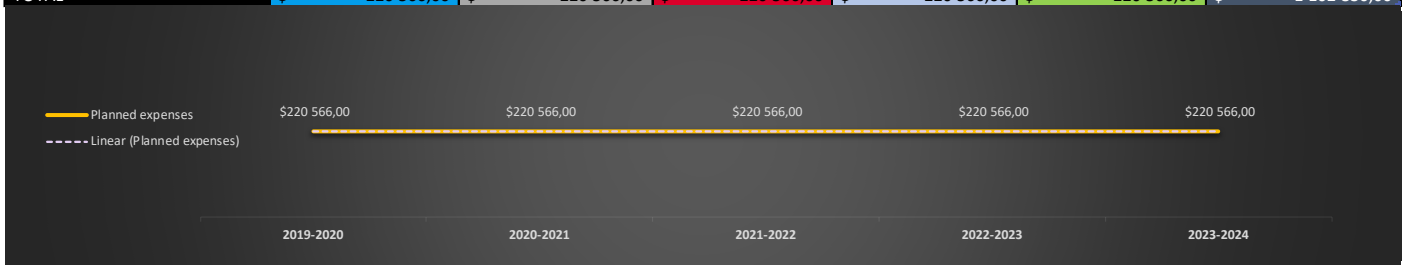
In addition, every year, an annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

Furthermore, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. One of the health topics that was included in the survey is substance abuse, which included tobacco. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

5.3.3.5 Budget

Although funding for FTCS is not permanent, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Federal Tobacco Control Strategy					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses
Hudson (55% of the population)	$ 32 013,12	$ 32 013,12	$ 32 013,12	$ 32 013,12	$ 32 013,12	$ 160 065,62
Ungava (45% of the population)	$ 26 192,56	$ 26 192,56	$ 26 192,56	$ 26 192,56	$ 26 192,56	$ 130 962,78
Salary	$ 157 949,00	$ 157 949,00	$ 157 949,00	$ 157 949,00	$ 157 949,00	$ 789 745,00
Administration fees	$ 4 411,32	$ 4 411,32	$ 4 411,32	$ 4 411,32	$ 4 411,32	$ 22 056,60
TOTAL	$ 220 566,00	$ 220 566,00	$ 220 566,00	$ 220 566,00	$ 220 566,00	$ 1 102 830,00



5.3.4 Nutrition North Canada

5.3.4.1 Service Delivery

The NNC program aims to support nutrition-education initiatives or culturally relevant activities focused on communities and retail food markets. Those activities aim to complement the contributions granted to the retail sector in the form of subsidies for healthy perishable items, in order to encourage the adoption of healthy eating habits in remote northern communities. The goal of these initiatives is to improve knowledge regarding nutrition and develop skills in choosing and preparing healthy store-bought food and traditional (country) foods.

Among the current priorities in terms of healthy lifestyles and food security in Nunavik are support for community kitchens, promotion of healthy choices at the grocery stores, and development of a regional inter-organizational food-security policy, aimed at improving access to traditional foods and healthy store-bought food.

At the NRBHSS, the NNC program falls under the responsibility of the Public Health department. One agent works specifically on the NNC file. The agent also works closely with the other team members from the public health department and in collaboration with both health centres and many community organizations.

5.3.4.2 Goals

To improve knowledge regarding nutrition and the skills in choosing and preparing healthy store-bought food and traditional (country) foods.

5.3.4.3 Health Program Planning

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Nutrition North Canada								
Goals: Increase the number of individuals/families adopting healthy eating habits by improving access, knowledge and skills.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- Improve access and availability to healthy store bought food and traditional food.	1.1- Contribute to the implementation of the regional food security policy. (See activities under ADI 2.1)	Local and regional organizations Families in food insecure situations	Prevention and health promotion officer (Léa Laflamme)	Public health nutritionist (Amélie Bouchard)	Ongoing	See ADI 2.1	See ADI 2.1	See ADI 2.1
	1.2- Support and fund the development of small-scale gardening projects.	All individuals, but particularly families in food insecure situations		Public health nutritionist (Amélie Bouchard) Municipalities Schools Local workers/organizations (e.g.. Youth houses)	Ongoing	Nb of gardening projects implemented	Nb of families or individuals benefitting from crops	Project reports Evaluation component of the regional food security policy
	1.3- Pursue work with KI (School board) to promote drinking water in schools. Imatsiaq! Project	Children and youth in schools	Public health nutritionist (Amélie Bouchard)	KI (School board) Schools Health centers/CLSCs	Ongoing	Nb of participating schools Nb of water dispensers distributed	Nb students drinking water instead of juice or pop	Evaluation (before and after) as planned withi+A1:I10n project

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Nutrition North Canada								
Goals: Increase the number of individuals/families adopting healthy eating habits by improving access, knowledge and skills.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2- By 2025, increase the number of individuals making healthy nutritious choices.	2.1- Implement the revitalized in-store nutrition program across the region. (e.g.: reinforce program and develop partnerships)	All Nunavimmiut	Public health nutritionist (Amélie Bouchard)	Retailers Health centers/CLSCs Community Liaison Wellness Workers (CLWWS)	Ongoing	Nb of communities reached Nb of partnerships developed Nb of events per community Nb of participants	Volume of healthy vs. unhealthy foods sold in participating stores	Reports from retailers Reports from local workers organizing activities.
	2.2- Pursue work with regional organizations to implement nutrition policies.	All Nunavimmiut		Regional organizations	Ongoing	Established nutrition policy	Nb of organizations implementing policy	Public health nutritionist report
	2.3- Support and fund community kitchens and regular cooking activities.	All individuals, but particularly families in food insecure situations		Local workers/organizations (e.g.. Youth houses) Health centers/CLSCs	Ongoing	Nb of activities (by type) Nb of participants	Nb of individuals and/or families reporting having better access to healthy foods Nb of communities reached per year	Project reports Evaluation component of the regional food security policy
	2.4- Support and fund community based initiatives aimed at promoting healthy nutrition. (e.g.. Nutrition education activities, promotional campaign, Breastfeeding week, nutrition month, etc.).	All Nunavimmiut		Health centers/CLSCs	Ongoing	Nb of activities (by type) Nb of participants Nb of tools/materials provided for activity	Nb of individuals making healthy choices Nb of communities reached per year	Reports from health centers/CLSCs Participant evaluation / assessment
	2.5- Make adequate and adapted nutrition tools available.	All Nunavimmiut		Retailers Health centers/CLSCs Community Liaison Wellness Workers (CLWWs) Regional organizations	Ongoing	Nb of tools available Nb of tools distributed	Nb of individuals making healthy choices	Public health nutritionist report

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Nutrition North Canada								
Goals: Increase the number of individuals/families adopting healthy eating habits by improving access, knowledge and skills.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
3- By 2025, empower local workers involved in nutrition and food security to provide high quality service to the population.	3.1- Organize an annual regional training on nutrition promotion and community cooking.	Local workers	Public health nutritionist (Amélie Bouchard)	Health centers/CLSCs CLWWs Local workers/organizations (e.g.. Community kitchen coordinators and animators)	Ongoing	Nb of trainings (by type) Nb of participants Nb of communities reached per year	Nb of workers feeling better equipped	Participant evaluation Public health nutritionist report
	3.2- Offer adapted on the job training to cooks and other workers in community organizations who prepare meals. (nutrition, cooking, food safety/hygiene).	Local workers		Health centers/CLSCs CLWWs Local workers/organizations (e.g.. Community kitchens)	Ongoing	Nb of trainings (by type) Nb of participants	Nb of workers feeling better equipped	Participant evaluation Public health nutritionist/consultant report
	3.3- Make adequate and adapted nutrition tools available.	Local workers		Health centers/CLSCs CLWWs Local workers/organizations (e.g.. Community kitchens)	Ongoing	Nb of tools available Nb of tools distributed	Nb of workers feeling better equipped	Participant evaluation Public health nutritionist report

5.3.4.4 Evaluation

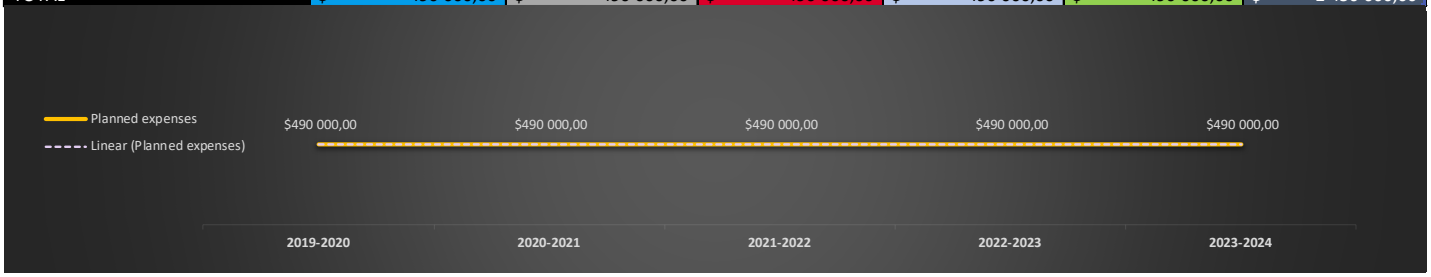
Every year, an annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

Furthermore, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics included in the survey is food security and nutrition. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

5.3.4.5 Budget

Although funding for NNC is not permanent, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Nutrition North Canada					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses
Regional projects	$ 314 500,00	$ 314 500,00	$ 314 500,00	$ 314 500,00	$ 314 500,00	$ 1 572 500,00
Salary	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 165 700,00	$ 828 500,00
Administration fees	$ 9 800,00	$ 9 800,00	$ 9 800,00	$ 9 800,00	$ 9 800,00	$ 49 000,00
TOTAL	$ 490 000,00	$ 490 000,00	$ 490 000,00	$ 490 000,00	$ 490 000,00	$ 2 450 000,00



5.4 Communicable Disease Control and Management

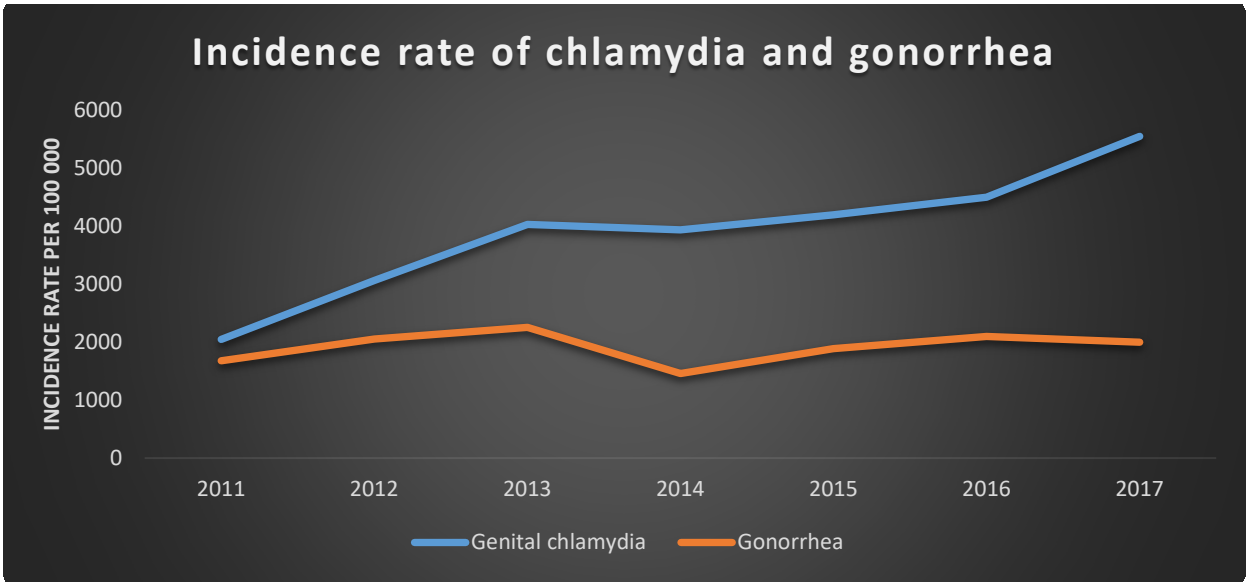
5.4.1 Health Status and Context

The NRBHSS department of Public Health, jointly with the MSSS and the INSPQ, ensures a follow-up for all portfolios under occupational health and safety, prevention of infections, promotion of health and screening and control of diseases, such as tuberculosis (TB) and sexually transmitted and blood-borne infections (STBBI).

Sexually transmitted and blood-borne infections:

When compared to other administrative regions, Nunavik has the highest incidence of reported STBBIs in the province. For chlamydia, the reported rate in 2015, was of 4 194 per 100 000, compared to an average of 294,9 per 100 000 for the whole population of Quebec. As for gonorrhea, reported rates for 2015 were of 1 891,1 per 100 000, compared to an average of 47,4 per 100 000 for the whole population of Quebec.[132]

Figure 27 Incidence rate of genital chlamydia and gonorrhea, Nunavik 2011-2017*[133]



Nunavik is also currently fighting an outbreak of syphilis, affecting multiple communities. The outbreak, ongoing since late 2016, has affected 35 individuals in five communities. There were no cases of congenital syphilis. There are a limited number of known HIV cases in the Nunavik region and there is no evidence of ongoing transmission. However, with extremely high rates of gonorrhea and chlamydia, the future rise of HIV is a source of constant concern. There is urgent need for concerted action in the field of sexual health to decrease bacterial infection transmission in the region, eradicate syphilis from Nunavik and prepare communities for the foreseeable rise of HIV.

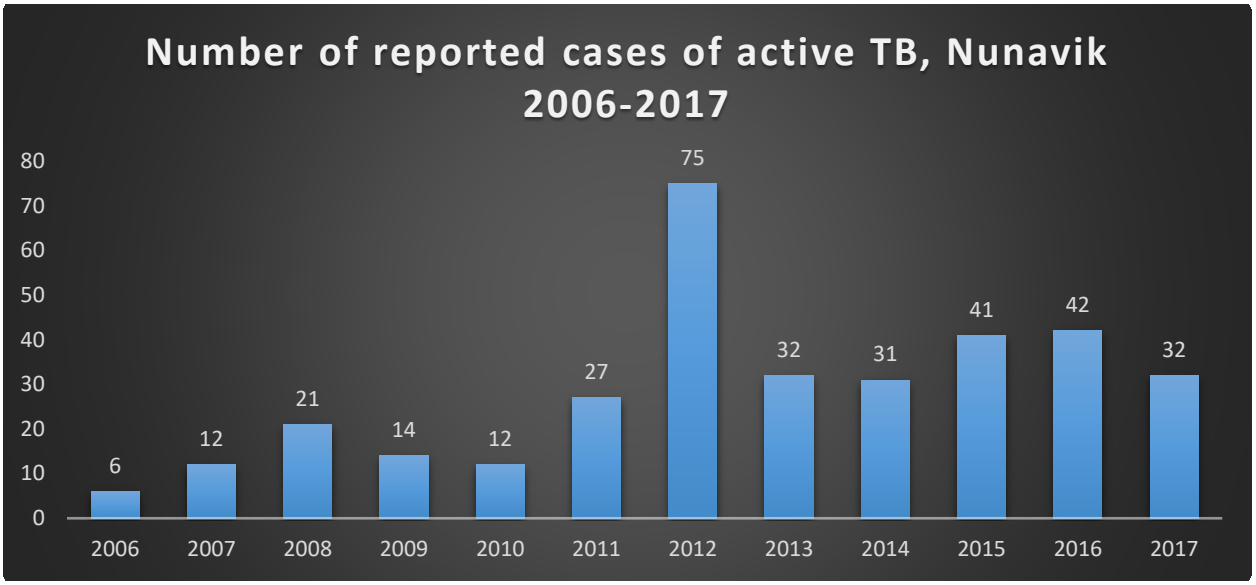
[132] Institut national de santé publique du Québec. (2016, Novembre). *Portrait des ITSSS au Québec : 2015 et projections 2016*. Retrieved from https://www.inspq.qc.ca/sites/default/files/publications/2201_portrait_infections_transmissibles_sexuellement_sang_2015_0.pdf, p. 19

[133] Registre central des Maladies à déclaration obligatoire (MADO), Compilation Direction de la Santé Publique Nunavik, 2011-2013, le 6 septembre 2016; 2014-2017 le 23 mars 2018

Tuberculosis:

Another infectious disease with high-recorded incidence in the Nunavik region is tuberculosis. In 2017, 34 cases of active TB were detected in the region. There was one death in the past year caused by pulmonary TB. Adverse socioeconomic risk factors of tuberculosis, such as low income, crowded housing, difficult access to quality food, low levels of education, alcohol and drug abuse and smoking are common in the region. Nunavik has the highest rate of TB in the province, with 41 cases of reported active TB in 2015. This represents an incidence rate of 312,6 per 100 000, compared to 2,9 per 100 000 for the province.[134]

Figure 28 Number of reported cases of active tuberculosis, Nunavik 2006-2017[135]



The management of tuberculosis outbreaks can be complex, as many cases have to be followed as well as the individuals they have been in contact with. Furthermore, tuberculosis is perceived as a highly contagious disease, creating rejection and shame for those who are diagnosed with it. It is common for people with tuberculosis to suffer from social stigma. This context strongly influences those affected to delay being diagnosed or even not complying with their treatments in fear of being ostracized. In order to diminish social stigma related to tuberculosis and increase the number of people being diagnosed, there needs to be more information and public awareness, to improve knowledge and support.

Immunization:

The Nunavik health establishments apply the provincial vaccination schedule as per the Protocol of Immunization of Quebec (PIQ). Considering the health context of the region, there are specificities regarding the immunization service offer. More specifically, the BCG vaccine is offered for children under two years of age in communities with

[134] Registre central des Maladies à déclaration obligatoire (MADO), Compilation Direction de la Santé Publique Nunavik, 2006-2017, avril 2018.
[135] Idem

high risk of tuberculosis[136] and an additional dose of the pneumococcal vaccine if offered for children under five years of age in all the communities.

The Nunavik health establishments use the provincial immunization registry. The overall vaccination rate for children under two years of age is estimated at 87,9%, which is superior to the rest of the province (80% - 2012)[137]. However, for the scholar vaccination rate, the most up-to-date data seems to reveal that Nunavik has the lowest rate of vaccine coverage for hepatitis B at 57,4%, compared to 82,4% for the rest of the province.[138] This being said, a variety of factors could explain the current rates, such as data entry issues and misinformation regarding the side effects of vaccines. In order to clarify the situation, as mentioned in the regional public health action plan, the Public health department will be investigating the reasons of the low rates. Once the reasons have been clarified, a specific action plan will be developed to address this issue.

[136] 6 communities are target by this initiative

[137] Rapport sur la couverture vaccinale des enfants de 2 ans du Nunavik pour la cohorte 2010-2011/Report on immunization coverage for two-year old Nunavik children for the cohort 2010-2011. April 2014. Marie-Line Gilbert, Agence de santé publique du Canada et al.

[138] CV VPH Milieux Scolaires. Données préliminaires 2018-08-09 (VPH)_2018-08-13 (VHB). Rapport de l'onglet Registre de vaccination produit par l'Infocentre de santé publique à l'Institut national de santé publique du Québec, le 9 août 2018

5.4.2 Tuberculosis

5.4.2.1 Service Delivery

The NRBHSS has a regional action plan on tuberculosis (See Annex 9.7), which will be updated in accordance with the work of the ITK TB working group. Nonetheless, based on the existing plan and the regional public health plan, major initiatives are undertaken towards developing and implementing community mobilization projects to fight the disease.

The clinical services of the regional Health centres are responsible for the diagnosis and treatment of active and latent TB cases. In the event of a major outbreak, the Public Health department of the NRBHSS can mobilize resources, both human and financial, to allocate them to the Health centres for investigation surrounding outbreaks and care of the infected individuals.

The NRBHSS Public Health department validates case reports, establishes the period and degree of contagiousness, and makes recommendations regarding the period of isolation and the individuals to investigate. When the outbreak is widespread, external resources such as the Canadian Field Epidemiology Program or the National Institute of Public Health of Quebec (INSPQ) may be mobilized. In addition to monitoring infectious diseases, the NRBHSS also develops and implements prevention and health promotion interventions.

The Public Health department also supports the Health centres' staff by providing consulting expertise, clinical tools and training. Both Health centres provide their new employees with a basic training on TB, as part of their expanded role training. The NRBHSS offers a more detailed training to the Health centres' staff upon request. There are also two more advanced training modules offered by the NRBHSS, also upon request. These trainings are provided by a public health nurse from the NRBHSS.

Community leaders expressed the need to make accessible and culturally appropriate communication tools available. Education being a key part of the regional action plan on TB, the NRBHSS developed a communication strategy. The two main objectives are to:

- Develop tools to improve knowledge of detection, diagnosis and treatment of tuberculosis (sleeping and active), prevention and protection of others;
- Work with communities on ways (i.e. health policies) to prevent and control tuberculosis.

5.4.2.2 Goals

- Diminish the number of tuberculosis (TB) cases by implementing an integrated approach to fighting the disease.
- Diminish the number of tuberculosis (TB) cases by increasing the number of individuals being screened and complying with treatment.

5.4.2.3 Health Program Planning

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Tuberculosis								
Goals: : 1-Diminish the number of tuberculosis (TB) cases by implementing an integrated approach to fighting the disease.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1.1- Implement an integrated approach to fighting TB in Nunavik.	1.1.1- Take part in ITK working group on TB.	All Nunavik population	Public health director (Marie Rochette)	Infectious diseases coordinator (T.B.D. - interim Jessica Trahan) Advisor for Infectious diseases (Jessica Trahan)	Ongoing since 2017-2018	Nb of meetings	ITK plan	ITK plan
	1.1.2- Based on the work of the working group, update regional action plan.	All Nunavik population	Infectious diseases coordinator (T.B.D. - interim Jessica Trahan)	Other members of the infectious disease team at NRBHSS Health centres ITK working group representative	2019-2020	Updated regional action plan	Integrated approach to TB developed	Regional plan
	1.1.3- Implement action plan.	All Nunavik population	Infectious diseases coordinator (T.B.D. - interim Jessica Trahan)	Other members of the infectious disease team at NRBHSS Health centres Regional and local Nunavik organizations	Ongoing as of 2020-2021	Nb of action plan elements implemented	Nb of individuals screened Nb of detected TB cases Nb of patients complying to treatment	Annual report from Advisor for infectious diseases Annual reports from Health centres OGETN

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Tuberculosis								
Goals: 2- Diminish the number of tuberculosis (TB) cases by increasing the number of individuals being screened and complying to treatment.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2.1- Increase the number of individuals getting screened for TB.	2.1.1- Build a survey to be used annually in order to obtain an overview of TB awareness, stigmatization associated with TB and perception of health staff.	All of Nunavik population Health staff	Advisor for infectious diseases (Jessica Trahan)	NRBHSS Communications team	2019-2020	Survey built Nb of participants	Annual overview of TB awareness and perception of health staff	Survey
	2.1.1- Develop a communication strategy to inform population about symptoms, screening, transmission, treatment and stigmatization.	All of Nunavik population		NRBHSS Communications team	2019-2020	Communication strategy and communication products produced	N/A	Communication plan
	2.1.2- Deploy communication strategy which includes: 1- Newsletters/flyers 2- Videos 3- Electronic message boards 4- Messages on the radio 5- Branding material for events (banners, streamers, backdrops)	All of Nunavik population		Health centres / CLSCs Municipalitites Airports Radio stations	Ongoing as of 2019-2020	1- Nb of newsletters / flyers produced and sent 2- Nb of views, Nb of shares on social media, Nb of likes 3- Nb of electronic message boards posting messages 4- Nb of radio stations airing message, nb of times radio stations aired message 5- Nb of branding products created	Nb of individuals screened Nb of detected TB cases Increased awareness about TB	Annual report from Advisor for infectious diseases Survey *Outil pour la gestion des éclosions de tuberculose au Nunavik* (OGETN)
	2.1.3- Support Health centres and CLSCs in the organization of screening clinics in high risk communities.	All of Nunavik population		Health centres / CLSCs	Ongoing as of 2019-2020	Nb of screening clinics organized	Nb of individuals screened Nb of detected active TB cases Nb of detected latent TB cases	Annual report from Advisor for infectious diseases Annual reports from Health centres OGETN

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Tuberculosis								
Goals: 2- Diminish the number of tuberculosis (TB) cases by increasing the number of individuals being screened and complying to treatment.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
2.2- Destigmatize TB to increase the number of screening and compliance to treatment.	2.2.1- In collaboration with KI, develop a TB 101 curriculum for schools that covers history, symptoms, screening, transmission, treatment and the impacts of stigmatization.	Nunavik youth that attend school	Advisor for infectious diseases (Jessica Trahan)	KI (school board) Health centres	2020-2021	Curriculum built	N/A	Curriculum
	2.2.2- In collaboration with KI, implement TB 101 curriculum in all Nunavik schools.	Nunavik youth that attend school		KI (school board) Health centres	Ongoing as of 2021-2022	Nb of schools implementing curriculum Nb of students who received the training	Nb of individuals screened Nb of detected TB cases Nb of patients complying to treatment Increased awareness about TB	Annual report from Advisor for infectiopus diseases Survey OGETN
	2.2.3- Provide tools and training to health staff (profesionnals, paraprofesionnals, interpreters, etc.) regarding TB and stigmatization.	Health staff		Health centres / CLSCs	Ongoing as of 2019-2020	Nb of tools provided Nb of training / support provided Nb of health professional/paraprofessionnals trained	Nb of individuals screened Nb of detected TB cases Nb of patients complying to treatment Increased awareness about TB	Annual report from Advisor for infectiopus diseases Survey OGETN
	2.2.4- Sensitize population regarding the impacts of stigmatization (See 2.1.1 and 2.1.2)	All of Nunavik population		See 2.1.2	Ongoing as of 2019-2020	See 2.1.2	Nb of individuals screened Nb of detected TB cases Nb of patients complying to treatment Increased awareness about TB	Annual report from Advisor for infectiopus diseases Survey OGETN
	2.2.5- Work with elders to develop integenarational sharing project on the evolution of TB. (History of TB in Nunavik and evolution of treatment) Production of a short documentary	Youth Elders		Elders association of Nunavik	Ongoing as of 2020-2021	Nb of youth and elders involved	Nb of individuals screened Nb of detected TB cases Nb of patients complying to treatment Nb of views of the video	Annual report from Advisor for infectiopus diseases Survey OGETN

5.4.2.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

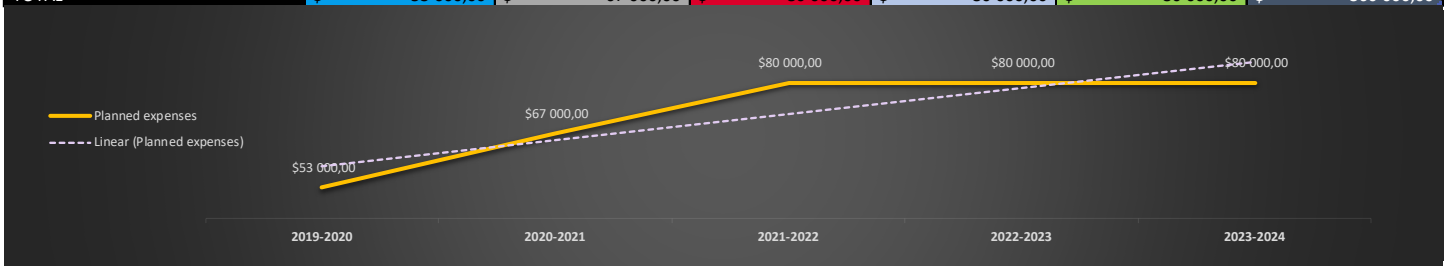
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics included in the survey are physical health and infectious diseases. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.4.2.5 Budget

Although funding for Tuberculosis has not been confirmed beyond 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Tuberculosis					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Activities: - Communication strategy, developement of tools, etc.	$ 51 940,00	$ 65 660,00	$ 78 400,00	$ 78 400,00	$ 78 400,00	$ 352 800,00
Administration fees	$ 1 060,00	$ 1 340,00	$ 1 600,00	$ 1 600,00	$ 1 600,00	$ 7 200,00
TOTAL	$ 53 000,00	$ 67 000,00	$ 80 000,00	$ 80 000,00	$ 80 000,00	$ 360 000,00



5.4.3 Sexually Transmitted and Blood-Borne Infections

5.4.3.1 Service Delivery

Clinical services related to STBBIs are dispensed by the CLSCs or Health centres. STBBI clients are usually screened, examined and treated by nurses through collective prescriptions. In communities where the service is available, midwives provide sexual health services for women of reproductive age, but are not legally allowed to dispense treatment when an infection is suspected or confirmed. The NRBHSS supports health professionals and community workers across the region by sharing knowledge, gathering and analyzing data on STBBIs, populations affected and access to care and supporting outreach initiatives as well as outbreak management.

Considering the high incidence of STBBI cases in Nunavik, the Public Health department of the NRBHSS has developed a specific action plan to address this issue. (See Regional public health action plan[139]) This action plan includes initiatives aiming to improve communications with youth, access to education (both through institutional and more organic channels) and access to care.

Access to Care: Social Marketing Initiative

The NRBHSS launched the CheckUp Project, a communication campaign that uses social marketing and social media to influence the social norms surrounding STBBI screening. In parallel, the NRBHSS is collaborating with the Health centres to improve access by introducing fast-track screening services: the 'Quick Check Up'. Offered in every community, this program addresses the concerns of nurses for a simple, quick, standardized procedure and the needs of youth for a fast and less embarrassing encounter.

The CheckUp Project has emerged as a promising Inuit specific practice focusing on the secondary prevention of STBBIs. This project has proven to effectively engage and empower Inuit youth, by encouraging them to practise their agency, while engaging with the healthcare system. Healthcare workers and stakeholders in the region are also encouraged to engage with the campaign. Many are exposed to campaign content on social media, which may influence the quality of care, by shifting the attitude of staff towards youth needing sexual health services.

The CheckUp Project is now working on addressing determinants of sexual health, with a pilot of 5 podcasts on self-esteem and cultural pride, alcohol and at-risk behaviours, STBBIs and screening, being ready for sex, choosing to have one versus many partners and finally homosexuality and gender identity. These podcasts are available via the CheckUp Project Facebook page; involving youth in a deeper discussion, sharing views and tools to mitigate the risks of STBBIs and achieve better overall sexual health.

In the upcoming years, the NRBHSS plans to continue the CheckUp Project as well as proceed to a summary evaluation on the podcast initiative in order to improve its reach and results. Workshops in communities across the region could be foreseen, to increase presence in communities and evaluate current initiatives.

For more information regarding the Checkup project, please visit the CheckUp project Facebook page[140]

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[139] Nunavik Regional Board of Health and Social Services. (2016). Regional action plan for public health 2016-2020, https://nrbhss.ca/sites/default/files/action_plan_regional_en.pdf

[140] https://www.facebook.com/CheckUpProject/

Access to care: Peer to peer initiative

Peer-to-peer programs are used to improve access to care and to empower vulnerable populations. Building on successful experiences with vulnerable youth, the NRBHSS would like to run a pilot project, using peer workers in the community of Salluit. The program would include training peers, to provide them with tools to intervene, and increase their sexual health knowledge. Peers would be involved in prevention / health promotion interventions and would be offering screening services outside of the clinic (outreach). These peer to peer interventions would help set bases for outreach intervention using peers on a larger scale. The use of peer workers also aims to empower at-risk populations.

Sexual health education:

- Family-centred sexual education is a need that has been expressed by communities for many years. Parents are concerned and willing to take action to ensure the sexual health of their youth and of their community members. An intervention program is being developed in order to improve parents' knowledge.

- A sexual education program, Think before you start, was developed in 2007 by the Nunavik health network, in an effort to create a culturally sensitive sexual health curriculum. The program is built as toolkit, including modules and teaching material, making it a one-stop tool, easy to use for inexperienced educators and workers. The program has been used in many schools across the region for years, but needs to be updated.

  In the 2019-2021 span, a review and update of the sexual health toolkit is planned. This review includes the addition of a parent/child component, to enable community health nurses and workers to address the need expressed by young parents for a tool to address the topic of sexuality with their children. Following this, training and implementation would be done across the region, to continue to engage and empower families and communities.

  Once up-to-date, the KI school board will make the toolbox the standard sexual health teaching tool, for a mandatory sexual education module in the curriculum.

5.4.3.2 Goals

- Decrease the prevalence of STBBIs in Nunavik, by improving knowledge and increasing the number of individuals being tested.

5.4.3.3 Health Program Planning

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
STBBI								
Goals: Decrease the prevalence of STBBIs in Nunavik, by improving knowledge and increasing the number of individuals being tested.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- Increase self-efficacy and knowledge towards sexuality and sexual health in youth.	1.1- Develop and broadcast podcasts addressing sexual health and the determinants of sexual health in Inuit youth.	Youth 15-25	Medical advisor for infectious diseases (Véronique Morin)	Production and marketing firms.	Ongoing as of 2019-2020	Nb of podcasts developed Nb of airings Nb of subscribers	Increased self efficacy and knowledge in youth	Survey to subscribers Data from sound cloud/iTunes and Google play
	1.2- Offer workshops for parents to ease discussions about sexuality at home.	Children and youth (all ages) Parents		Planning and programming team, UQAM (through student), Community health teams, Sexual educators (community dependent)	Ongoing as of 2019-2020	Nb of participants and type (parents, local educators, elders, etc.)	Increased perceived behavioral control in parents willing to engage in a conversation about sexual health with youth in their community.	Survey/evaluation of trainees
	1.3- Review and update the existing sexual health education toolkit "think before you start".	School aged children		KI (School board) / Schools	2020-2021	Nb of key stakeholders interviews	Updated toolkit	Key stakeholders interviews Data from KI (School board)
	1.4- Support deployment of updated toolkit by providing training to school resources.	School resources / educators		KI (School board) / Schools	2021-2022	Nb of resources trained Nb of schools involved	Nb of children and youth receiving the updated sexual education program Increase knowledge Nb of condoms distributed Nb of youth getting tested	Survey/evaluation of trainees Reports from participating schools

5.4.3.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

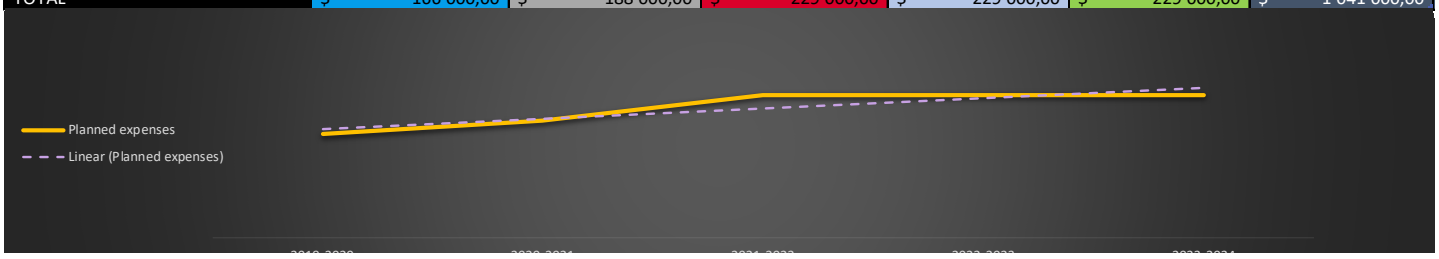
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. Some of the health topics included in the survey are sexual health and infectious diseases. This survey will also provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.4.3.5 Budget

Although funding for STBBI has not been confirmed beyond 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Sexually Transmitted and Blood-Borne Infections					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Activities: - Communications, tools, development and deployment of peer to peer initiative	$ 162 680,00	$ 184 240,00	$ 224 420,00	$ 224 420,00	$ 224 420,00	$ 1 020 180,00
Administration fees	$ 3 320,00	$ 3 760,00	$ 4 580,00	$ 4 580,00	$ 4 580,00	$ 20 820,00
TOTAL	$ 166 000,00	$ 188 000,00	$ 229 000,00	$ 229 000,00	$ 229 000,00	$ 1 041 000,00



5.5 Environmental Health

Environmental health falls under the responsibility of the Public health department. The team supports the regional efforts in relation to disease prevention, health promotion, information for the public, monitoring of the population's state of health and its determining factors, and particularly the field of health protection. The team works in collaboration with the MSSS and the INSPQ.

The environmental health team responds to reports from various interveners of the health network, other organizations or ministries such as the Kativik Regional Government and the KI School Board, the municipalities and the public concerning exposure to environmental risk factors. It maintains a constant duty roster (24/7) in order to respond at all times to emergencies of an environmental nature.

As needed, it conducts epidemiological investigations and issues health advisories in areas such as contamination of indoor and outdoor air, drinking water, water in swimming pools and traditional foods, as well as sanitary conditions, industrial pollution, waste management and so forth.

For more information on the topics covered, please visit the NRBHSS's website[141]

[141] https://nrbhss.ca/en/departments/public-health/environmental-health

5.6 Clinical and Client Care

The NRBHSS, through its Department of Planning and Programming, and the health establishments of Nunavik ensure the coordination and organization of health and social services in accordance with MSSS guidelines: youth-protection services, rehabilitation services for youths with adjustment difficulties, services for adults, youths, families and elders, services against violence, abuse, addictions and suicide, services to promote health and well-being, mental-health services, medical services and physical-health services.

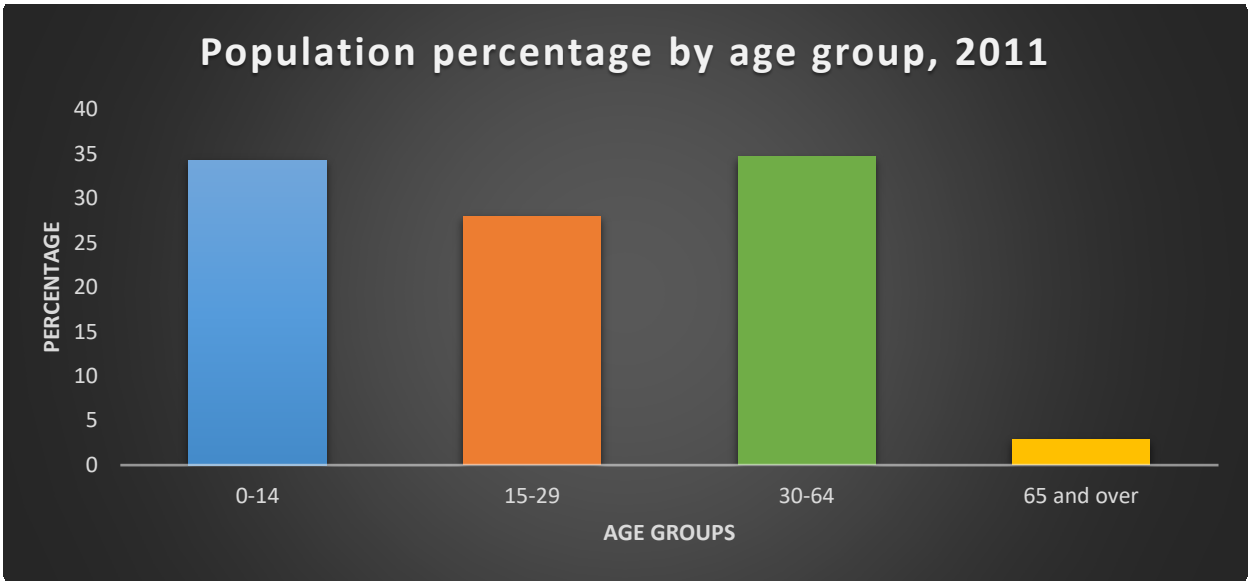
For a complete list of professionals and services, please refer to section 2.1.5 and annex 9.2 of this document.

5.7 Home and Community Care

5.7.1 Health Status and Context

In Nunavik the service offer for individuals with decreasing independence is limited in quantity and quality. Two main factors influence the current situation: 1) the low number of elderly individuals and 2) the low level of life expectancy compared to the rest of the province. Although the 65 and over population is much lower than the rest of the other age groups, the former will be growing considerably in the upcoming years.

Figure 29 Population percentage by age group[142]



In addition, according to the 2004 health survey, some risk factors linked to the health status of the population could influence the number of individuals with decreased independence in the future.

- Approximately 60% of adults are overweight or obese;
- Three out of four adults smoked daily or occasionally;
- 77% of adults drank alcohol on an occasional or regular basis, one quarter of whom reported high alcohol consumption (five or more drinks) at least once a week during the previous year.

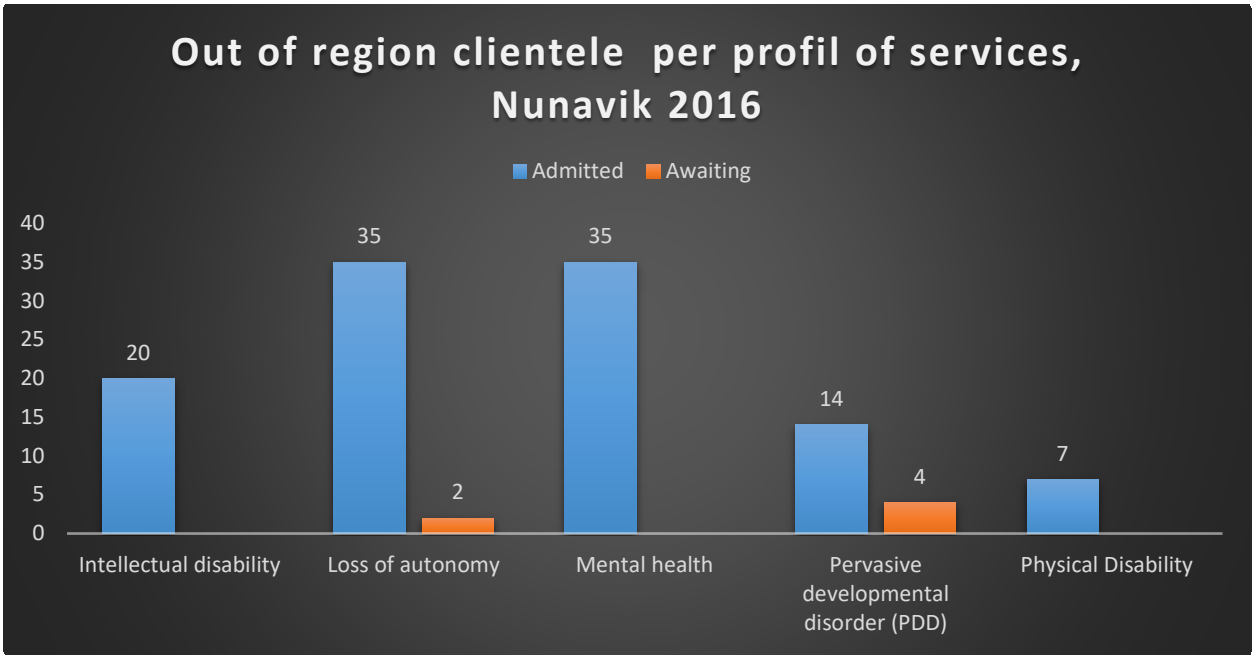
Furthermore, a status report on cancer in Nunavik, completed in 2014, revealed that the incidence of cancer is higher in the region, particularly for younger age groups, than in the rest of Quebec.[143] Nurses, in the region report significant rates of comorbidities, including a large number of individuals with lung problems that greatly affect their autonomy and thus, their need for care and services at home.

[142] Chaire de recherche du Canada sur la condition autochtone comparée – Université Laval. (2015). *Le Nunavik en chiffre 2015*. Retrieved from http://www.chaireconditionautochtone.fss.ulaval.ca/documents/pdf/Nunavik-en-chiffres-vf-fr.pdf

[143] NRBHSS and CBHSSJB. (2014). Des soins et des services de qualité et culturellement adaptés pour les patients Inuit et Eeyouch atteints de cancer- État de situation, p. 23

The current needs of individuals with decreasing independence are not being completely met in the region. Very few long-term care facilities are available in the region and there are no intensive functional rehabilitation units. Many individuals have to leave the region to have access to the appropriate services.

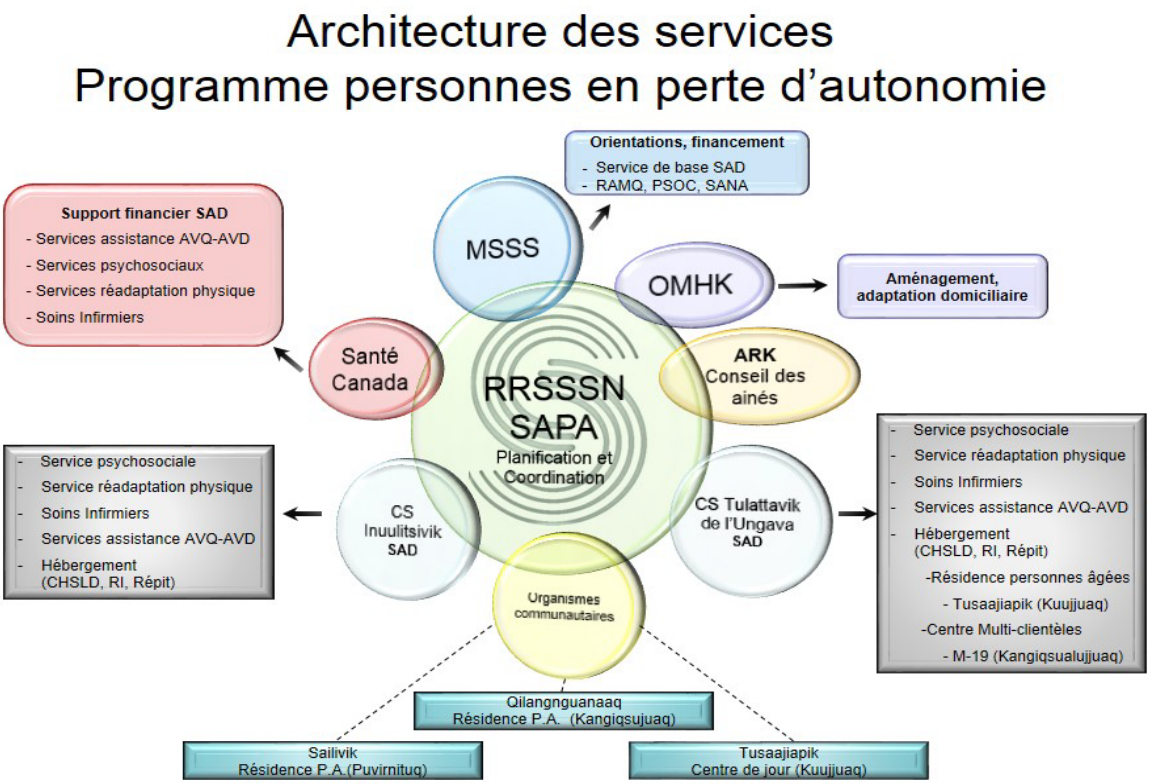
Figure 30 Out of region clientele, 2016[144]



The Program for the Care of Persons with Loss of Autonomy falls under the Health centre's CLSCs mission. The program also follows the guidelines of the MSSS. It is an integral part of the program entitled "Persons with Loss of Autonomy" (PLA), which is the former name of the MSSS program, now known as the *Soutien à l'autonomie de la personne âgée* or SAPA Program.

[144] Nunavik Regional Board of Health and Social Services. (2018). *Strategic Regional Plan 2018-2025*.(N.D.)

Figure 31 Architecture of services for individuals with loss of autonomy



5.7.2 First Nations and Inuit Home and Community Care

5.7.2.1 Service Delivery

The NRBHSS receives funding from Indigenous Services Canada under the First Nations and Inuit Home and Community Care Program (FNIHCCP) in order to optimize the care and services provided at home to individuals requiring such services. At the NRBHSS, there is one Persons lacking autonomy Agent that is responsible for the administration of the program at the regional. This person provides support to the Health centres for the implementation of the program.

Most of the funding received is decentralized to the two Health centres, who ensure the delivery of services in communities. Federal funding is mainly used to fund salaries for nurses and specialists (e.g.: respiratory therapists and physical therapists) as well as specialized medical equipment.

The program's overall vision is to foster proximity services for persons with loss of autonomy, particularly by making the home the first option to consider as a living environment. The notion of "home" is meant to be inclusive of non-institutional substitute living environments, and implies that the individual may remain in his own home, with his family members, in an elders' residence, or in any other living environment that does not provide the necessary care or services.

In concrete terms, the following services are offered in every community:

- Intake, needs assessment, development of an intervention plan, service plan or care plan;
- Coordination of requests for long-term home care of residential services;
- Coordination of long-term home care services;
- Nursing;
- Services for home support and assistance;
- Personal hygiene, domestic and daily living activities;
- Psychosocial services;
- Functional rehabilitation services in the home: physiotherapy, occupational therapy;
- Medical services at home.

For more details regarding service delivery for this program, please see the Service delivery plan at Annex 9.8.

5.7.2.2 Goals

Establish foundations for the intake of persons with loss of autonomy in Nunavik, to clarify the access procedures and the care and services offered. The main objectives of the program are to:

- Ensure equitable access to care and services in each community of Nunavik;
- Provide support of good quality adapted to the individual's condition, in a patient-partner approach;
- Foster maintaining the individual in the living environment of his choice, according to his condition;
- Support the individual's family.

5.7.2.3 Health Program Planning

The Service delivery plan is considered the program planning for HCC and is regularly updated. A series of policies and procedures also serve as a basis for the implementation of the program. A list of all policies and procedures pertaining to HCC, including their review date, is available at Annex 9.9.

Although Nunavik's population is much younger than the rest of the province, an important mass of the population is aging. In order to be able to respond to this population's needs, the NRBHSS will work more specifically on the following files in the upcoming years:

- Developing a systematic approach to tracking chronic diseases in order to anticipate the needs of this population and develop services accordingly.
- Consolidate palliative care services by first assessing the needs and expectations of the population in order to secondly, enhance access to these types of services and provide adequate support to families and individuals.
- Support the work done by the Kuujjuaq Day centre by providing funding for a traditional Inuit tent and support for the associated programming. The activities being planned aim to keep elders independent and help them remain in their home by carrying out activities fostering their physical and mental wellness.

5.7.2.4 Evaluation

An annual report will be produced in accordance with the data requested by Indigenous Services Canada. This report will be supported by a more contextual review of the year's work.

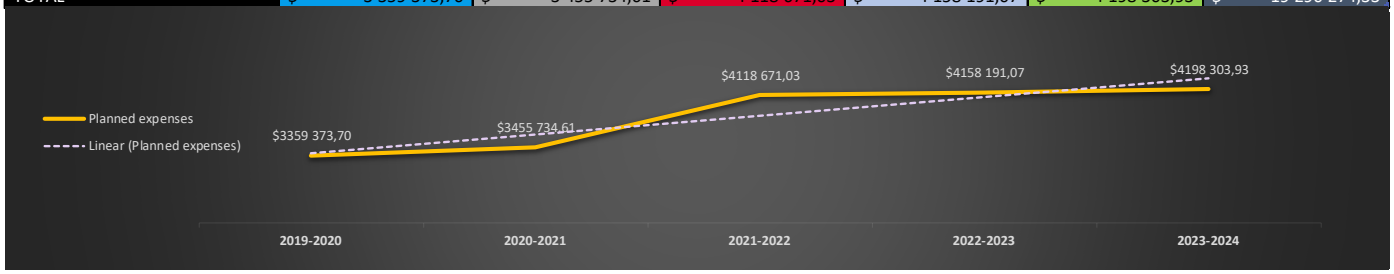
In addition, the 2017 Qanuilirpitaa health survey (See Annex 9.3) will provide the NRBHSS with an updated portrait of the health status of Inuit in Nunavik. This survey will provide indicators to follow in the next years in order to assess the evolution of the regional health status.

Furthermore, every program that receives funding from the provincial government must answer to a management and accountability agreement, which affects future funding allocations.

5.7.2.5 Budget

Although part of the HCC funding has only been confirmed up to 2021-2022, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned First Nations and Inuit Home and Community Care					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
NRBHSS Salaries and activites	$ 526 749,80	$ 541 859,19	$ 645 807,62	$ 652 004,36	$ 658 294,06	$ 3 024 715,02
Transfer to IHC	$ 1 382 718,21	$ 1 422 380,37	$ 1 695 244,99	$ 1 711 511,44	$ 1 728 021,90	$ 7 939 876,91
Transfer to UTHC	$ 1 382 718,21	$ 1 422 380,37	$ 1 695 244,99	$ 1 711 511,44	$ 1 728 021,90	$ 7 939 876,91
Administration fees	$ 67 187,47	$ 69 114,69	$ 82 373,42	$ 83 163,82	$ 83 966,08	$ 385 805,49
TOTAL	$ 3 359 373,70	$ 3 455 734,61	$ 4 118 671,03	$ 4 158 191,07	$ 4 198 303,93	$ 19 290 274,33



5.8 Supplementary Health Benefits

Section 15.0.19 of the JBNQA refers to non-insured health benefits (NIHB) for which additional funding is provided for the Nunavik health institutions on top of the provincial funding for services destined for the entire provincial population.

"15.0.19 *The budget from the Province of Quebec 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."*[145]

Inuit registered under the beneficiaries of the JBNQA and residing in Nunavik, or temporarily absent (students, inmates, etc.) are eligible to the Inuit Non Insured Health Benefit Program (INIHB). The program covers drugs, dental, eye and vision care, medical supplies and equipment, medical transportation and short-term crisis intervention mental health counselling.[146]

Inuit whose permanent residence is outside the Nunavik and James-bay territories could be eligible under the Indigenous Services Canada Non-Insured Health Benefits program.

[145] N.D. *The James Bay and Northern Quebec Agreement (JBNQA)*. P. 197 Retrieved from http://extwprlegs1.fao.org/docs/pdf/que136636.pdf, p. 200

[146] Health Canada. (2014, March). *Your health benefits – A guide for Inuit to Access Non-insured Health Benefits*. Retrieved from https://nrbhss.ca/sites/default/files/3.6.1_Inuit%20NIHB%20Handbook_VApdf.pdf, p. 24-31.

5.9 Health System Capacity

5.9.1 Planning and Quality Management

5.9.1.1 Service Delivery

In 2016-2017, two resources were hired to ensure a more efficient management of the federal government agreement. As part of their mandate, they also developed internal capacity to ensure the conformity of activities, and programs as well as developed accountability and performance management tools. Their role as a liaison with the federal government has proven effective for both parties. Various initiatives are currently in place to improve the overall governance of the NRBHSS. In the upcoming years, these two resources will continue to shape the way the federal agreement is managed, and more particularly, integrated with provincial funding.

5.9.1.2 Health Program Planning

To do so, the team will pursue the development and standardization of knowledge and decision-aiding tools. These tools will support program officers and managers in the evaluation, financial management and reporting of programs. The team also plans to develop electronic data collecting tools for specific programs, in order to aid health centres and CLSCs in gathering consistent and standardized data. These actions will contribute to careful monitoring of spending's, which will allow for simple and easy management of surpluses, should there be any. Having these tools in place will also allow the team to easily prepare and support federal auditing processes.

In the upcoming year, new health data will be made available with the publication of the results from the Qanuilirpitaa health survey. The team will integrate the latest health results in the current planning and work with the NRBHSS teams to ensure the coherence of the health planning developed and the new published health survey results.

The team also aims to work towards a better integration of federal and provincial programs, all the while increasing interdepartmental collaborations. In order to achieve this, the team will continue to work with the Nunavik Clinical Plan (See 5.10.1) group from the Planning and programming Department to integrate federal data and programs in the clinical plan under development. In addition, the team will work with the various departments of the NRBHSS to identify the available services and projects on the continuum of services. This undertaking will strive to better identify gaps and overlapping services and projects. It will serve as a basis to ensure a more efficient integration of programs and ultimately better answer the population's needs.

The NRBHSS also plans on modifying the human resource structure for the management of the federal government agreement. In the past years, many efforts were invested in the development and tracking of performance indicators. In order to maintain and pursue the development of this management practice as well as to enable the thorough administration required for a block funding agreement, the team will be expanded to three positions. The two existing planning and programming officers will remain, and a coordinator's position will be added. Having a coordinator position will also allow for better representation of all the NRBHSS departments.

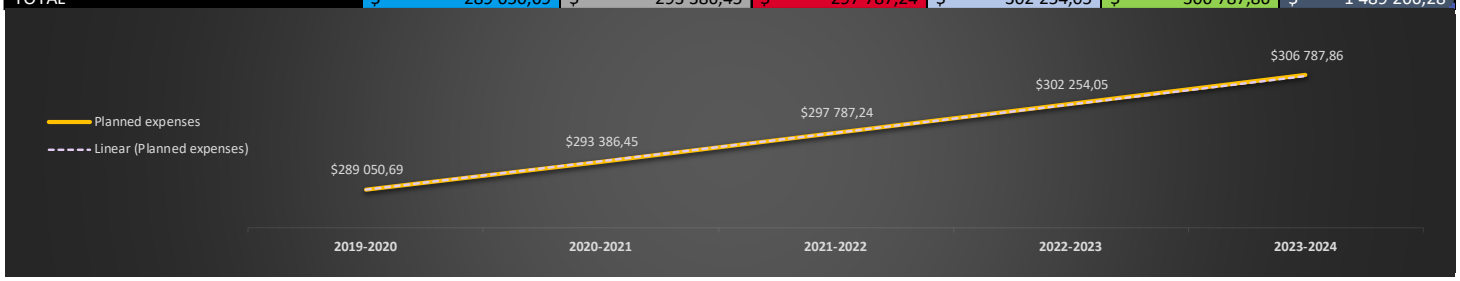
5.9.1.3 Evaluation

There is no formal evaluation planned of the activities carried out by the team. Their performance is evaluated by their manager on an annual basis.

5.9.1.4 Budget

A conservative indexation of 1.5% was forecasted for the duration of the health plan

	Distribution of funds and expenses planned Planning and Quality Management					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**	**Planned expenses**
Salaries	$ 283 269,67	$ 287 518,72	$ 291 831,50	$ 296 208,97	$ 300 652,10	$ 1 459 480,96
Administration fees	$ 5 781,01	$ 5 867,73	$ 5 955,74	$ 6 045,08	$ 6 135,76	$ 29 785,33
TOTAL	$ 289 050,69	$ 293 386,45	$ 297 787,24	$ 302 254,05	$ 306 787,86	$ 1 489 266,28



5.9.2 Health Human Resources

5.9.2.1 Service Delivery

The department of Human resources development ensures the planning, coordination and evaluation of training programs that meet the needs in terms of service provision in the health and social services network. It contributes to improving attraction and retention of personnel and the development of the Inuit succession plan. In collaboration with the Executive Management Department, the department supports the efforts to hire, maintain, train and mobilize Inuit personnel towards a sustainable workforce.

The department is composed of two training officers, two career promotion officers and one planning and programming officer. It represents the health establishments and the regional board before the MSSS for the improvement of northern benefits (Inuit and non-Inuit) as well as on various provincial committees on human resources, regional disparities.

5.9.2.2 Goals

- Develop the skills of Inuit working in the health and social network.

5.9.2.3 Health Program Planning

As part of the previous agreement with Indigenous Services Canada, under the Aboriginal health human resource initiative, the Health Care Assistance Training was developed. By the end of 2018-2019, the first cohort will have finished their training.

A summary evaluation is planned in order to continually improve the training programs developed by the NRBHSS. In the upcoming years, it is planned to have at least one new cohort per year and expand the training program to the Hudson Coast.

Health Program Planning								
Timeframe: 2019-2020 to 2023-2024								
Aboriginal Health Human Ressource Initiative								
Goals: Develop the skills of Inuit working in the health and social network.								
Objectives	Activities	Target Population	Person Responsible	Collaborators	Time frame	Indicators		Data sources Evaluation
						Implementation	Results (impact, effects)	
1- By 2024, 50% of Inuit health care assistants will have received the Health care assistance training.	1.1- Summary evaluation of the first cohort trained.	Health assistant workers	Planning and programming officer (Stéphanie Mathieu)	KI (School Board) Health centres/CLSCs	2019-2020	Summary evaluation	Improved training	Participants and employer evaluations Teacher evaluation
	1.2- Based on summary evaluation results, improve training.				2019-2020	Updated and improved training	Better adapted training	Updated training
	1.3- Deploy the training on the Hudson coast (Puvirnituq)				Ongoing as of 2020-2021	Nb of trainings Nb of workers trained	Better trained workers Better quality services to patients Employee retention rates	Participants and employer evaluations Annual report from planning and programming officer
	1.4- Identify and develop strategies to reach workers outside of Kuujjuaq and Puvirnituq.				2020-2021	Nb of strategies identified	Nb of strategies implemented Nb of workers trained	Annual report from planning and programming officer Meeting minutes when applicable
	1.5- Hold at least one training annually.				Ongoing as of 2019-2020	Nb of trainings Nb of workers trained	Better trained workers Better quality services to patients Employee retention rates	Participants and employer evaluations Annual report from planning and programming officer

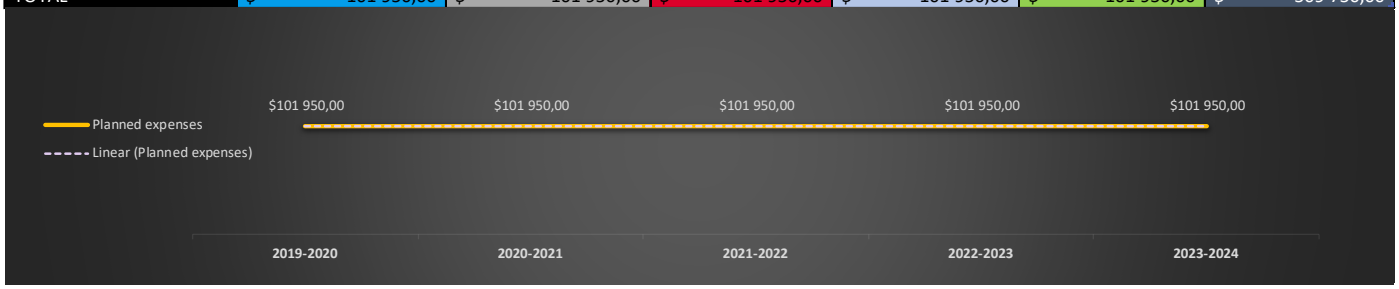
5.9.2.4 Evaluation

An annual activity report including the implementation and result indicators mentioned in the program planning will be produced. At the end of the planning cycle, those indicators will be compared and demonstrate the level of achievement of the objectives and activities.

5.9.2.5 Budget

Although funding for AHHRI has not been confirmed beyond 2018-2019, for planning purposes, funding was forecasted for the duration of the health plan.

	Distribution of funds and expenses planned Health Human Resources					
	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	TOTAL 5 years
Categories of expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses	Planned expenses
Training	$ 101 950,00	$ 101 950,00	$ 101 950,00	$ 101 950,00	$ 101 950,00	$ 509 750,00
TOTAL	$ 101 950,00	$ 101 950,00	$ 101 950,00	$ 101 950,00	$ 101 950,00	$ 509 750,00



5.9.3 Health Facilities

As part of the Strategic Regional Plan (2018-2025), the development of capital facilities, housing and equipment at a pace that respects the development of services in taken into account. The department of administrative services of the NRBHSS supports the Health centres in the maintenance of major assets, through renovations and replacement projects.

The NRBHSS has a Capital Master Plan (CMP) supported by the MSSS, which includes health and social services and housing for employees. As part of this plan, the NRBHSS in collaboration with the advisory committee, establishes priorities for short and long-term capital investments. The CMP is regularly updated by the advisory committee. The Nunavik Clinical Plan (See 5.10.1) in development also includes a section dedicated to capital investments.

5.10 Health System Transformation

5.10.1 Systems Integration

The NRBHSS is currently working on the development of the Nunavik Clinical Plan aiming to redefine and reorganize health care in Nunavik, according to Nunavimmiut values and vision as well as offer more care of good quality directly in the communities. In order to achieve this, the NRBHSS is working to assess the health needs of the population for the next 20 years and define the needs for structures to patriate new services to the region.

Although the NRBHSS does not receive federal funding under this program, the new block funding approach will provide the required flexibility to ensure federal programs and funding is included in this large scale endeavour.

5.10.2 E-Health Info structure

The development of technical-support systems, including information-technology, communications and management systems were included in the Strategic Regional Plan (2018-2025). Considering the geographical context of the region, technology and telehealth play important roles in the organization and delivery of services in Nunavik. As part of the provincial health networks, the NRBHSS, the Health centres and CLSCs use the software available in the network, for example I-CLSC. The NRBHSS does not receive federal funding under this program.

6. EVALUATION

The NRBHSS wishes to continue implementing assessment and evaluation processes to support the continuous improvement of its programs and ultimately contribute to the health and well-being of Nunavik's population. Some evaluative processes are already in place, for example, the NRBHSS has a management and accountability agreement with the provincial government, which is determinant of the funding allocations received. This evaluation process is done on an annual basis.

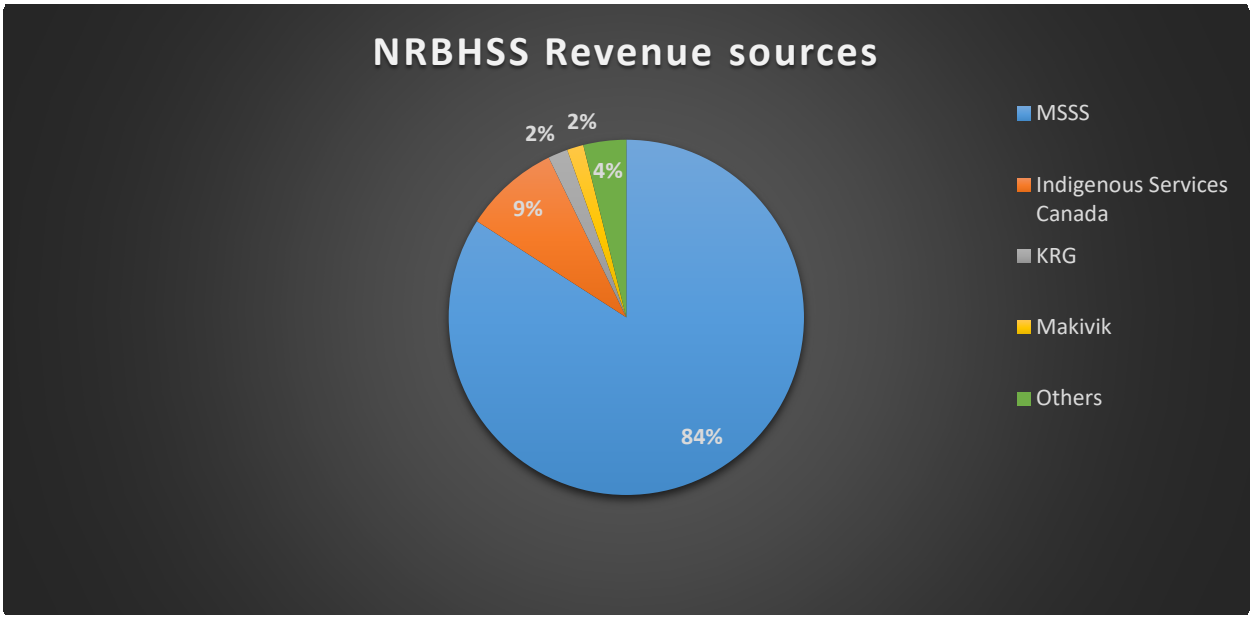
Furthermore, the results of the 2017 Qanuilirpitaa health survey will be published in the fall of 2018 and the winter of 2019. With this new data, in comparison with the results of the 2004, Qanuippitaa health survey, it will be possible for the NRBHSS to determine if there have been changes to the health of the population. This information will allow the NRBHSS to adapt its programs and interventions in order to be better aligned with the health status of the population.

In addition, as part of the block funding agreement with Indigenous Services Canada, an annual activity report including the implementation and result indicators mentioned in the program planning will be produced. These results will be compiled and analyzed, in order to demonstrate the level of achievement of the objectives and activities. Ultimately this information will be used to review the NRBHSS'S program planning.

7. BUDGET

The Nunavik Health Network receives the majority of its funding through the MSSS ($ 93 million in 2017-2018). There are also significant investments for the Non-Insured Health Services ($ 37 million in 2017-2018), which has increased sharply in the last years.

Figure 32 Source of Funding Nunavik Health Network, 2017-2018



The following table presents the expected funding from Indigenous Services Canada over the next ten years.

Table 3 Overall budget forecast 2019-2029

Nunavik Block Funding Agreement 2019-2029		
2019-2020	$	10 495 192
2020-2021	$	10 898 021
2021-2022	$	11 865 184
2022-2023	$	11 956 698
2023-2024	$	12 049 584
2024-2025	$	12 184 267
2025-2026	$	12 286 252
2026-2027	$	12 389 767
2027-2028	$	12 494 835
2028-2029	$	12 601 479
TOTAL	**$**	**119 221 281**

The tables on the next pages present the detailed forecasted budget. A number of funds were forecasted without knowledge of program or initiative renewal. For example, the funding announced for the period of 2017-2018 to 2021-2022 was, for planning purposes, considered as ongoing for the years that followed. In addition, although the budgets are unknown, we indicated that the agreement would include the same funding as 2018-2019 for the MMIWG initiative. Indexation on the applicable programs were calculated at a 1.5% rate. Furthermore, administrative fees were estimated at 2% for all programs. The NRBHSS considers services to the population as a more important priority of spending. This being said, administrative costs could be modified, should the need arise.

Please note that the budget presented reflects the available funding, to the best of the NRBHSS's knowledge. Considering the high cost of doing business in the northern and isolated region that is Nunavik the expenses for all programs increase faster than the funding available. Hence, the budgets presented do not represent the funding needed, but rather what is considered available at this time. In addition, some programs require more funding than what is currently available to carry-out the planned activities.

Table 4 Budget forecast 2019-2024 (1/2)

Nunavik Block Funding Agreement 2019-2024			Distribution of funds and expenses planned					
Programs			2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total 5 years
Primary Health Care	Indigenous Services Canada code	Health Promotion and Disease Prevention						
		Healthy Child Development						
	KA03	Maternal and Child Health (MCH - Inuit Component)	126 000 $	179 000 $	234 000 $	234 000 $	234 000 $	1 007 000 $
	KA01	Canadian prenatal nutrition program (CPNP)	338 372 $	343 447 $	348 599 $	353 828 $	359 135 $	1 743 381 $
	KA02	Fœtal alcholism spectrum disorder (FASD)	357 038 $	362 394 $	367 830 $	373 347 $	378 947 $	1 839 557 $
		Fœtal alcholism spectrum disorder (FASD - Inuit Component)	63 000 $	90 000 $	118 000 $	118 000 $	118 000 $	507 000 $
	KA04	Children's Oral Health Initiative (COHI - Inuit Component)	300 000 $	365 000 $	424 000 $	424 000 $	424 000 $	1 937 000 $
		Sub total Healthy Chld Development	**1 184 410 $**	**1 339 841 $**	**1 492 429 $**	**1 503 175 $**	**1 514 082 $**	**7 033 937 $**
		Mental Wellness						
	KB03	National Aboriginal Youth Suicide prevention strategie (Inuit Component)	225 000 $	250 000 $	270 000 $	270 000 $	270 000 $	1 285 000 $
		National Aboriginal Youth Suicide prevention strategie (NAYSPS)	240 000 $	240 000 $	240 000 $	240 000 $	240 000 $	1 200 000 $
	KB01	Building healthy communities (CLWW)	937 602 $	951 666 $	965 941 $	980 430 $	995 137 $	4 830 777 $
	KB02	Brighter Future (BF)	1 242 527 $	1 261 165 $	1 280 083 $	1 299 284 $	1 318 773 $	6 401 833 $
		Missing and Murdered Indigenous Women and Girls (MMIWG)	150 000 $	150 000 $	150 000 $	150 000 $	150 000 $	750 000 $
	KB32	Indian residential schools resolution health support Program (RHSW)	675 030 $	675 030 $	675 030 $	675 030 $	675 030 $	3 375 150 $
	KB33	Indian residential schools resolution health support Program (CSP)	- $	- $	- $	- $	- $	- $
	KB05	Mental Wellness Teams (MWT - Inuit Component)	420 000 $	470 000 $	507 000 $	507 000 $	507 000 $	2 411 000 $
	N/A	Substance abuse prevention and treatment (SAPT)	- $	- $	- $	- $	- $	- $
		Sub-total Mental Wellness	**3 890 160 $**	**3 997 862 $**	**4 088 054 $**	**4 121 744 $**	**4 155 940 $**	**20 253 760 $**
		Healthy Living						
	KC11	Nutrition North Canada (NNC)	490 000 $	490 000 $	490 000 $	490 000 $	490 000 $	2 450 000 $
	KC01	Aboriginal diabetes initiative (ADI) (includes phyAct 40K + FoodSec 100K)	540 682 $	540 682 $	540 682 $	540 682 $	540 682 $	2 703 410 $
	KC40	Federal Tobacco Control Strategy	220 566 $	220 566 $	220 566 $	220 566 $	220 566 $	1 102 830 $
		Sub-total Healthy Living	**1 251 248 $**	**1 251 248 $**	**1 251 248 $**	**1 251 248 $**	**1 251 248 $**	**6 256 240 $**
		Sub-total Health promotion and disease prevention	**6 325 818 $**	**6 588 950 $**	**6 831 731 $**	**6 876 168 $**	**6 921 271 $**	**33 543 937 $**

Table 5 Budget forecast 2019-2024 (2/2)

Nunavik Block Funding Agreement 2019-2024			Distribution of funds and expenses planned					
		Programs	2019-2020	2020-2021	2021-2022	2022-2023	2023-2024	Total 5 years
Primary Health Care		Primary Care						
		Communicable Disease Control and Management						
	KD20	Tuberculosis (Inuit Component)	53 000 $	67 000 $	80 000 $	80 000 $	80 000 $	360 000 $
	KD40	Sexually Transmited and Blood-Born Infections (STBBI - Inuit Component)	366 000 $	391 000 $	435 045 $	438 135 $	441 272 $	2 071 452 $
		Sub-total Infectious Disease	**419 000 $**	**458 000 $**	**515 045 $**	**518 135 $**	**521 272 $**	**2 431 452 $**
		Home and Community Care						
	KG01	First and Inuit Home and community care (FNIHCC)	2 557 374 $	2 595 735 $	2 634 671 $	2 674 191 $	2 714 304 $	13 176 274 $
		First and Inuit Home and community care (FNIHCC - Inuit Component)	726 000 $	739 000 $	1 303 000 $	1 303 000 $	1 303 000 $	5 374 000 $
		Palliative Care (Inuit Component)	76 000 $	121 000 $	181 000 $	181 000 $	181 000 $	740 000 $
		Sub-total Seniors	**3 359 374 $**	**3 455 735 $**	**4 118 671 $**	**4 158 191 $**	**4 198 304 $**	**19 290 274 $**
		Sub-total Primary Care	**3 778 374 $**	**3 913 735 $**	**4 633 716 $**	**4 676 326 $**	**4 719 576 $**	**21 721 726 $**
		Total Primary Health Care	**10 104 191 $**	**10 502 685 $**	**11 465 447 $**	**11 552 494 $**	**11 640 847 $**	**55 265 663 $**
Health infrastructure support		Health System Capacity						
		Health Planning and Quality Management						
	KJ00	Nunavik Health Services Planning and Quality Management (Governance)	289 051 $	293 386 $	297 787 $	302 254 $	306 788 $	1 489 266 $
		Sub total Health planning and Quality management	**289 051 $**	**293 386 $**	**297 787 $**	**302 254 $**	**306 788 $**	**1 489 266 $**
		Health Human Resources						
	KK20	Aboriginal Health human resources initiatives (AHHRI)	101 950 $	101 950 $	101 950 $	101 950 $	101 950 $	509 750 $
		Sub total Health Human Resources	**101 950 $**	**101 950 $**	**101 950 $**	**101 950 $**	**101 950 $**	**509 750 $**
		Sub total Health Infrastructure support	**391 001 $**	**395 336 $**	**399 737 $**	**404 204 $**	**408 738 $**	**1 999 016 $**
Total (Nunavik Block Funding Agreement 2019-2024)			**10 495 192 $**	**10 898 021 $**	**11 865 184 $**	**11 956 698 $**	**12 049 584 $**	**57 264 680 $**

Table 6 Budget forecast 2024-2029 (1/2)

Nunavik Block Funding Agreement 2024-2029			Distribution of funds and expenses planned					
	Programs		2024-2025	2025-2026	2026-2027	2027-2028	2028-2029	Total 5 years
Primary Health Care	Indigenous Services Canada code	Health Promotion and Disease Prevention						
		Healthy Child Development						
	KA03	Maternal and Child Health (MCH - Inuit Component)	234 000 $	234 000 $	234 000 $	234 000 $	234 000 $	1 170 000 $
	KA01	Canadian prenatal nutrition program (CPNP)	364 522 $	369 990 $	375 540 $	381 173 $	386 890 $	1 878 115 $
	KA02	Fœtal alcholism spectrum disorder (FASD)	384 631 $	390 401 $	396 257 $	402 201 $	408 234 $	1 981 723 $
		Fœtal alcholism spectrum disorder (FASD - Inuit Component)	118 000 $	118 000 $	118 000 $	118 000 $	118 000 $	590 000 $
	KA04	Children's Oral Health Initiative (COHI - Inuit Component)	424 000 $	424 000 $	424 000 $	424 000 $	424 000 $	2 120 000 $
		Sub total Early childhood dvelopment	**1 525 153 $**	**1 536 391 $**	**1 547 796 $**	**1 559 373 $**	**1 571 124 $**	**7 739 837 $**
		Mental Wellness						
	KB03	National Aboriginal Youth Suicide prevention strategie (Inuit Component)	270 000 $	270 000 $	270 000 $	270 000 $	270 000 $	1 350 000 $
		National Aboriginal Youth Suicide prevention strategie (NAYSPS)	240 000 $	240 000 $	240 000 $	240 000 $	240 000 $	1 200 000 $
	KB01	Building healthy communities (CLWW)	1 010 064 $	1 025 215 $	1 040 593 $	1 056 202 $	1 072 045 $	5 204 120 $
	KB02	Brighter Future (BF)	1 338 555 $	1 358 633 $	1 379 012 $	1 399 698 $	1 420 693 $	6 896 591 $
		Missing and Murdered Indigenous Women and Girls (MMIWG)	186 968 $	189 772 $	192 619 $	195 508 $	198 441 $	963 307 $
	KB32	Indian residential schools resolution health support Program (RHSW)	675 030 $	675 030 $	675 030 $	675 030 $	675 030 $	3 375 150 $
	KB33	Indian residential schools resolution health support Program (CSP)	- $	- $	- $	- $	- $	- $
	KB05	Mental Wellness Teams (MWT - Inuit Component)	507 000 $	507 000 $	507 000 $	507 000 $	507 000 $	2 535 000 $
	N/A	Substance abuse prevention and treatment (SAPT)	- $	- $	- $	- $	- $	- $
		Sub-total Mental Wellness	**4 227 616 $**	**4 265 650 $**	**4 304 254 $**	**4 343 438 $**	**4 383 209 $**	**21 524 167 $**
		Healthy Living						
	KC11	Nutrition North Canada (NNC)	490 000 $	490 000 $	490 000 $	490 000 $	490 000 $	2 450 000 $
	KC01	Aboriginal diabetes initiative (ADI) (includes phyAct 40K + FoodSec 100K)	540 682 $	540 682 $	540 682 $	540 682 $	540 682 $	2 703 410 $
	KC40	Federal Tobacco Control Strategy	220 566 $	220 566 $	220 566 $	220 566 $	220 566 $	1 102 830 $
		Sub-total Healthy Living	**1 251 248 $**	**1 251 248 $**	**1 251 248 $**	**1 251 248 $**	**1 251 248 $**	**6 256 240 $**
		Sub-total Health promotion and disease prevention	**7 004 017 $**	**7 053 289 $**	**7 103 299 $**	**7 154 059 $**	**7 205 581 $**	**35 520 245 $**

Table 7 Budget forecast 2024-2029 (2/2)

Nunavik Block Funding Agreement 2024-2029			Distribution of funds and expenses planned					
		Programs	2024-2025	2025-2026	2026-2027	2027-2028	2028-2029	Total 5 years
Primary Health Care		Primary Care						
		Communicable Disease Control and Management						
	KD20	Tuberculosis (Inuit Component)	80 000 $	80 000 $	80 000 $	80 000 $	80 000 $	400 000 $
	KD40	Sexually Transmited and Blood-Born Infections (STBBI - Inuit Component)	447 891 $	454 609 $	461 428 $	468 349 $	475 374 $	2 307 652 $
		Sub-total Infectious Disease	**527 891 $**	**534 609 $**	**541 428 $**	**548 349 $**	**555 374 $**	**2 707 652 $**
		Home and Community Care						
	KG01	First and Inuit Home and community care (FNIHCC)	2 755 019 $	2 796 344 $	2 838 289 $	2 880 863 $	2 924 076 $	14 194 591 $
		First and Inuit Home and community care (FNIHCC - Inuit Component)	1 303 000 $	1 303 000 $	1 303 000 $	1 303 000 $	1 303 000 $	6 515 000 $
		Palliative Care (Inuit Component)	181 000 $	181 000 $	181 000 $	181 000 $	181 000 $	905 000 $
		Sub-total Seniors	**4 239 019 $**	**4 280 344 $**	**4 322 289 $**	**4 364 863 $**	**4 408 076 $**	**21 614 591 $**
		Sub-total Primary Care	**4 766 910 $**	**4 814 953 $**	**4 863 717 $**	**4 913 213 $**	**4 963 450 $**	**24 322 243 $**
		Total Primary Health Care	**11 770 927 $**	**11 868 242 $**	**11 967 016 $**	**12 067 272 $**	**12 169 031 $**	**59 842 488 $**
Health infrastructure support		Health System Capacity						
		Health Planning and Quality Management						
	KJ00	Nunavik Health Services Planning and Quality Management (Governance)	311 390 $	316 061 $	320 802 $	325 614 $	330 498 $	1 604 363 $
		Sub total Health planning and Quality management	**311 390 $**	**316 061 $**	**320 802 $**	**325 614 $**	**330 498 $**	**1 604 363 $**
		Health Human Resources						
	KK20	Aboriginal Health human resources initiatives (AHHRI)	101 950 $	101 950 $	101 950 $	101 950 $	101 950 $	509 750 $
		Sub total Health Human Resources	**101 950 $**	**101 950 $**	**101 950 $**	**101 950 $**	**101 950 $**	**509 750 $**
		Sub total Health Infrastructure support	**413 340 $**	**418 011 $**	**422 752 $**	**427 564 $**	**432 448 $**	**2 114 113 $**
Total (Nunavik Block Funding Agreement 2024-2029)			**12 184 267 $**	**12 286 252 $**	**12 389 767 $**	**12 494 835 $**	**12 601 479 $**	**61 956 601 $**

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9. ANNEXES

9.1 Resolution for Block Funding Agreement from Board of Directors

NUNAVIK REGIONAL BOARD
OF HEALTH AND SOCIAL SERVICES

BOARD OF DIRECTORS MEETING

RESOLUTION 2017 -16

Concerning the renewal of the Contribution Agreement with Health Canada for 2019-2024;

WHEREAS the NRBHSS assumes the mandate of planning, organizing, implementing and evaluating the provision of health and social services on its territory;

WHEREAS the NRBHSS has signed a 2016-2019 flexible contribution agreement with Health Canada (#1617-QC-000010) in order to support its effort to ensure the dispensation of health and social services within Nunavik;

WHEREAS the actual 3 years Flexible Contribution Agreement with Health Canada will end March 31st, 2019;

WHEREAS the NRBHSS would like to engage into a process of changing the actual funding agreement with Health Canada towards greater flexibility for 2019-2024 – (Block Funding Agreement).

THEREFORE, UPON MOTION DULY SECONDED, IT IS HEREBY RESOLVED THAT:

1. The preamble shall form an integral part of this resolution.

2. The NRBHSS Executive Director be and is hereby mandated to take all appropriate steps to ensure the negotiation and the conclusion of a minimal 5 years block funding agreement with Health Canada

3. This resolution comes into force on the date of its adoption.

CERTIFICATE

I, the undersigned Minnie Grey, Secretary of the Board of Directors of the Nunavik Regional Board of Health and Social Services, certify by the present, under my oath of office, that the present document is true to its original as a resolution of the Board of Directors of the Nunavik Regional Board of Health and Social Services held on April 25-27, 2017, in Kuujjuaq, and in witness thereof, I have signed and sealed the present certificate in Kuujjuaq, this 16th day of May 2017.

Minnie Grey
Secretary

General Services (2017) 1/3

Description (MSSS)		Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2022	New houses needed 2018-2022	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Tusaalijapik day centre (Kuujjuaq)		Ullivik****	Ruis McGill	Other
1st line services (General Services)	Nursing Services (CLSC) • Intake, orientation,info, reference 24/7 • Health-Line • On call 24/7 • Diagnostics • Intervention/Treatment • Information	NEL-nur. (enla.role)24/7 LN-Liaison Nurse N-Nurse 24/7 SEX-Nurse (ITSS, Famiiy plan) SNU-School Nurse CNU-Com. Health Nurse HOM-Homecare Nurse IPS-Spec. Nurse pract	3X NEL, 5X IPS, 2X N, 1X pn, 2X ADM, 2X LN	$ 5 460 000	14	NEL CNU* HOM **NEL18**	NEL **LN, LN18, ADM18** SEX SNU CNU HOM N **N20**	NEL CNU*	NEL CNU*	NEL CNU* HOM **IPS20**	NEL CNU* **IPS 20**	NEL CNU HOM **NEL19** **IPS 19**	NEL CNU* **N19** **IPS18**	NEL CNU*	NEL CNU SEX HOM LN **NEL18**	NEL **LN18, ADM18, PN18** SEX CNU HOM N **N20** LN	NEL CNU IPS**	NEL CNU*	NEL CNU* HOM SEX LN **NEL19**	**N18**	CNU							LN HOM***	LN N	LN N
	Nutrition • Information • Education • Intervention (group, ind.)	NEL-Nurse(enlarge role)24/7 N-Nurse 24/7 NUT-Nutritionist CNU-Com. Health Nurse HOM-Homecare Nurse	3X NUT	$ 450 000	3	NEL CNU* HOM NUT*	NEL CNU HOM NUT N **NUT20**	NEL CNU* NUT*	NEL CNU* NUT*	NEL CNU* NUT*	NEL CNU* NUT*	NEL CNU* NUT*	NEL CNU*	NEL CNU*	NEL CNU HOM	NEL CNU HOM N **NUT19, NUT20**	NEL CNU*	NEL CNU*	NEL CNU*		CNU NUT								NUT	NUT
	Physical rehabilitation • Physiotherapy • Occupational therapy	PHY-Physiotherapist TRP-Phys. Rehab Thera. ERG-Occupational therapist, Orto=Orthophonist RAS-Rehabilitation Ass. MEC-Mechanical tech. ORT-Orthesist NEL- NEL-Nurse(enla. role) CLE-Constance Lethbridge ORS-Out of region serv. MDR-MD technical aids prescriptor)	2X PHT,2XERG,2X ORTO,2X TRP, 2X MEC 2X PROTH,1X REHA ASS	$ 4 930 000	13	PHY* TRP* ERG* RAS NEL MDR*	PHY TRP ERG RAS MEC ORT* CLE* MDR **PHT20 ORT19 ERG19 TRP19 MEC20 PROT20**	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR	PHY TRP ERG RAS MEC ORT* CLE* MDR **PHT20 ORT19 ERG19 TRP19 MEC20 PROT20**	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR*	PHY* TRP* ERG* RAS NEL MDR							PHY* TRP* ERG* RAS			PHY ORT ERG MEC ORS	PHY ERG CLE ORS ORT MEC

General Services (2017) 2/3

Description (MSSS)		Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2022	New houses needed 2018-2022	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Tusaajiapik day centre (Kuujjuaq)		Ullivik***	Ruis McGill	Other
1st line services (General services)	General medecine • Information • Treatment • Consultation • Reference	MD-Doctors NEL-Nurse. (enlarge.role)24/7 RX-Pharmacist MDS = SPÉCIALISTE ATP	25xMD, 22x MDS, 5X RX, 5X ATP	$ 1 874 000	42	MD NEL RX21, ATP21	MD NEL PHA MD18-25 MDS18-25, RX19, ATP20	MD* NEL RX*	MD* NEL RX*	MD* NEL RX*	MD* NEL RX*	MD* NEL RX 22, ATP22	MD* NEL RX*	MD* NEL RX*	MD NEL RX19 ATP19	MD NEL RX MD18-25 MDS18-25, RX19, ATP20	MD* NEL RX*	MD* NEL RX*	MD NEL RX20, ATP20							MD* RX*		MD* RX*	MD RX	MD RX
	Diagnostic Services • Hematology • Medical imagery	Lab-Analyze Lab (hema) BLO-Blood sampling XRA-Radiology/X-ray US-Ultrasound CTS-CT-scan, ADBD=LAB SPECI	2X ADBD , 4X XRA, 2X US	$ 1 120 000	8	XRA19 BLO	LAB XRA US BLO ADBD19, US19	BLO	BLO	BLO	BLO	BLO XRA20	XRA* BLO	BLO	BLO XRA19 US*	LAB XRA US BLO ADBD19, US19	BLO	BLO	XRA20 BLO											
	Specialized medecine (CLSC)	SEE Physical health Specialized services	See general medecine																											
	Liaison Services • Liaise • Information • Appointment • Lodging • Transport	ULL-Ullivik lodging/transpo (Mtl) LN-Liaison Nurse NEL-Nurse. (enlarge.role)24/7 N-Nurse ADM-Admin Agent PN-Patient Navigator TRA-Interpretor	1x LN, 1x ADM	$ 130 000	0	NEL TRA	NEL N LN ADM PN TRA	NEL TRA	NEL TRA	NEL TRA	NEL TRA	NEL TRA	NEL TRA	NEL TRA	NEL LN TRA	NEL LN ADM TRA	NEL TRA	NEL TRA	NEL TRA									ULL LN ADM PN TRA LN20 ADM19	LN TRA	LN TRA
1st line services (Midwifery)	Midwifery services • Pregnancy F/up • Birth • Post-birth serv. • ISPEC • Training • Education	MID-Midwives SMI-Student Midwives APP-Midwifery affairs agent NEL-Nurse. (enlarge.role)24/7 MD-Doctors OBS-Obstetricians BH-Birthing House	1xAPP	$ 150 000,00	1	MID* SMI* NEL MD	MID SMI NEL MD BH	MID* SMI* NEL MD*	MID* SMI* NEL MD*	MID* SMI* NEL MD*	MID* SMI* NEL MD*	MID* SMI* NEL MD*	MID* SMI* NEL MD*	MID* SMI* NEL MD*	MID SMI NEL MD BH	MID SMI NEL MD BH	MID* SMI* NEL MD*	MID* SMI* NEL MD*	MID SMI NEL MD BH					APP19			MID* SMI*				

General Services (2017) 3/3

	Description (MSSS)	Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2022	New houses needed 2018-2022	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Tusaajiapik day centre (Kuujjuaq)		Ullivik****	Ruis McGill	Other
1st line services (Psychosocial services)	Psychosocial services • Intake • Evaluation • Reference • Consultation	AEO-Intake services SW-Social workers SA-Social Assistant PSY-Psychologist	3XAEO, 6X SW, 5X PSY	$ 2 270 000	14	SW SA AEO19 SW19 PSY*	AEO SW SA PSY SW19, PSY19 , PSY20	SW SA	SW SA	SW SA PSY*	SW SA PSY*	SW SA AEO20 SW20 PSY*	SW SA Psy*	SW SA	SW SA AEO PSY* SW20, PSY18 psy20	SW SA AEO PSY SW20, PSY18	SW SA PSY*	SW SA	SW SA AEO20 SW20 PSY*	Community and psychosocial affairs division								SW SA	SW SA PSY	PSY
	Info-Social 24/7 • On Call, crisis • Information • Reference • Education	AEO-Intake services SW-Social workers SA-Social Assistant	6X SA	$ 600 000	6	SW SA SA19	AEO SW SA SA19	SW SA	SW SA	SW SA	SW SA	SW SA SA20	SW SA	SW SA	SW SA AEO SA20	SW SA AEO SA20	SW SA	SW SA	SW SA SA20									SW SA	SW SA	
	Crisis Intervention 24/7 • Intervention • On Call 24/7	AEO-Intake services SW-Social workers SA-Social Assistant IVP-Health Com. Workers IVP CAFE-Int. Crisis team (family) SPW-suicide prev. worker CNH-Com. Natural Helper	3X SPLW,3X CNH, 1X CAFE	$ 840 000	7	SW SA CNH SPLW20 CNH20	AEO SW SA SPW NH CNH20 CAFE20	SW SA	SW SA	SW SA CNH	SW CNH SA	SW SA CNH SPLW20 CNH20	SW SA CNH	SW SA CNH	SW SA AEO SPW CNH	SW SA AEO CAFE CNH SPLW20	SW SA CNH	SW SA CNH	SW SA CNH SPLW					IVP				SW SA	SW SA	
	Psychosocial Services (civil security mandate)	CSC-Civil security coordinator PCS-Psychoso. civil sec Coord. SW- social workers SA- Social assistant IVP-Health com. Workers IVP	2X CSC	$ 280 000	2	SW SA	CSC19 PCS SW SA	SW SA	SW SA	SW SA	SW SA	SW SA	SW SA	SW SA	SW SA	SW SA CSC19 PCS	SW SA	SW SA	SW SA	CSC PCS				IVP						
	Community Pharmacy	PHA-Pharmacist NEL-nur. (enla.role)24/7 ATP-Pharmacist assistant	SEE PREVIOUS			NEL PHA*	PHA ATP	NEL PHA*	NEL PHA*	NEL PHA*	NEL PHA*	NEL PHA*	NEL PHA*	NEL PHA*	NEL PHA*	PHA ATP	NEL PHA*	NEL PHA*	NEL PHA*											
	Traditional Psychosocial counselling services • Consultation • Intervention • Grieving	SA-Social Assistant IVP-Health Com. Workers IVP SPW-suicide prev. worker CNH-Com. Natural Helper CLW-Com. wellness work. CLWC-CLWW coordinator	CLWW Completion team / community population	$ 1 400 000	14	SA CNH IVP* SPW* CLW CLWW20	SA CLWC CNH IVP SPW CLW CLW18	SA CNH IVP* SPW* CLW CLW20	SA CNH IVP* SPW* CLW CLW22	SA CNH IVP* SPW* CLW CLW22	SA CNH IVP* SPW* CLW CLW23	SA CNH IVP* SPW* CLW CLW19	SA CNH IVP* SPW* CLW CLW20	SA CNH IVP* SPW* CLW CLW23	SA CNH IVP* SPW CLW CLW18	SA CNH IVP* SPW* CLW CLW18	SA CNH IVP* SPW* CLW CLW19	SA CNH IVP* SPW CLW CLW23	SA CNH IVP* SPW CLW CLW19					IVP				SA		
	Community Organization • Collaboration	APP- Com. Org. Agent WS-Women shelter EH-Elders House FH-Family House ASS- Association ADD-Add. treatment cen.	3X APP	$ 360 000	3	EH FH	EH ADD WS ASS' APP20					EH	FH		WS FH ASS"	FH EH APP21			FH WS	APP APP21										

Physical health (2017) 1/2

Description (MSSS)		Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2022	Housing needed 2018-2025	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Out of region			Ullivik	Ruis McGill	Other
Medical services	Management	DSP- Professional services Director DRM-Nunavik general Medical Director CRA- Regional medical counsellor DSMGS= Specialized and general medical services Director	1x dsmgs, -2x dsp, 1x adm	$ 100 000	2		~~DSP*17~~									~~DSP*18~~				DSMGS17 Adm 18				DRM*						
	General medicine team	MD- Doctors (general medicine)	see general services			MD1	MD7	MD*	MD*	MD*	MD*	MD*	MD*	MD*	MD3	MD4	MD*	MD*	MD2											
	Liaison nurse	LNU- Ungava liaison nurse LNH- Hudson liaison nurse LNM-Ullivik liaison nurse LNO- Other liaison nurse	see general services				LNU3								LNH	LNH			LNH									LNM9	LNO3	
1st line services (acute, ambulatory care	Emergency	EMH-Emergency 24/7 (Health Centre) EMC-Emergency 24/7(CLSC)	see general services			EMC	EMH	EMC	EMC	EMC	EMC	EMC	EMC	EMC	EMC	EMH	EMC	EMC	EMC											
	Intake, evaluation, orientation (triage) Stabilisation Reference	TRI- Intake, evaluation, orientation (CLSC) STA-Stabilisation Ressources MD-Doctors NUR-Nurse (enlarge role) ORI-Orientation to Hosp. REF-Reference centre	see general services			TRI STA MD NUR	TRI STA MD NUR ORI	TRI STA MD* NUR	TRI STA MD* NUR	TRI STA MD* NUR	TRI STA MD* NUR	TRI STA MD* NUR	TRI STA MD* NUR	TRI STA MD* NUR	TRI STA MD NUR	TRI STA MD NUR ORI	TRI STA MD* NUR	TRI STA MD* NUR	TRI STA MD NUR										REF	REF
Specialized services	Specialized services coordination • Appointment • Request • Corridor	LNU- Ungava liaison nurse LNH- Hudson liaison nurse LNM-Ullivik liaison nurse LNO- Other liaison nurse ADM-Administrative agent, Tele= Telehealth agent UGO-Ullivik Go Software, Inha=Inhalotherapist (appointment) PN-Patient Navigator LNPED=Liaison nurse Pediatrics Ste=sterilization tech OCS-Official Corridor	2x tele , 2 inhal, 2 ste, 2x Lnped	$ 1 190 000	8	UGO'	LNU3 UGO ADM PN **tele19** **Inha20** **Ste20** **Lnped19**	UGO'	UGO'	UGO'	UGO'	UGO'	UGO'	UGO'	LNH UGO	LNH UGO ADM **tele19** **Inha20** **Ste20** **Lnped19**	UGO'	UGO'	LNH UGO'									LNM9 UGO ADM PN	LNO3 OCS'	OCS"

Physical health (2017) 2/2

Description (MSSS)		Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2022	Housing needed 2018-2025	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Out of region	Tusaajapik	Sailivik	Ullivik	Ruis McGill	Other
Specialized services	Hospital Acute care • Acute care • Nutrition • Phys. rehab	ACM- Acute medical care NUT- Nutrition PHT- Physical rehabilitation	See general services				ACM NUT PHT									ACM PHT				Physical health and medical affairs division									ACM PHT NUT	ACM PHT NUT
	Intensive physical rehabilitation services (URFI)	URF-Out of region URFI/Rehab. CLC- Constance Lethbride Rehab. Centre	See general services																										URF	CLC
	Palliative Care	SAD-Palliative Homecare SAU-Palliative care bed (non-excl. dedicated) PAL-Palliative care bed				SAD	SAU SAD	SAD*	SAD*	SAD*	SAD*	SAD SAU	SAD*	SAD*	SAD	SAU SAD	SAD*	SAD*	SAD							SAU	SAU		PAL**	PAL**
	Chronic diseases and continuous f/up	CHR-Chronic diseases nurse OXY-Oxygenotherapy ONC-Oncology Services N-Enlarge role nurse INT-Internist	See general services			N OXY* ONC* INT*	CHR N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	CHR N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*	N OXY* ONC* INT*							N* OXY* ONC* INT*	N* OXY* ONC* INT*	OXY* ONC* INT*	OXY ONC INT CHR	OXY ONC INT
	Specialized services (Nunavik)	INT-Internal medicine PED-Pediatrician PSY-Psychiatrist CPS-Child Psychiatrist GAS-Gastro enterologist ENT-Ear nose Throat ORT-Orthopedist OPH-Ophtalmologist RAD-Radiologist ONC-Oncologist PNE-Pneumologist MDM-Musculoskeletic SUR-General Surgeon ANE-Anestesiologist	See general services				INT* PED* PSY* CPS* GAS* ORT* OPH* MDM* ANE*" ENT*									INT* PED* PSY* CPS* GAS* ORT* OPH* MDM* ANE*" SUR*' ENT*														INT PED PSY CPS GAS ORT OPH ANE SUR PNE RAD ONC ENT	
Dental services	Dental health	Dent=Dentist HyDent=Dental hygieneist Cdent=Dentist advisor Adent=Dental Assistant	1x cdent	$ 7 000	1	Dent Adent	Dent Adent Hydent	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent Adent	Dent Adent	Dent* Cdent* Hydent*	Dent Adent	Dent Adent Hydent	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent Adent		Cdent18									
	Dental general intervention	Dent=Dentist HyDent=Dental hygieneist Cdent=Dentist advisor Adent=Dental Assistant	0.5 dent	$ 3 500,00	0,5	Dent Adent	Dent Adent Hydent	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent Adent	Dent Adent	Dent* Cdent* Hydent*	Dent Adent	Dent Adent Hydent	Dent* Cdent* Hydent*	Dent* Cdent* Hydent*	Dent Adent	Cdent18										
	Specialized dental services	Dent=Dentist Dturo=Denturologist Pdent=Parondontist Maxi=maxilofacial surgeon Sdent=Dental surgeon odent=Orthodontist					Dent dturo Pdent Maxi sdent odent									Dent dturo Pdent Maxi sdent odent															Dent dturo Pdent Maxi sdent odent

Youth in difficulty (2017) 1/3

[redacted]	[redacted]	New Positions required 2018-2022	Development Budget Required 2018-2021	Housing Required 2018-2022	UTHC							IHC							NRBHSS					Community Organization			Out of region		
					Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Qiqqisiq (Salluit)	Tasiurvik (Kpak)	Qarmaapik (GR)	Ullivik	Ruis McGill	Other
1st line services (General Services)	Base services • Intake, evaluation, orientation & reference	N-Enlarge Role nurse SW- Social worker (CLSC) SA-Social Assistant (CLSC) AEO-Social intake (CLSC) MD-Doctors PED-Pediatrician			N SW SA MD PED*	N SW PED* SA AEO MD	N SW SA MD* PED*	N SW SA MD* PED*	N SW SA MD* PED*	N SW SA MD* PED*	N SW SA MD* PED*	N SW SA MD* PED*	N SW SA MD* PED*	N SW SA MD PED*	N SW SA MD PED*	N SW SA MD* PED*	N SW SA MD* PED*	N SW SA MD PED*	Child, youth & family	ISPEC				SW* SA* PED*	SW* SA*	SW* SA* PED*		PED	PED
	Psychosocial services (CLSC) • Parents support • ISPEC • Intervention plan • At School	CPS-Child psychologist CYFHP-CYF head of program (CYFT) Speech=Speech Therapist OT- Occupational therapist PHT -Physiotherapist PEDN-Ped nurse SW-Social workers Stre=Street worker SA-Social assistant PE-Psycho-educators CYFT-CYF Team ED- Educator CHP-Child-psychiatrist SNU-School nurse SIP-ISPEC Team PED-Pediatrician FH- Family/safe house	CYF Team (pop 1800+) Ungava (partial) Hudson (Complete) (1x head of program 1 X social worker, 1X psycho-educator, 1x Educator, 1x Child Psychologist, 1x social assistant, 1 Ped Nurse, 1 OT, 1 PHT, 1 speech therapist, 1 X MD, 1X PED, 2 street workers)	$ 10 380 000	39	SW SA PE MD PED* SIP* CHP* FH	PHT(CYFT)18 OT(CYFT)18 Speech(CYFT)19 PEDN(CYFT)18 ED(CYFT)18 SW (CYFT) PED*(CYFT) SA(CYFT) PE(CYFT) CPS(CYFT) CYFHP(CYFT) MD(CYFT) SNU PED* SIP* CHP*	SW SA MD* PED* CHP*	SW SA MD* PED* CHP*	SW SA MD* PED* CHP*	SW SA MD* PED* CHP*	SW SA MD* PED* CHP*	SW SA MD* PED* CHP*	SW SA MD* PED* CHP* FH	SW SA MD* PED* CHP*	SW SA MD PED* SIP CHP* FH CYFT20	CPS* Stre SW PE MD PED* SIP* FH CYFT18	SW SA MD* PED* CHP*	SW SA MD* PED* CHP*	SW SA MD* PED* PE CHP* CYFT 21						SW* SA* FH	SW* SA* FH	SW* SA* MD* PED* PE* FH	SW SA	CPS SW PE PED CHP	CPS SW PE PED CHP
	Crisis intervention • Complex issues • Placement (ARHSS) • Group intervention	CPS-Child psychologist SW-Social workers SA-Social assistant PE-Psycho-educators CHP-Child-psychiatrist RTF-Foster Families ED-Educator PED- Pediatrician CAF-Crisis intervention team (youth) FH- Family/safe house	Crisis Intervention Team Hudson + Ungava (per HC) 1X Social Worker 1X Social Assistant 1x Educator	$ 830 000 $ 165 000	6 1	SW SA PE PED* CHP* RTF FH	SW SA PE CPS CHP* RTF PED* CAF19	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF FH	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF FH CPS20	SW SA PED* CHP* RTF CAF FH CAF19	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF	SW SA PED* CHP* RTF FH						SW* SA* FH	SW* SA* FH	SW* SA* MD* PED* PE* FH	SW SA	CPS SW PE PED CHP	CPS SW PE PED CHP
	Adoption • Before • After • Access & rights	SW-Social workers SA-Social assistant LAW- Lawyer (Makivik)			SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*	SW SA LAW*						SW* SA* LAW*	SW* SA* LAW*	SW* SA* LAW*	SW SA LAW*	SW	SW
	Rehabilitation (Natural enviro) •Shelters (Crisis) •Justice (com.work)	WS-Women shelter ED-External educator SSS- Social serv. Shelters FH- Family/safe house JCY-Justice com (youth)	See CYFT + CAF + REHAB		SSS FH	WS JCY EXED						FH EXED		WS FH EXED	SSS FH EXED			WS FH EXED						FH	FH	FH			
	Community initiative	FH- Family/safe house YC-Youth centre	Family House (Operation) Annual recurrent budget	$ 2 700 000		FH20 YC	YC	YC	YC FH22	FH21 YC	FH20 YC	FH YC	YC	YC FH	YC FH	YC FH21	YC	YC FH18						FH	FH	FH			

Youth in difficulty (2017) 2/3

			New Positions required 2018-2022	Development Budget Required 2018-2021	Housing Required 2018-2022	UTHC							IHC							NRBHSS					Community Organization			Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Qiqisiviq (Salluit)	Tasiurvik (Kpik)	Qarmaapik (GR)	Ullivik	Montreal	Other
2nd line services (Youth Protection+ Rehabilitation)	Youth Protection • Reception, Treatment signalement	SWY- Social worker (YP) SAY-Social Assistant (YP) RTS-Social Worker (Only RTS)	8 x sw RTS	$ 1 200 000		SWY SAY RTS19	SWY SAY RTS	SWY SAY RTS23	SWY SAY RTS*	SWY SAY RTS21	SWY SAY RTS23	SWY SAY RTS22	SWY SAY RTS20	SWY SAY RTS*	SWY SAY RTS	SWY SAY RTS RTS20	SWY SAY RTS20	SWY SAY RTS23	SWY SAY RTS	Child, youth & family	ISPEC						SWY* SAY* RTS*			
	Youth Protection • Evaluation, Orientation • Ind. Int. Plan	SWY- Social worker (YP) SAY-Social Assistant (YP) EO-Social Worker (Only EO)				SWY SAY EO19	SWY SAY EO	SWY SAY EO*	SWY SAY EO*	SWY SAY EO*	SWY SAY EO*	SWY SAY EO20	SWY SAY EO22	SWY SAY EO*	SWY SAY EO	SWY SAY EO	SWY SAY EO	SWY SAY EO*	SWY SAY EO								SWY* SAY* EO*			
	Youth Protection • Application of measures	SWY- Social worker (YP) SAY-Social Assistant (YP) AM-Social W.(only AM)				SWY SAY AM	SWY SAY AM	SWY SAY AM20	SWY SAY AM*	SWY SAY AM	SWY SAY AM19	SWY SAY AM	SWY SAY AM	SWY SAY AM*	SWY SAY AM	SWY SAY AM	SWY SAY AM	SWY SAY AM*	SWY SAY AM								SWY* SAY* AM*			
	Youth Protection • Revision	REV-Clinical revisor (YP) MAN-Manager/revisor				REV20 MAN*	REV MAN	REV* MAN*	REV* MAN*	REV22 MAN*	REV* MAN*	REV21 MAN*	REV* MAN*	REV19 MAN*	REV* MAN	REV MAN	REV* MAN*	REV* MAN*	REV20 MAN											
	Foster type res. •Emergency pla. •Short, mid, long term placement • Support RTF • Recruitment • Tutorship	RTF-Foster Families (RTF) SWF-Social worker (RTF) FH- Family/safe house FFA-Nunavik RTF sup 612-group home (6-12yo) GH-Group home (12-18) RTFADM-RTF administrative agent	FFA= PPA FTR Training, support, recruitment, evaluation RTFADM= administrative agent responsible of contribution to FTR SWF=			RTF SWF* FH FFA*	RTF SWF FFA 612 GH FFA19 RTFADM19	RTF SWF* FFA*	RTF SWF* FFA*	RTF SWF* FFA*	RTF SWF* FFA*	RTF SWF* FFA*	RTF SWF* FFA* 612	RTF SWF* FFA*	RTF SWF FFA*	RTF SWF20 FFA* GH RTFADM19 FFA19	RTF SWF* FFA*	RTF SWF* FFA*	RTF SWF* FFA* FH					FH		FH			
	Rehabilitation •Open Rehab Unit (12-18) •Group homes Unit (12-18) •Group homes Unit (6-12) • External rehab	612-group home(6-12yo) GH-Group home (12-18) REA-Open Unit (12-18) YOFM-Male Closed unit (12-18) YOFF-Female Closed unit (12-18) EED-External educator (Natural environment)	YOFF + auto finance vs UTHC Operation budget	$ -	0	EED	612 GH EED						612		REA'	GH			REA"									YOFM" YOFF"18	YOFM'"
	Young offender (YCJA) • Evaluation • Report • Application • Reevaluation	SWY- Social worker (YP) SYO-Social worker (young offenders) YOF-Closed unit (12-18) JYO-Justice committee (young offender)	2 X Social Worker JYO install where a FTE SYO based (40 000$)	$ 420 000	2	SWY SYO*	SWY SYO JYO18	SWY SYO*	SWY SYO*	SWY SYO*	SWY SYO*	SWY SYO21	SWY SYO*	SWY SYO*	SWY SYO	SWY SYO JYO19	SWY SYO*	SWY SYO*	SWY SYO20 JYO20										SWY SYO YOF"	YOF"'

Youth in difficulty (2017)		3/3																														
Description (MSSS)		Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2021	Housing Required 2018-2022	UTHC							IHC							NRBHSS					Community Organization			Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Qiqisiviq (Salluit)	Tasiurvik (Kpik)	Qarmaapik (GR)	Ullivik	Montreal	Other
2nd line services (Youth Protection+ Rehabilitation)	Other Services • Mediation (families) • Reunion • Qualification (youth 16-19)	SWY- Social worker (YP) SAY-Social Assistant (YP) EED-External educator (Natural environment) FH- Family/safe house	Significant persons council			SWY SAY EED FH	SWY SAY EED	SWY SAY EED*	SWY SAY EED*	SWY SAY EED*	SWY SAY EED*	SWY SAY EED*	SWY SAY EED FH	SWY SAY EED*	SWY SAY EED	SWY SAY EED	SWY SAY EED*	SWY SAY EED*	C	Child, youth & family	ISPEC				SWY* SAY* EED* FH	SWY* SAY* EED* FH	SWY* SAY* EED* FH			
	Medico-Legal expertise	PIN-Pinel Institute MCH-Montreal childrens Hospital																											PIN** MCH**	
	Specialized Psychiatric treatment (Youth) • Severe Anxiety problematic • Anorexia • Personality disorder • Sexual behavior disorder	CRO-Out of region resources PIN-Pinel Institute MCH-Montréal child. hospital																											MCH PIN	CRO

Addiction (2017)

			New Positions required 2018-2022	Development Budget Required 2018-2022	Housing Required 2018-2023	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Out of region	Isuarsivik	Nunalituratʼ ikajusta	Ulivik	Ruis McGill	Other
1st line services	1.1-Early intervention, Prevention of situations detoriation	ACC-Addiction clinical counsellors CAC-Community Addiction Counselors SG-Support Groups D-Responsible consumption camoaien +Workshop Saq-Saqijuq N-Nurse	6X ACC, 14X CAC, 13X SG, 1X SAQ + training HR +support groups activities	$ 2 970 000	18	D N CAC20** SG20 ACC20	ACC CAC D N ACC19 CAC19** SG19	D N CAC21** SG21	D N CAC22** SG20	D N CAC18** SG18 SAQ19	D N CAC21** SG21	D N CAC20** SG20 ACC22	D N CAC20** SG20	D N CAC21** SG21	SG D N ACC19 CAC19**	ACC B CAC SAQ D N ACC19 SG CAC21**	D N CAC22** SG22	D N CAC23** SG23	D N CAC19** SG19 ACC20	ACC ACC						B C AAC18 CAC19 AAC19 CAC19 CAC20 CAC20	A C D		A	
	1.2 Psychosocial Follow-up: During treatment Methadone Detoxification int. + ext.	A-Addiction clinical counsellors B-Community Addiction Counselors C-Support Groups G-Social workers H-Psychologist				G	A C G H	G	G	G	G	G	G	G	G	A B C G H	G	G	G							A B C		G	A G H	A C G H
2nd line services	2.1 Regional evaluation services	A-Addiction clinical counsellors B-Community Addiction Counselors I-Doctors				I	A B I	I*	I*	I*	I*	I*	I*	I*	I	A B I	I*	I*	I							A B				
	2.2 External & Internal : rehabilitatiion, Intensive Detoxification with lodging	J-Isuarsivik Trauma healing and treatment (6 weeks closed gender cycles) K-External Treatment AMT=addiction mobile treatment team	Isuarsivik services development plan + mobile treatment intervention team (8 fte) +Activities+training hr	$ 6 200 000	14																					AAC18 AMT18 (3) CAC19 AMT18 AAC19 AMT18 CAC19 AMT18 CAC20 AMT18 CAC20 AMT18				K
	2.3 Caregiver Support	A-Addiction clinical counsellors B-Community Addiction Counselors C-Support Groups F-Saqijuq G-Social workers H-Psychologist	See 1st line			G	A C G H	G	G	G	G	G	G	G	G	A B C F G H	G	G	G							C		G		
3rd line services	3.3 Overspecialized services	K-External Treatment L-Mamisarvik M-Onentakon N-Portage	Officialized over specialized corridor +treatment	$ 1 500 000																									K	L M N

Mental health (2017) 1/4

			New Positions required 2018-2022	Development Budget Required 2018-2021	House Required 2018-2022	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Uvattinut	Hèberg. Com. Ungava	Douglas Mental health Institute	Ruis McGill	Ullivik
1st line (General services)	Basic General services • Intake, evaluation , orientation • Medical services • Nursing • psychosocial services	AEO-Intake services MD-Doctors SW-Social workers N-Nurse LN-Liaison Nurse	sw 8x,	$ 1 200 000	8	MD N SW sw20	AEO MD SW N sw19	MD* N SW	MD* N SW	MD* N SW sw19	MD* N SW	MD* N SW	MD* N SW sw20	MD* N SW	MD N SW LN sw19	AEO MD SW N LN sw20	MD* N SW	MD* N SW	MD* N SW sw19	Community and psychosocial affairs division						MD* SW* N*	MD* SW* N*	AEO MD SW N LN	AEO MD SW N	SW N LN
	Early detection and evalulation	AEO-Intake services				MD	AEO	MD* N	MD* N	MD* N	MD* N	MD* N	MD* N	MD*	MD N	AEO	MD*	MD*	MD*							MD* SW* N* H* PSY*	MD* SW* N* H* PSY*	MD SW N H PSY LN	MD SW N H PSY	SW N LN
	Diagnostics, intervention in order to prevent crisis	MD-Doctors / SW-Social workers N-Nurse LN-Liaison Nurse H-Psychologist PSY-Psychiatrist/child-psychiatrist	See General services PSY See Youth in difficulty Child psychologist			N SW PSY*	MD SW N H PSY LN	SW	SW	SW PSY*	SW PSY*	SW PSY*	SW PSY*	N	SW H* PSY* LN	MD N SW H* PSY* LN	N	N	N PSY* LN											
1st line services (Specific services)	Mental Health Team & Services (Youth & Adult) Including	MHN-Mental health Nurse MHD-Doctors (mental health) PSY-Psychologist (adult) CPS-Child psychologist PedMHN=Mental health nurse (Youth) SW-Social workers SA-Social assistant PE-Psycho-educators PSY-Psychiatrist/child-psychiatrist	1x PE, 1x PEDMHN	$ 315 000	2	PSY* SW SA	MHN MHD PSY PEDMHN CPS SW SA PE PSY	SW SA	SW SA	PSY* SW SA	PSY* SW SA	PSY* SW SA	PSY* SW SA	SW	PSY SW SA	MHN MHD PSY CPS PE19 SW SA PSY PEDMHN19	SW SA	SW SA	PSY* SW SA							SW* SA*	SW* SA*	MHN MHD H SW PE PSY	MHN MHD H CH SW PE PSY	SW SA
	Support Services for parents	MHN-Mental health Nurse SW-Social workers SA-Social assistant PE-Psycho-educators IVP-IVP Health counsellors CLW-Com. liaison wellness work. FH-Family House	See previous measures			SW SA PE CLW FH	MHN SW SA PE CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW FH	SW SA CLW	SW SA CLW FH	MHN SW SA CLW FH	SW SA CLW	SW SA CLW	SW SA CLW					IVP				MHN SW PE	MHN SW PE	SW SA
	Caregiver Support	MHN-Mental health Nurse SW-Social workers SA-Social assistant PE-Psycho-educators IVP-IVP Health counsellors CLW-Com. liaison wellness work. RESP=Respite services (7x NA, 2x Nurse)	7x NA, 2x N	$ 1 170 000	9	SW SA PE CLW	MHN SW SA PE CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW	SW SA CLW	MHN SW SA CLW RESP19	SW SA CLW	SW SA CLW	SW SA CLW					IVP				MHN SW PE	MHN SW PE	SW SA

Mental health (2017) 2/4

			New Positions required 2018-2022	Development Budget Required 2018-2021	House Required 2018-2022	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Uvattinut	Hèlberg. Com. Ungava	Douglas Mental health instuute	Ruis McGill	Ullivik
1st line services (Specific services)	Crisis situation • Mobile services • Lodging services	MD-Doctors SW-Social workers N-Nurse LN-Liaison Nurse CC-Mental health Crisis center SPLW-Suicide prev. liaison work. IVP-IVP Health counsellors NATH=Narural Helpers	14 X NATH	$ 700 000	-	MD N SW NATH20	AEO MD SW N LN SPLW (2) NATH19	MD* N SW NATH22	MD* N SW NATH22	MD* N SW NATH20	MD* N SW NATH21	MD* N SW NATH20	MD* N SW NATH20	MD* N SW NATH22	MD N SW LN CC SPLW NATH19	AEO MD SW N LN NATH20	MD* N SW NATH20	MD* N SW NATH20	MD* N SW SPLW NATH21	Community and psychosocial affairs division				IVP		MD* SW* N*	MD* SW* N*	AEO MD SW N LN	AEO MD SW N	SW N LN
	Suicide • Training • Intervention services • Postvention + grieving services • Individual support • Liaison services	MD-Doctors / SW-Social workers N-Nurse LN-Liaison Nurse H-Psychologist PSY-Psychiatrist CPS-Child-psychiatrist SPW-Suicide prev. liaison work. IVP-IVP Health counsellors MHSUP=Mental health workers support team	2x MHSUP team , 2x SPLW	$ 490 000	2	MD N SW PSY* CPS*	AEO MD SW N H PSY* LN SPLW CPS* MHSUP19	MD* N SW	MD* N SW	MD* N SW PSY* CPS* SPLW20	MD* N SW PSY*	MD* N SW PSY* CPS* SPLW	MD* N SW PSY*	MD* N SW	MD N SW H* PSY* LN CPS* SPLW	AEO MD N SW H* PSY* LN CPS*	MD* N SW	MD* N SW	MD* N SW PSY* LN CPS* SPLW					IVP		MD* SW* N* H* PSY*	MD* SW* N* H* PSY*	MD SW N H PSY LN	MD SW N H PSY CPS	SW N LN
	Mental Health specific resources • Reintegration (job, social) • Education services • Supervised lodging	MHN-Mental health Nurse MHD-Doctors (mental health) H-Psychologist (adult) SW-Social workers SA-Social assistant PE-Psycho-educators PSY-Psychiatrist	2x MHN , 2 x sw , 2x SA	$ 880 000	6	PSY* SW SA PE	MHN MHD H CH SW SA PE PSY	SW SA	SW SA	PSY* SW SA	PSY* SW SA	PSY* SW SA	PSY* SW SA	SW SA	PSY* H* SW SA PE	MHN MHD H* CH* SW SA PSY	SW SA	SW SA	PSY* SW SA PE							SW19 SA20 PE MHN20	SW19 SA20 PE MHN20	MHN MHD H SW PE PSY	MHN MHD H CH SW PE PSY	SW SA
	Community base services • Adaptative intensity community f/up • Emergency necessity needs (food, shelter) • Help line / tools	MHN-Mental health Nurse SW-Social workers SA-Social assistant PE-Psycho-educators MK-Makivik food coupon SHE-Homeless Shelter HL-Helpline Inuktitut (Nunavut): Help line in Inuktitut, open 24 hours a day, 365 days a year, and individual Web-based and face to face intervention services.	7 x SW (HL)	$ 1 050 000	7	SW SA MK HL	MHN SW SA PE SHE MK HL19 /2	SW SA MK HL	SW SA MK HL	SW SA MK HL	SW SA MK HL	SW SA MK HL	SW SA MK HL	SW SA MK HL	SW SA MK HL	MHN SW SA MK HL19 /2	SW SA MK HL	SW SA MK HL	SW SA MK HL							SHE	SHE	MHN SW PE	MHN SW PE	SW SA MK SHE

Mental health (2017) 3/4																															
						UTHC							IHC							NRBHSS						Community Organization		Out of region		
			New Positions required 2018-2022	Development Budget Required 2018-2021	House Required 2018-2022	Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Out of region	Uvattinut	Hélberg. Com. Ungava	Douglas Mental health instuute	Ruis McGill	Other
2nd line services (Specialized services)	Specialized Evaluation • Psychiatry • Child psychiatry • Pivot psychiatrist	PSY-Psychiatrist CPS-child-psychiatrist NPS-Nunavik Psychiatrist NCP-Nunavik Child psychiatrist	See Physical health			NPS* CPS*	NPS* CPS* PSY* NCP*			NPS* CPS*	NPS* CPS*	NPS* CPS* NCP*			NPS* CPS*	NPS* CPS* PSY			NPS* CPS*	Community and psychosocial affairs division								NPS PSY	PSY CPS NCP	
	Child Psychiatry • Consultation • Treatment • Emergency • Hospitalization • Intensive F/up • External F/up	CPS-child-psychiatrist NCP-Nunavik Child psychiatrist MCH-Montréal child. hospital	See Physical health			NCP*	NCP*			NCP*	NCP*	NCP*			CPS*	CPS*			CPS*										CPS NCP MCH	
	Psychiatry • Consultation • Treatment • Emergency • Hospitalization • Intensive F/up • External F/up	PSY-Psychiatrist NPS-Nunavik Psychiatrist DMH-MH Corridor of services	See Physical health			NPS*	NPS*			NPS*	NPS*	NPS*	NPS*		NPS*	NPS*			NPS*									NPS* DMH	PSY	
	Youth mental health rehabilitation services • Adapt facility with Intensive f/up • Long term care	NRF-Nunavik youth rehabilitaton facilities CRO-Out of region resources	See youth in difficulty												NRF"				NRF"'											CRO

Mental health (2017) 4/4																																
			New Positions required 2018-2022	Development Budget Required 2018-2021	House Required 2018-2022	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Out of region	Uvattinut	Hèlberg. Com. Ungava	Douglas Mental health instuute	Ruis McGill	Other
(Spec. serv.) 2nd line serv.	Adult mental health rehabilitation services • Adapt facility with Intensive f/up • Long term care	NRA-Nunavik Adult rehabilitaton facilities CRO-Out of region resources	See previous measures													NRA				Physical health and medical affairs division						NRA	NRA	CRO	CRO	CRO
3rd line services (Over-Specialized services)	Socio-medico-legal expertise • Youth • Adult	PIN-Youth Socio-medico-legal Reference centre (Pinel) MAL-Youth Socio-medico-legal Reference centre (Malartic)																												PIN** MAL**
	Specialized Psychiatric treatment (Youth & Adult) • Severe Anxiety problematic • Anorexia • Personality disorder • Sexual behavior disorder	CRO-Out of region resources DMH-MH Corridor of services MCH-Montréal child. hospital	see physical health See youth in difficulty																									DMH	MCH	CRO

Physical, intellectual impairment & Autism Spectrum Disorder (2017)

Description (MSSS)		Nunavik programmation	New Positions required 2018-2023	Development Budget Required 2018-2023	Housing Required 2018-2023	UTHC							IHC							NRBHSS						Community Organization			Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Tusaajiapik Elders house Daycentre	Sailivik elders house (puv)	Qilanguanaaq (wb)	Ullivik	Ruis McGill	Other
Services	Base Services • Intake/detection • Evaluation • Psychosocial • Medical & nursing • Homecare • Intervention	See General services (1st line services)																		Community and psychosocial affairs division											
	Specifics services • Psychosocial • Evaluation • Diagnostic • Psychology • Rehabilitation • Nutrition • Speech Therapist	MD-Doctors / SW-Social workers N-Nurse H-Psychologist PSY-Psychiatrist CPS-Child-psychiatrist NEL-Nur. enla.role 24/7 PED-Pediatrician Speech=Speech Therapist REH-Phys. Rehab services NUT-Nutritionist	See PLA + General services + Addiction			MD SW NEL CPS PED* REH* CPS* PSY* NUT*	MD SW NEL CPS PED* REH* CPS* PSY* NUT Speech	MD* SW NEL CPS PED* REH* NUT*	MD* SW NEL CPS PED* REH* NUT*	MD* SW NEL CPS PED* REH* CPS* PSY* NUT*	MD* SW NEL CPS PED* REH* CPS* PSY* NUT*	MD* SW NEL CPS PED* REH* CPS* PSY* NUT*	MD* SW NEL CPS PED* REH* CPS* PSY*	MD* SW NEL CPS PED* REH*	MD SW NEL CPS PED* REH* CPS* PSY*	MD SW NEL CPS PED* REH* CPS* PSY*	MD* SW NEL CPS PED* REH* CPS* PSY*	MD* SW NEL CPS PED* REH*	MD SW NEL CPS PED* REH* CPS* PSY*	NUT			IVP		MD* SW* N* H* PSY* REH*	MD* SW* N* H* PSY* REH*	MD* SW* N* H* PSY* REH*	MD SW N H PSY LN	MD SW N H PSY CPS	SW N LN
	Community Serv.	See Elders & PLA Services (Com. Serv.)																													
	Caregiver services		See SAPA + Gen Services																												
	Ressource (lodging)	See Elders & PLA services (Ress. Lodging)	RI Project Hudson-Ungava 2X(1X nurse, 4 XAux. Nurse, 12 X N.Attendant, 1X psycho-ed)	$ 2 235 000,00	37		RI Project18								RI Project19					APPR19											

Elders & persons lacking of autonomy (SAPA) (2017) 1/2

	Description (MSSS)	Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2021	Housing Required 2018-2022	UTHC							IHC							NRBHSS						Community Organization			Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Tusaajapik Elders house Daycentre	Sailivik elders house (puv)	Qilanguanaaq (wb)	Ulliivik	Ruis McGill	Other
1st line services (General services)	• Intake, orientation, reference 24/7 • Diagnostics • Information	NEL-nur. (enla.role)24/7 CHR-Chronic disease Nurse CNU-Com. Health Nurse HOM-Homecare Nurse MD-Doctors	3 x Homecare nurse 4 X CHR	$ 1 155 000	7	NEL HOM MD	NEL HOM MD CNU CHR	NEL MD* CHR20*	NEL MD* CHR20*	NEL MD* HOM	NEL MD* HOM20	NEL MD* HOM	NEL MD* HOM20	NEL MD* CHR20*	NEL MD HOM CHR19	NEL MD HOM CNU CHR20	NEL MD* HOM21	NEL MD* CHR20*	NEL MD HOM	Physical health and medical affairs division						HOM* MD* N	HOM* MD*	HOM* MD*			
	Professionals base services • Medical • Psychosocial • Nursing	MD-Doctors SW-Social workers N-Nurse NEL-nur. (enla.role)24/7 SA-Social Assistant CHR-Chronic disease Nurse HOM- Homecare Nurse	See general services See mental health			MD SW SA NEL HOM	MD SW SA NEL N CHR HOM	MD* SW SA NEL	MD* SW SA NEL	MD* SW SA NEL HOM	MD* SW SA NEL	MD* SW SA NEL HOM	MD* SW SA NEL	MD* SW SA NEL	MD SW SA NEL HOM	MD SW SA NEL HOM	MD* SW SA NEL	MD* SW SA NEL	MD SW SA NEL HOM							MD* SW* SA* N HOM*	MD* SW* SA* HOM*	MD* SW* SA* HOM*	SW* SA*		
	Homecare base services • Nursing • Daily activity • Hygiene Activity • Medication	HOM- Homecare Nurse PLA-Family helper/aux. HMD-Homecare MD NEL-nur. (enla.role)24/7	See general services			HOM PLA HMD*	HOM PLA HMD	PLA NEL* HMD*	PLA NEL* HMD*	PLA HMD* HOM	PLA NEL* HMD*	PLA HMD* HOM	PLA NEL* HMD*	PLA NEL* HMD*	PLA HMD* HOM	PLA HMD HOM	PLA NEL* HMD*	PLA NEL* HMD*	PLA HOM HMD*							PLA HOM HMD*	PLA HOM HMD*	PLA HOM HMD*	PLA HOM HMD*		
	Homecare Specialized services	• Physical rehab Servi. • Pharmacy services • Nutritionist	See general services																												
	Assistance services • Personnal Hyg. • Daily Activities • Housekeeping	PLA-Family helper/aux. HOM- Homecare Nurse HRX-Medication EQU-Equipment AID-Technical aids NEL-nur. (enla.role)24/7	See general services			PLA HOM HRX EQU AID	PLA HOM HRX EQU AID	PLA NEL HRX EQU AID	PLA NEL HRX EQU AID	PLA NEL HRX EQU AID	PLA NEL HRX EQU AID	PLA HOM HRX EQU AID	PLA NEL HRX EQU AID	PLA NEL HRX EQU AID	PLA HOM HRX EQU AID	PLA HOM HRX EQU AID	PLA NEL HRX EQU AID	PLA NEL HRX EQU AID	PLA HOM HRX EQU AID							PLA NEL HRX EQU AID	PLA NEL HRX EQU AID	PLA NEL HRX EQU AID			

Elders & persons lacking of autonomy (SAPA) (2017) 2/2

Description (MSSS)		Nunavik programmation	New Positions required 2018-2022	Development Budget Required 2018-2021	Housing Required 2018-2022	UTHC							IHC							NRBHSS						Community Organization			Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaarapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Inuit Values & practices	Out of region	Tusaajiaqik Elders house Daycentre	Sallivik elders house (puv)	Qilanguanaaq (wb)	Ullivik	Ruis McGill	Other
1st line services (General services)	Ressource (lodging) • Long term beds • Respite Beds • Convalescence • Daycentre	LTC-Long term beds RES-Respite beds CON-Convalescence ORS-Out of region serv. RI-Intermediate ress. COR-Com. Ress (elders) DAY-Daycentre	Procjet LTC PUV (3X nurse, 7 x Aux. Nurse, 12 x Northern Att. 1X Coordo, 1 x act ani, 2x cook, 1 Janitor, 1 receptionist, 7 security guard) Project LTC Kuujjuaq (7 x Aux Nurse, 10 North attendant, 1x jan,	$ 4 400 000,00 $ 2 170 000,00	36 18	COR	LTC RES CON RI DAY LTC18			COR21		COR			COR19	COR LTC CON RES LTC 20			COR20							LTC RES CON COR RI DAY	COR RES CON	COR RES CON			ORS RI LTC RES CON
	Community Serv. • Transport • Kitchen • Recreation • Health com.	BUS-Elders Transport KIT-Com. Kitchen REC-Recreation com. WEL-Wellness com.				BUS KIT REC WEL	BUS KIT REC WEL	BUS REC	BUS REC	BUS REC	BUS REC KIT	BUS REC WEL KIT	BUS REC	BUS REC KIT WEL	BUS REC KIT WEL	BUS REC KIT WEL	BUS REC	BUS REC WEL	BUS REC KIT WEL												
	Caregiver services • Support • Training • Respite • Daycentre	HOM- Homecare Nurse PLA-Family helper/aux. HMD-Homecare MD NEL-nur. enla.role 24/7 DAY-Daycentre RES-Respite beds	See Project LTC PUV			HOM PLA HMD*	HOM PLA HMD RES DAY	PLA NEL* HMD*	PLA NEL* HMD*	PLA HMD* HOM	PLA NEL* HMD*	PLA HMD* HOM RES	PLA NEL* HMD*	PLA NEL* HMD*	PLA HMD* HOM	PLA HMD HOM RES	PLA NEL* HMD*	PLA NEL* HMD*	PLA HOM HMD*							PLA HOM HMD* RES DAY	PLA HOM HMD* RES	PLA HOM HMD* RES	PLA HOM HMD*		
2nd Line serv.(non-ambulatory)	Spec. Diagnostics & treatment services • Geriatry • Psychogeriatry • Rehabilitation • Orthesis/prost.	GER-Geriatrist PGE-Psychogeraitrist URF-URFI ORT-Orthesist	See physical health URFI Project Puv within LTC project (3X PHT, 3 X OT, 3X PRT, 2 speech therapist, 2 X ORT)	$ 1 715 000	13	URFI*	URFI*	URFI*	URFI*	URFI*	URFI*	URFI*	URFI*	URFI*	URFI*	URFI21	URFI*	URFI*	URFI *											GER PGE URF ORT	GER PGE URF ORT
3rd line services	Over spec. serv. • Soc. reintegration • Interv. support	ORS-Out of region serv.																													ORS

Physical health and medical affairs division

HR development (2017)

			New Positions required 2018-2022	Development Budget Required 2018-2022	Housing Required 2018-2023	UTHC							IHC							NRBHSS						Community Organization		Out of region		
						Kangiqsualujjuaq	Kuujjuaq	Tasiujaq	Aupaluk	Kangirsuk	Quaqtaq	Kangiqsujuaq	Kuujjuaraapik	Umiujaq	Inukjuak	Puvirnituq	Akulivik	Ivujivik	Salluit	Planning & Programming	Public Health	HR development	Administrative	Executive	Out of region		Nunalituvait ikajusta	Ulivik	Ruis McGill	Other
Youth in difficulties	1st line services	Marie-Victorin AEC communication aids= AEC1		$ 350 000	0	AEC1-18	AEC1									AEC1														
Youth in difficulties	2nd lines services	Refer to 1st line + dev Attachmnet disorder training=Atta		$ 350 000,00	0										AEC1-18				AEC1			APPR18								
General services	1st lines services	SS Refer to 1st line services Nunavik Nurse enlarge role training=NEL 1St responders =1RES		$ 1 036 250,00	0	1RES	NEL18 1RES	1RES	1RES	1RES	1RES	1RES	1RES	1RES	1RES	NEL 18 1RES	1RES	1RES	1RES											
General services	2nd lines services	see 1st lines																												
Addictiion		Necchi=NEC Addiction 1st line=ADD				ADD	NEC ADD	ADD	ADD	ADD	ADD	ADD	ADD	ADD	ADD	ADD NEC	ADD	ADD	ADD											
Mental health		Mental aid first aid =MHFA Assist=ASS Suicide intervent Best practices =SUI				MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI	MHFA ASS SUI											
Serv support clinique		McGill management training =McG Language training (inultitut + english)=LAN	1 x teacher (McGill 4 x /year)	$ 150 000			MCG LAN									MCG														
PLA		Healthcare assistant =PAB	Training fees	$ 300 000			PAB18									PAB18														
Public Health	Prevention	Goodt touch bad touch +GTBT Tobacco=Tab work environment =work Tuberculose =TB Baby book = BB STBBI																												

	SRP Actuel	18-19 Ressource	19-20 Ressource	20-21 Ressource	21-22 Ressource	22-23 Ressource	23-24 Ressource	24-25 Ressource
Axe Transversal								
Sub-Regional - Ungava				1. Agent monitoring Eval				
Local - Ungava								
Sub-Regional - Hudson				1. Agent monitoring Eval				
Local Hudson								
NRBHSS		1. Coordo Programs & Recherches en PH	1. Épidémiologiste 2. Tech Data base		1. Épidémiologiste			
TOTAL								
Axe 1 - Développement global des enfants et des jeunes								
Sub-Regional - Ungava								
Local - Ungava	SIPPE: 1 nurse SIPPE: 3 FEW (Kuujjuaq, Wakeham Bay, (SIPPE: social worker FASD coordinator	1. Clinique Jeunesse - Inf 2. Clinique Jeunesse - TS 3. Street Worker 4. Social Aid SIPPE TBD 5. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD
Sub-Regional - Hudson								
Local Hudson	SIPPE: Human relations officer SIPPE: 5 FEWs (2 Salluit, 2 Inukjuaq, 1 TB SIPPE: nurse FASD coordinator	1. Clinique Jeunesse - Inf 2. Clinique Jeunesse - TS 3. Street Worker 4. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Inf scolaire 3. Clinique Jeunesse - Inf 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Inf scolaire 3. Clinique Jeunesse - Inf 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD	1. Inf scolaire 2. Clinique Jeunesse - Inf 3. Clinique Jeunesse - TS 4. Street Worker 5. Social Aid SIPPE TBD 6. Social Aid SIPPE TBD
NRBHSS	2 agents SIPPE 1 agent development of parental competences (babybook)	1. Dentiste Conseil				1. Agent Milieu scolaire		
TOTAL								
Axe d'intervention 2 - L'adoption de modes de vie et la création d'environnements sains et sécuritaires								
Sub-Regional - Ungava	Nutritionist (?) Coordinator of public health	1.Tech admin	2. Organisateur comm	1. Agent Promo santé				
Local - Ungava								
Sub-Regional - Hudson	Coordinator of public health	1. Nutritioniste 2. Tech Admin	2. Organisateur comm	1. Agent Promo santé				
Local Hudson								
NRBHSS	1 agent promotion of physical activity 1 coordinator health promotion an ddisease prevention Tobacco prevention (?) + Psycho-social (?)agent	1. Agent Devlpmt Comm	1. Agent Prev Agressions Sex	1. Agent Promo Santé Globale 2. Sécurité Alimentaire	1. Agent Prév Dépendances	1. Agent Santé Sex	1. Agent Prev Trauma	1. Agent Prev Violence

TOTAL								
Axe 3 : La prévention des maladies infectieuses								
Sub-Regional - Ungava	1 protection nursing advisor		1. Inf Protection					
Local - Ungava								
Sub-Regional - Hudson	1 protection nursing advisor		1. Inf Protection					
Local Hudson		1. Inf STBBI (PUV)						
NRBHSS	1 Immunisation advisor 2 infectious diseases advisor	1. Inf Infections nosocomiales	1. Agent Protection (Inuit) 2.Tech admin					
TOTAL								
Axe 4 : La gestion des risques et des menaces pour la santé et la préparation aux urgences sanitaires								
Sub-Regional - Ungava								
Local - Ungava								
Sub-Regional - Hudson								
Local Hudson								
NRBHSS	1 environmental officer		1. Agent environnement					

Qanuilirpitaa 2017 – Nunavik Health Survey Project

When: From August 8, 2017 to September 26, 2017

Where: In the 14 Nunavik villages

Context

Measuring the health status of Inuit is an important challenge for Nunavik health authorities. Unlike in other regions of Québec, medico-administrative data cannot be used to establish the incidence and prevalence of chronic diseases in the Nunavik population. Québec and Canadian surveys on diseases, lifestyles and other health determinants have never extended beyond the 49th parallel. There are several reasons for this: linguistic and cultural barriers, methodological and logistical considerations, the need to adapt tools and transportation costs. So far, two surveys have been conducted by Nunavik authorities: the Santé Québec Survey in 1992 and the *Qanuippitaa* (How are we?) survey in 2004. Thus, the overall aim of the *Qanuilirpitaa* (How are we now?) 2017 survey is to establish an up-to-date portrait of the health status of the Inuit in Nunavik.

In February 2014, the Board of Directors of the Nunavik Regional Board of Health and Social Services (NRBHSS), composed of representatives from the region's 14 communities and from its two health centres, unanimously adopted a resolution to conduct a new health survey comprising three components: adult health, youth health and community health. The survey is to be conducted in all Nunavik communities, in support of the Strategic Regional Plan.

Justifications for the survey

- Obtain reliable up-to-date data on the health status of the Inuit population of Nunavik.
- Document the emergence of new health and social problems and monitor previously identified issues: youth health, community health, chronic diseases, food security, mental health, distress, suicide, addictions, violence, etc.
- Obtain data to support clinical projects that aim at implementing new preventive strategies and services in close partnership with communities, with a focus on developing and strengthening their capacities.

We aim for continuity between this new survey and previous ones so that the evolution of certain trends can be assessed. In addition, the new survey is intended to move beyond traditional survey approaches, in accordance with contemporary paradigms for developing knowledge in Aboriginal communities, in order to properly document the situation of youth and of communities.

Survey objectives

1) **Adult health component** – Document the mental and physical health status of adults in 2017 and follow up on the adult cohort of 2004 (N= 1000).
2) **Youth health component** – Establish a new cohort of Inuit youth aged 16 to 30 years old (N = 1000) to document their mental and physical health status. The youth demographic is larger proportionally in Nunavik than in the rest of Québec.
3) **Community health component** - Establish the health profiles and assets of communities in the framework of participatory research, using culturally-relevant quantitative traits.
4) **Community mobilization project**: We also aim to mobilize the communities and to foster their development, in line with Inuit aspirations so a community mobilization project will be carried out as a pilot alongside the survey , in 2-3 communities.

Overview of selected health topics (defined in consultation with Inuit experts)

Physical health: cardiometabolic health, respiratory health;

Infectious diseases: gastroenteritis, Helicobacter Pylori, sexually-transmitted infections;

Oral health: cavities, periodontal disease, inflammation, dental trauma;

Food security and nutrition: food quality, access and availability; nutritional status and anemia;

Sexual health: at-risk behaviours for sexually transmitted infections, teen pregnancies and obstacles to contraception;

Mental health and resilience: quality of life, life satisfaction, psychological distress (stress, anxiety, post-traumatic-stress-disorder, depression, suicide), self-esteem, coping mechanisms, social support;

Victimization during childhood and adulthood: emotional, physical and sexual; within couple, family and community;

Housing and homelessness;

Community safety and security;

Socio-cultural determinants of health: cultural identity, aspirations, community involvement/social integration, roles and responsibilities within community, discrimination/exclusion, spirituality;

Family: family relations, cohesion, support and trauma (residential school and foster care);

Substance use (tobacco, alcohol, drugs) and dependence, gambling;

Environmental health: health issues related to water and food quality;

Socio-economic status of individuals and communities included in the survey: education, income, employment, community assets;

Internet and social media: access to and communication of health related information; risk vs positive aspects for physical and mental health.

Governance

The governance structure that has been established calls for the participation of several representatives from Nunavik's communities, reflecting the participatory approach that characterizes this survey. Governance is overseen by a steering committee composed of the main regional leaders and key representatives of the Nunavik community: Kativik Regional Government, Makivik, Kativik School Board and two mayors representing the communities. Representatives of two major organizations, the *Institut national de santé publique du Québec* (INSPQ) and the CHU de Québec Research Centre/Université Laval, are also key members of the Steering Committee. The NRBHSSS chairs the steering committee and is responsible for the overall survey.

Three partners are working together toward the realization of this survey: the Nunavik Regional Board of Health and Social Services (NRBHSS), the *Institut national de santé publique du Québec* (INSPQ) and the CHU de Québec Research Centre/Université Laval. The INSPQ has been mandated to ensure the project's overall coordination and administrative management.

This decision-making body and the active involvement of communities, which is at the core of this project, are intended to allow Nunavimmiut to appropriate all phases of this health survey and its results, thus strengthening Nunavimmiut autonomy and their ability to manage their health.

Data ownership and access:

Funding

The major regional organizations have allocated funding from their organizations to the survey with the NRBHSSS being the major contributor. The MSSS of Quebec is also contributing money to the survey. INSPQ and CHU de Quebec Research Centre are providing in-kind resources with additionally some research funding. Funding is still required to complete the total requirements for the realization of the survey.

NRNHSSS: $2.5M
KRG: $1M
Makivik: $500,000.00
KSB: $600,000.00
MSSS: $764,330.00
Artic Net: $540,000.00

The Canadian Coast Guard Ship Amundsen will be used as a means of transportation for the research team in all communities. Since the only way to reach the 14 communities is either by plane or by boat, the latter constitutes, based on the 2004 experience, the best way to collect all the data relevant to the survey (clinical, biological and from administered questionnaires).

CADRE DE RÉFÉRENCE RÉGIONAL

(2015-2023)

POUR LE DÉPLOIEMENT DES MAISONS DE NAISSANCE ET DES SERVICES DE SAGES-FEMMES AU NUNAVIK

RÉSUMÉ ÉXÉCUTIF

Le développement de services de sages-femmes au Nunavik a d'abord été façonné par un besoin culturel et identitaire de se réapproprier la grossesse, l'accouchement et la naissance. Ces moments composaient autrefois un événement majeur pour la famille et la communauté, qui soudait et renforçait les liens familiaux à travers l'attachement éprouvé pour le nouveau membre de la famille. Les politiques d'évacuation des femmes enceintes, notamment dans les années 1960 et 1970, avaient participé de la déstructuration des liens familiaux et précipité la perte de plusieurs connaissances culturelles que les femmes inuit se transmettaient auparavant. Au contraire, depuis la fin des années 1980, la réappropriation progressive de la grossesse, de l'accouchement et de la naissance a rencontré un grand succès, grâce notamment à l'implantation au Nunavik de services de sages-femmes.

La maternité de Puvirnituq a fréquemment été citée en exemple de meilleure pratique permettant d'améliorer les soins périnataux et l'accouchement des femmes autochtones, permettant de concilier sécurité de l'accouchement pour la mère et l'enfant, et sécurisation des pratiques culturelles. Ce modèle développé à Puvirnituq a d'abord été étendu à deux autres communautés de la baie d'Hudson, Inukjuak (1998) puis Salluit (2004). Ces trois « maternités » offrent aujourd'hui un service de sages-femmes aux 7 communautés de la baie d'Hudson. Il a finalement été implanté à Kuujjuaq, de manière à offrir un service aux 7 communautés de l'Ungava. L'ouverture du service de sages-femmes de Kuujjuaq a permis que plus de 68% des naissances du Nunavik soient en 2012 assistées par des sages-femmes.

Privilégié par la RRSSSN dans les années 2000, ce modèle offre un service culturellement approprié et sécuritaire à la clientèle du Nunavik, et renforce ce processus de réappropriation en formant une nouvelle génération de sages-femmes inuit. Les services de sages-femmes sont culturellement sécuritaires, cliniquement valides, économiquement viables, et conformes aux politiques du MSSS en ce qui a trait aux services de proximité et de périnatalité.

Par contre, en raison notamment de contraintes immobilières, les locaux dans lesquels pratiquent les sages-femmes du Nunavik sont loin de correspondre aux standards du reste de la Province. Les locaux utilisés au Nunavik n'ont pas été conçus pour accueillir ce genre de services, et présentent de nombreux obstacles à leur développement, pourtant indispensable en raison d'une augmentation rapide de la population et du nombre de naissances.

La population du Nunavik a en effet augmenté de manière spectaculaire depuis 1960 : en 50 ans, la population totale a plus que quadruplé. Le taux de fécondité reste aujourd'hui bien plus élevé que pour l'ensemble du Québec (1,7), avec 3,3 enfants par femme sur la période 2007-2011. Ce contexte de croissance rapide de la population doit être pris en compte dans la planification des futurs services de sages-femmes. De 2001 à 2011, la population a encore augmenté de 19%, pour atteindre 12 211 habitants, et cette augmentation rapide devrait se poursuivre durant la prochaine décennie. L'ISQ envisage pour 2021 une population totale de

14 344 personnes, et pour 2031 une population totale de 17 062 personnes, soit une augmentation de 39,7%. Il faut également prévoir une augmentation significative du nombre de naissances durant les 20 prochaines années : le nombre de naissances annuelles pourrait s'approcher des 500 en 2033, pour 268 naissances vivantes en 2003.

En l'absence d'un changement de paradigme en termes d'infrastructures, avec le déploiement régional d'un réseau de maisons de naissance, les sages-femmes ne pourront plus offrir le service de qualité qui fait la fierté du Nunavik.

Le déploiement d'un réseau régional de maisons de naissance devrait donc impliquer, dans les 8 prochaines années (2015-2023), un effort sur les infrastructures des communautés ayant déjà des services de sages-femmes en place, soit Kuujjuaq, pour le CSTU, et Inukjuak, Salluit, et Puvirnituq pour le CSI. Une seconde étape verrait éventuellement la mise en place de nouvelles maisons de naissances, à Kangiqsualujjuaq (CSTU) ou à Kuujjuaraapik (CSI).

Ce réseau régional de maisons de naissances devrait s'insérer dans le réseau de la santé et des services sociaux en déployant des protocoles de collaboration avec ses divers partenaires du réseau de la santé. Certains liens pourraient être particulièrement nourris, notamment avec le programme SIPPE en déploiement dans la région, de manière à renforcer le continuum de services offerts aux jeunes familles, et à favoriser l'ancrage communautaire des maisons de naissances. Les sages-femmes ont déjà un rôle élargi dans les communautés du Nunavik, et un statut fort dans la communauté. Cette réalité pourra être encore renforcée grâce au déploiement des maisons de naissances.

Finalement, le déploiement de ces maisons de naissance verra l'avènement du programme régional de formation des sages-femmes inuit (*Nunavik Midwifery Education College*). Une maison de naissance est un espace de formation pour les sages-femmes, leur permettant de poursuivre des cours afin d'obtenir les connaissances nécessaires à la pratique sage-sage-femme. Les sages-femmes y agissent comme enseignantes et préceptrices auprès des étudiantes. Au Nunavik, le réseau régional des maisons de naissances permettra de pérenniser la formation des sages-femmes inuit, une étape essentielle à l'enracinement de ces services et à leur efficacité.

Les services de sages-femmes actuellement en place offrent un service culturellement sécuritaire, cliniquement valide, économiquement viable, et conforme aux politiques du MSSS en ce qui a trait aux services de proximité et de périnatalité. Le déploiement de maisons de naissances dans la région permettra de pérenniser ce modèle en lui donnant la capacité d'absorber la hausse importante du nombre de naissances à venir dans les 20 prochaines années, en renforçant l'ancrage communautaire des services de sage-femme, et en renforçant la formation des sages-femmes inuit.

AVANT-PROPOS

Les directrices générales du CSTU, du CSI et de a RRSSSN ont confié en octobre 2013 le mandat à la Direction des Valeurs et Pratiques inuit de la RRSSSN de coordonner le processus devant conduire à l'élaboration du Cadre de référence régional pour le déploiement des maisons de naissance et des services de sages-femmes au Nunavik (*Regional Framework for birthing houses and midwifery in Nunavik*).

Ce document est le résultat des consultations et rencontres que le Comité de travail régional a effectuées depuis cette date, sous le leadership de la Direction des Valeurs et Pratiques inuit.

ACRONYMES

CAM	*Canadian Association of Midwifes*
CBJNQ	Convention de la Baie-James et du Nord Québécois
CLSC	Centre Local de Services Communautaires
CS	Centre de Santé
CSI	Centre de Santé Inuulitsivik
CSN	Confédération des Syndicats Nationaux
CSTU	Centre de Santé Tulattavik de l'Ungava
ETC	Équivalent Temps Complet
ETCAF	Ensemble des Troubles Causés par l'Alcoolisation Fœtale
FASD	*Fetal alcohol spectrum disorder*
GARE	Grossesse À Risque Élevé
ISQ	Institut de la Statistique du Québec
ITS	Infections Transmissibles Sexuellement
MSSS	Ministère de la Santé et des Services Sociaux
NACM	*National Aboriginal Council of Midwifes*
NMWG	*Nunavik Midwifery Working Group*
OSFQ	Ordre des Sages-Femmes du Québec
RRSSSN	Régie Régionale de la Santé et des Services Sociaux du Nunavik
RSFQ	Regroupement des Sages-Femmes du Québec
RSSF	Responsable des Services de Sages-Femmes
SIPPE	Services Intégrés en Périnatalité et Petite Enfance
ETCAF	Ensemble de troubles causés par l'alcoolisation fœtale
OLO	Œufs-lait-orange

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1. POPULATION DESSERVIE PAR LES SERVICES DE SAGES-FEMMES DU NUNAVIK EN 2014

1.1 IMPORTANCE CULTURELLE ET IDENTITAIRE DES SERVICES DE SAGES-FEMMES DU NUNAVIK

Le développement de services de sages-femmes au Nunavik correspond à un besoin clinique mais a d'abord été façonné par un besoin culturel et identitaire de se réapproprier la grossesse, l'accouchement et la naissance. Ces moments étaient autrefois sous le contrôle des femmes inuit, qui conseillaient les femmes enceintes, et les assistaient lors de l'accouchement grâce à leurs riches connaissances (Pauktuutit 1995, Qinuajuak 1996, McGrath 2000, Pernet 2012). La naissance représentait alors un événement majeur pour la famille et la communauté, qui soudait et renforçait les liens familiaux ainsi que l'attachement qu'éprouvaient les membres de la famille les uns pour les autres (Pernet 2014).

Les politiques d'évacuation des femmes enceintes pour les hôpitaux du Sud de la Province ou vers Moose Factory (Ont.), notamment dans les années 1960 et 1970, avaient participé de la déstructuration des liens familiaux (Daviss-Putt 1990, O'Neil & Kaufert 1990, Jasen 1997, Van Wagner & al. 2007, Pernet 2014) et précipité la perte de plusieurs connaissances culturelles que les femmes inuit se transmettaient auparavant. Au contraire, depuis la fin des années 1980, la réappropriation progressive de la grossesse, de l'accouchement et de la naissance, a rencontré un grand succès, grâce à l'implantation au Nunavik de services de sages-femmes. La maternité de Puvirnituq a en ce sens fréquemment été citée en exemple de meilleure pratique permettant d'améliorer les soins périnataux et l'accouchement des femmes Autochtones, permettant de concilier sécurité de l'accouchement pour la mère et l'enfant, et sécurisation des pratiques culturelles (Fletcher 1994, Fletcher and O'Neil 1994, Couchie & Sanderson 2007).

Ce modèle, privilégié depuis par la RRSSSN, offre un service culturellement approprié et sécuritaire à la clientèle du Nunavik, et renforce ce processus de réappropriation en formant une nouvelle génération de sages-femmes inuit. Il offre un service sécuritaire, cliniquement valide, économiquement viable, et conforme aux politiques du MSSS en ce qui a trait aux services de proximité et de périnatalité[1].

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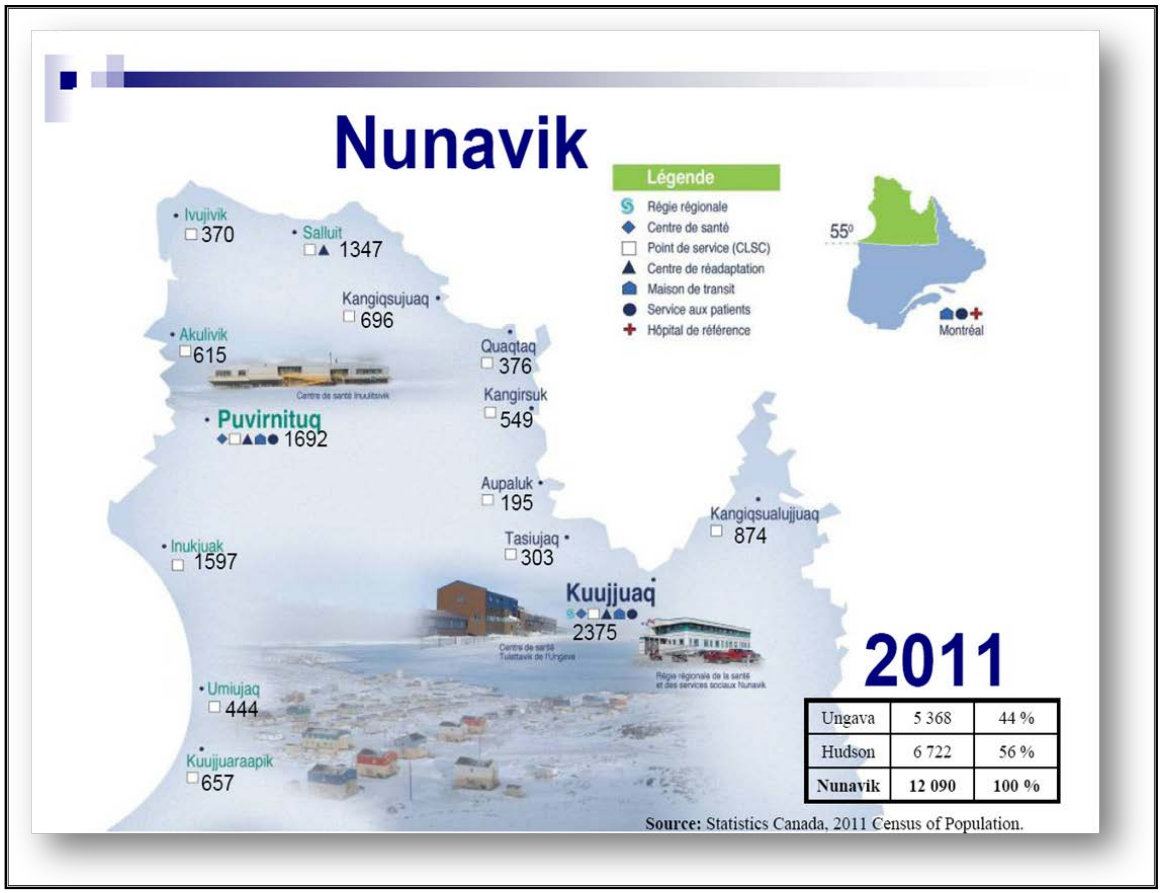
[1] MSSS Politique de périnatalité 2008-2018. http://publications.msss.gouv.qc.ca/acrobat/f/documentation/2008/08-918-01.pdf (Consulté le 3 décembre 2014).

1.2 UN PROGRAMME VICTIME DE SON SUCCÈS

Le modèle développé à Puvirnituq (1986) a d'abord été étendu à deux autres communautés de la baie d'Hudson (**carte 1**), Inukjuak (1998) puis Salluit (2004). Ces trois « maternités » offrent aujourd'hui un service de sages-femmes aux 7 communautés de la baie d'Hudson.

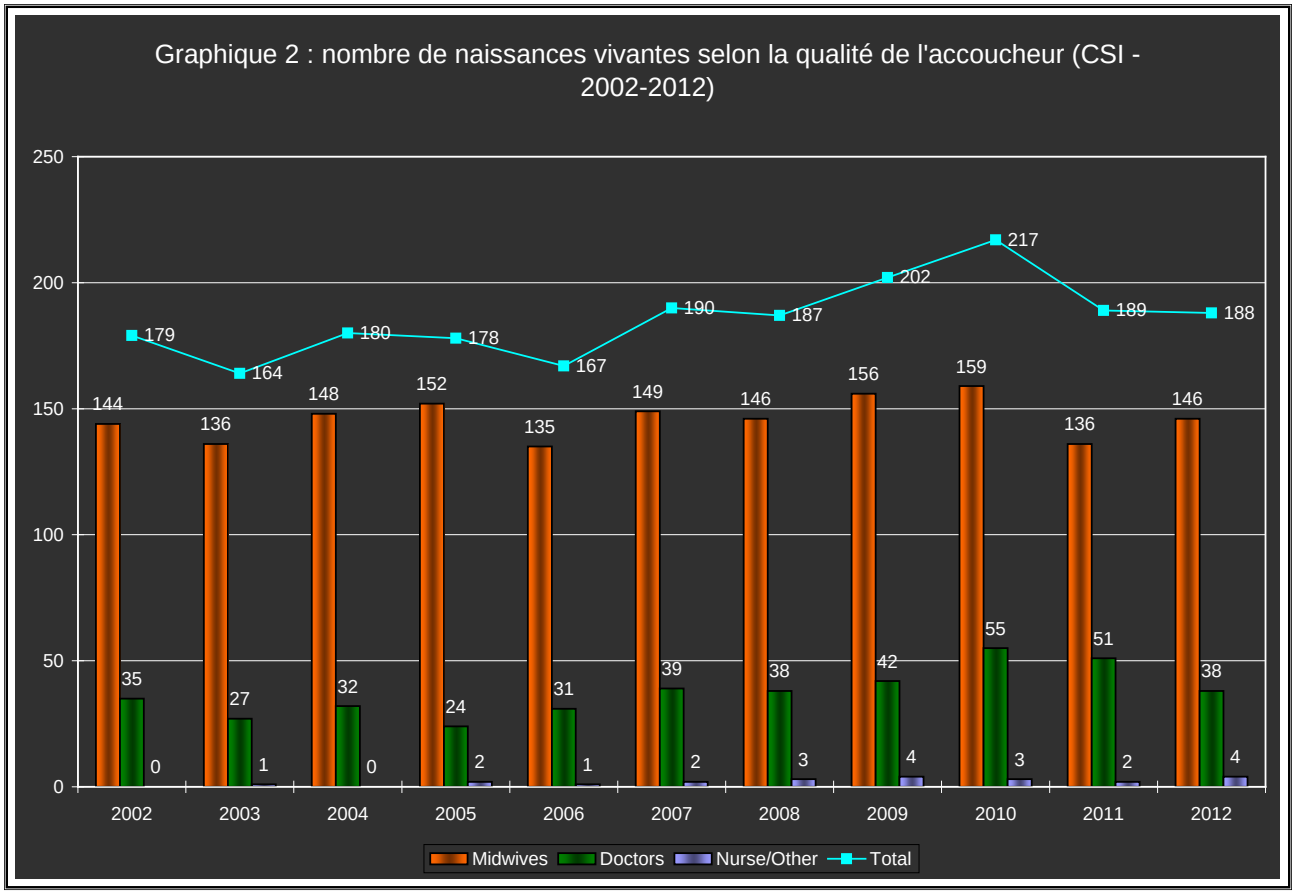
Carte 1 Le réseau de la santé et des services sociaux au Nunavik



Ces trois services (Inukjuak, Puvirnituq et Salluit) dépendent du CSI. Ils rencontrent depuis leur création un grand succès, puisque 79% des naissances ayant eu lieu sur cette côte au cours de la période 2002-2012 ont été assistés par des sages-femmes. Ces services ont donc permis de réduire structurellement le nombre de transports vers le Sud des femmes enceintes, conformément aux ambitions culturelles et identitaires du programme, tout en diminuant le ratio interventions/clients, et en évitant des couts de transport. Cette approche est de surcroît cohérente avec l'adoption de pratiques de dispensation de services de proximité dictées par le MSSS.

Victimes de leur succès, ces services souffrent pourtant déjà de saturation (**graphique 2**).

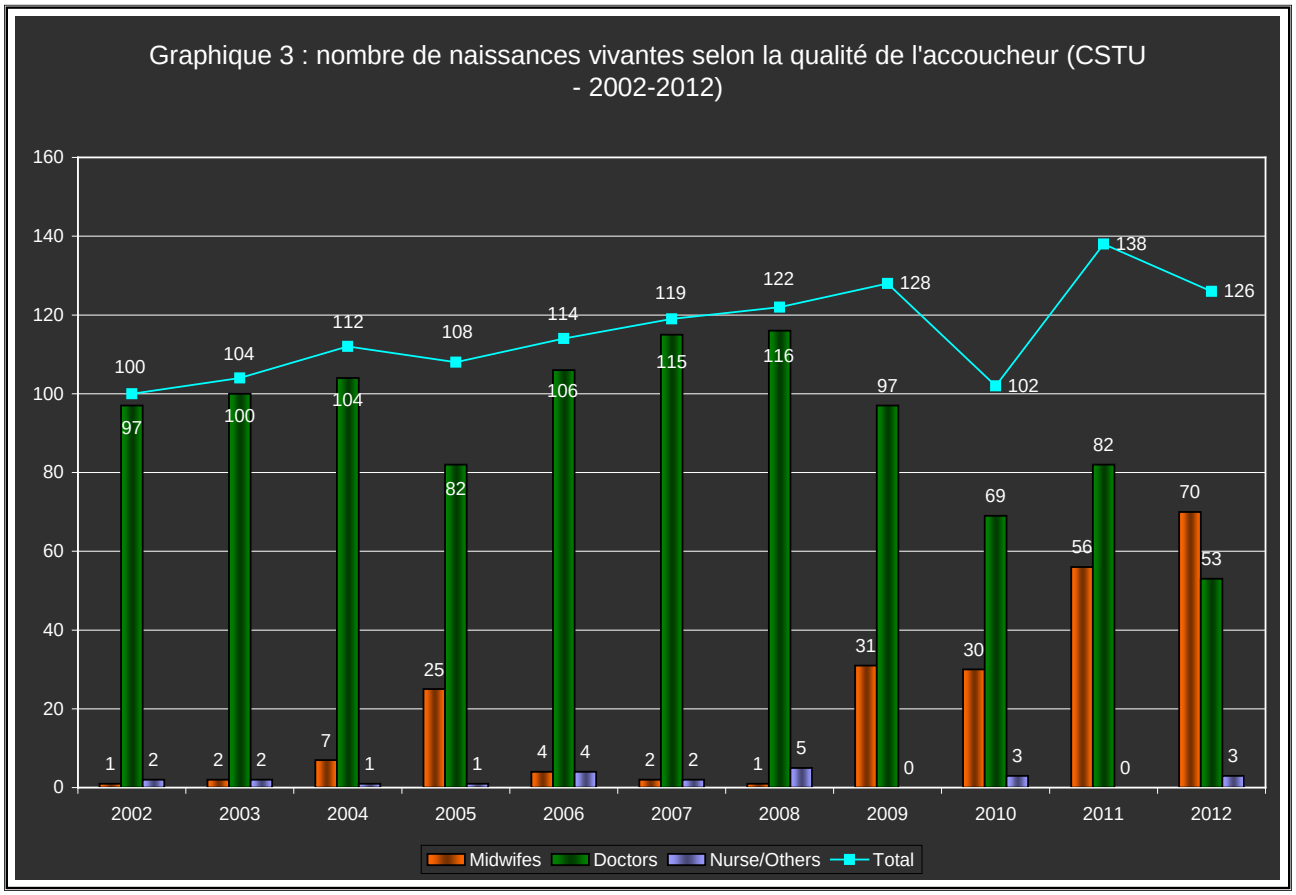
Graphique 2 : Nombre de naissances vivantes selon la qualité de l'accoucheur (CSI - 2002-2012)



La proportion de naissances assistée par des sages-femmes a eu tendance à diminuer dans cette région, alors pourtant que le nombre de naissances assistées par sages-femmes reste relativement constant. Cette évolution montre la façon dont le manque d'espace affecte les services de sages-femmes actuellement en place. Il est difficile d'offrir systématiquement ce service à plus de femmes dans un contexte où la population augmente plus rapidement que l'espace disponible. Se réapproprier la grossesse, l'accouchement et la naissance implique d'être capable d'offrir un suivi complet aux femmes, du premier jour jusqu'à 6 semaines après la naissance. Cela implique également d'avoir la capacité d'accompagner les femmes tout au long de ces expériences d'une manière culturellement sécuritaire. Chacun des services de sages-femmes de la Baie d'Hudson occupe les mêmes locaux depuis son ouverture, en dépit de la croissance de la population et des besoins de santé.

Sur la côte de l'Ungava, les services de sages-femmes ne sont disponibles à Kuujjuaq que depuis 2009, et desservent les 7 communautés de l'Ungava. Ces services ont également connu un succès rapide (**graphique 3**).

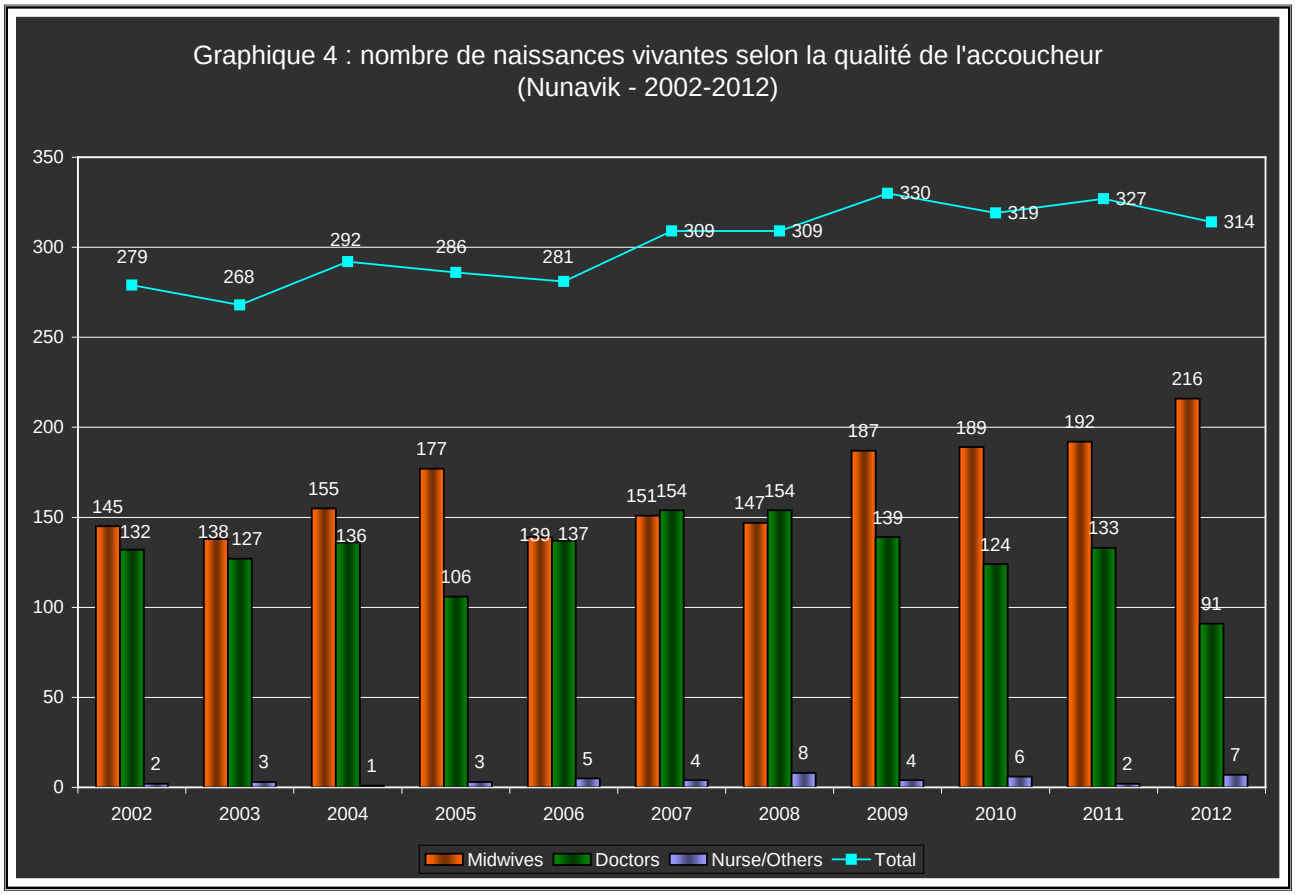
Graphique 3 : Nombre de naissances vivantes selon la qualité de l'accoucheur (2002-2012)



Le graphique 3 montre la forte progression des accouchements assistée par des sages-femmes sur la côte de l'Ungava. Ces services ont donc corrélativement permis de réduire de 54% le nombre de transports vers le sud depuis 2008, conformément aux objectifs culturels et identitaire de ces services, tout en diminuant le ratio interventions /clients, et en évitant des couts de transport. Là encore, ces services se développent en conformité avec l'adoption de pratiques de dispensation de services de proximité dictées par le MSSS.

Si on peut craindre une saturation rapide du service offert à Kuujjuaq, il faut reconnaître que le développement régional des services de sages-femmes au Nunavik, au cours des années 2000, représente un grand succès. L'ouverture des services de sages-femmes de Kuujjuaq a finalement permis que plus de 68% des naissances du Nunavik soient assistées par des sages-femmes en 2012 (**graphique 4**).

Graphique 4 : Nombre de naissances vivantes selon la qualité de l'accoucheur (Nunavik - 2002-2012)



1.3 DES SERVICES ADAPTÉS À UNE POPULATION JEUNE ET EN FORTE CROISSANCE

La population du Nunavik est une population jeune, 58,4% de la population ayant moins de 25 ans. Les femmes ont leurs premiers enfants plus jeunes que dans l'ensemble du Québec, et ont plus d'enfants (**tableau 1**).

Indicateurs démographiques	Nunavik	Ensemble du Québec
Proportion de la population ayant moins de 25 ans, 2011	58,4 %	28 %
Indice de fécondité, 2007-2011	3,29	1,72
Âge moyen des mères, 2007-2011	24,7	29,4
Proportion de familles comptant trois enfants ou plus à la maison, 2006	43 %	15 %

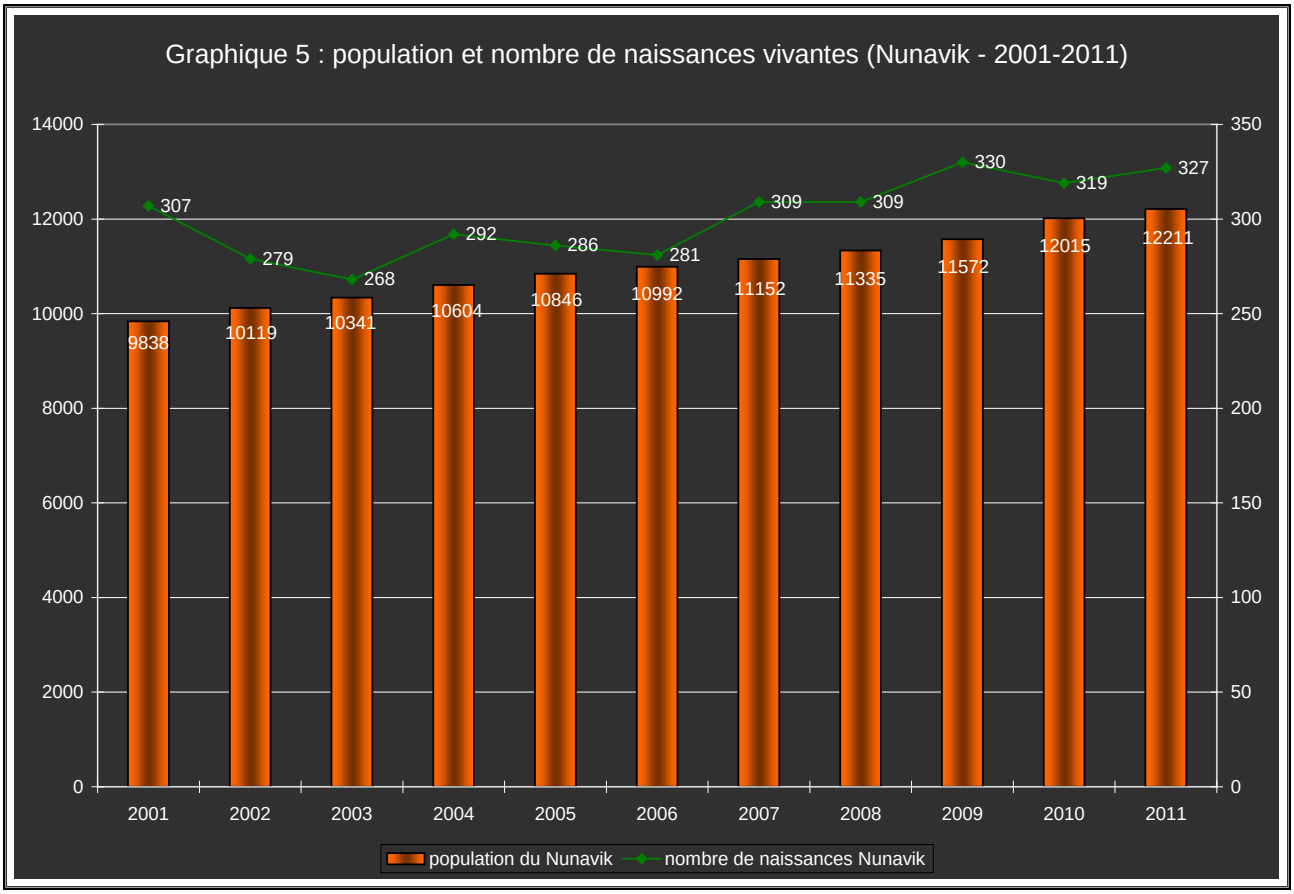
Tableau 1[2] : Quelques indicateurs démographiques des Nunavimmiut

La population du Nunavik a augmenté de manière spectaculaire durant la seconde moitié du XXe siècle : en 50 ans, la population totale a plus que quadruplé. Le plus haut taux d'indice de fécondité a été calculé en 1961, avec 8,1 enfants par femme, mais ce taux n'a cessé de diminuer depuis (Choinière et Robitaille 1988: 431). Le taux de fertilité était de 4,3 enfants par femme en 1981, à comparer avec 1,6 pour l'ensemble du Québec) (*ibid.* : 431). Le taux aujourd'hui reste bien plus élevé que pour l'ensemble du Québec (1,7), avec 3,3 enfants par femme sur la période 2007-2011.

[2] Les références citées dans ce tableau sont les suivantes : Institut de la statistique du Québec (2011); Données du recensement (2006), Enquête sur la santé dans les collectivités canadiennes (2009-2010); Fichier des naissances du MSSS.

Ce contexte de croissance rapide de la population doit être pris en compte dans la planification des futurs services de sages-femmes. De 2001 à 2011, la population a augmenté de 19%, et le nombre de naissances de 6% (**graphique 5**).

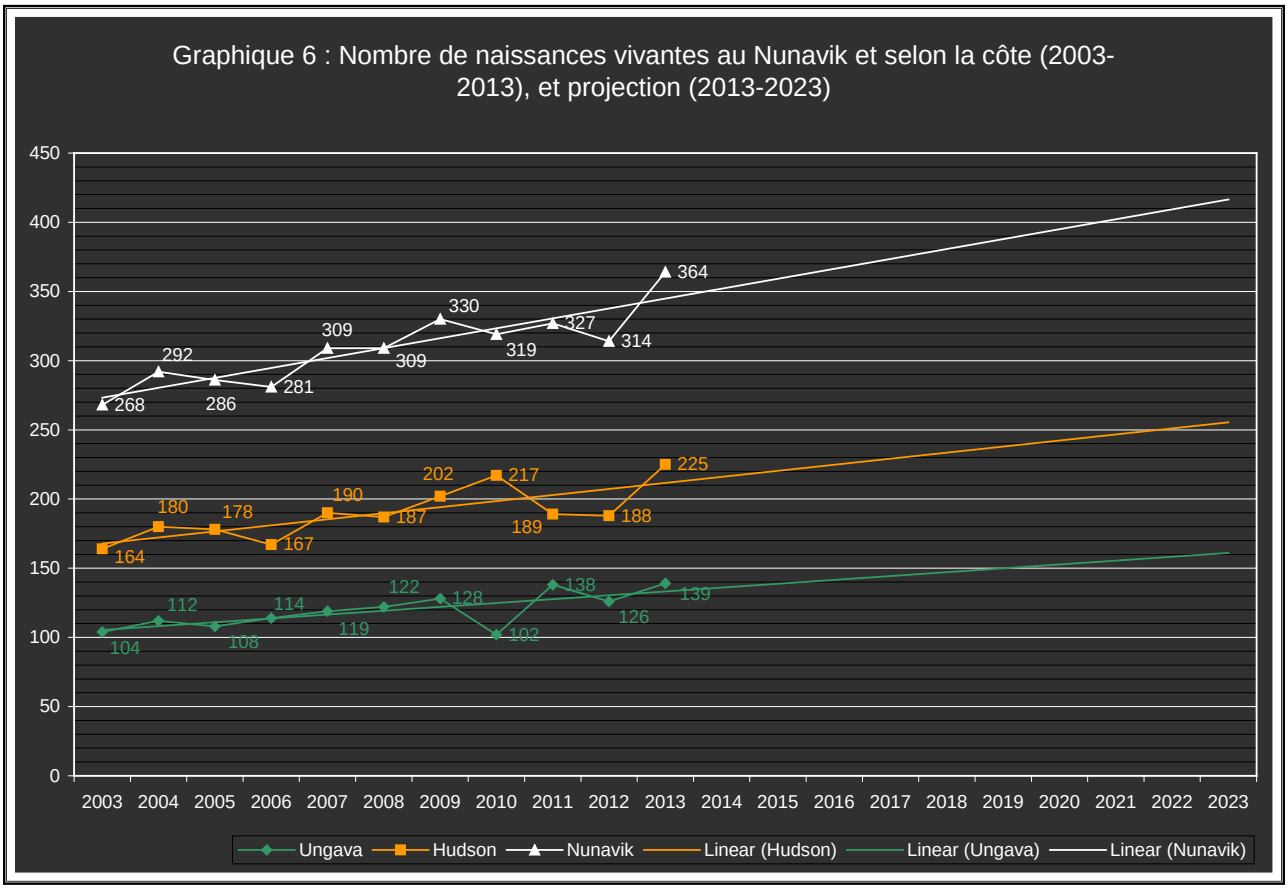
Graphique 5 : Population et nombre de naissances vivantes (Nunavik – 2001-2011)



Cette augmentation rapide de la population devrait se poursuivre durant la prochaine décennie. L'ISQ envisage pour 2021 une population totale de 14 344 personnes, et pour 2031 une population totale de 17 062 personnes, soit une augmentation finale de 39,7%. En considérant le faisceau constitué par d'autres indicateurs (**tableau 1**), il est donc à prévoir une augmentation significative du nombre de naissances durant les 20 prochaines années.

En considérant une augmentation linéaire du nombre de naissances au Nunavik sur la période 2013-2023 (**graphique 6**), il faudrait envisager que le nombre de naissances annuelles puisse s'approcher des 420 (environ 260 en Hudson et 160 en Ungava).

Graphique 6 : Nombre de naissances vivantes au Nunavik et selon la côte (2003-2013) et projection (2013-2023)



Si les bénéfices culturels, cliniques et économiques des services de sages-femmes actuels doivent être préservés, il importe de consolider le réseau régional de services de sages-femmes. Un tel réseau devrait s'appuyer sur l'implantation de maisons de naissance capables d'absorber la hausse du nombre de naissances à prévoir dans les 8 prochaines années.

1.4 PRINCIPES DIRECTEURS ET OBJECTIFS DES SERVICES DE SAGES-FEMMES ET MAISONS DE NAISSANCE AU NUNAVIK

La consolidation des services de sages-femmes disponibles à l'échelle régionale implique une nouvelle étape : la mise en place de maisons de naissance. Le modèle des maisons des naissances permettra d'offrir un service conçu de manière à répondre aux besoins grandissants de la population, dans des lieux spécifiquement conçus pour ce service, et qui permettront de le pérenniser à plus long-terme grâce à la formation de sages-femmes inuit.

Le modèle de la maison de naissance, développé en milieu urbain, est pourtant particulièrement adapté aux communautés isolées, offrant un établissement de taille humaine, ancré dans la communauté, qui permette à la fois de répondre aux besoins cliniques de la population du Nunavik, et à ses besoins culturels et identitaires (Couchie & Sanderson 2007). Les maisons de naissances devraient être considérées comme le cœur du futur réseau régional des services de sages-femmes, offrant des services culturellement adaptés, et participant de la sécurisation des pratiques et valeurs inuit.

L'établissement d'un réseau de maisons de naissances au Nunavik permettra notamment de renforcer la dynamique observée durant la décennie 2002-2012, qui a vu augmenter significativement la proportion de naissances assistées par des sages-femmes. Toutes ces naissances ont eu lieu sur le territoire du Nunavik, et ont permis d'éviter de coûteux déplacements jusqu'à Montréal. En cela, les maisons de naissances participeront de la baisse des coûts pour le réseau de la santé, tout en offrant un service de qualité, cliniquement et culturellement sécuritaire.

L'établissement de maisons de naissance offrira également la possibilité de mieux lier l'activité actuelle des services de sages-femmes aux services SIPPE, en développement dans la région. Ce rapprochement renforcera l'efficacité de chacun des services et participera d'un ancrage communautaire et culturel plus profond de ces programmes visant à maximiser le potentiel de santé et de bien-être des familles. La maison de naissance peut devenir le cœur d'un centre périnatal, en association avec le programme SIPPE.

Plus précisément, l'établissement de maisons de naissances répond aux objectifs suivants :

1. Améliorer la santé des jeunes Nunavimmiut dans le respect des valeurs et pratiques inuit;
2. Offrir des services de proximité grâce à des points de services locaux et mieux déployer les services de sages-femmes à l'échelle régionale;
3. Assurer la continuité des soins comme la sécurité des mères et des bébés en mettant la maison de naissance au cœur de collaborations interprofessionnelles locales et régionales;

4. Améliorer l'accès des Nunavimmiut aux services aux familles grâce à l'expertise des sages-femmes (retour au lien d'attachement familial autour de la naissance, prévention au niveau des ITSS, du ETCAF et de la prévention du bébé secoué);
5. Améliorer l'accès des Nunavimmiut aux services de périnatalité en collaboration avec les organismes communautaires impliqués dans ce domaine;
6. Accélérer le développement de la profession de sage-femme au Nunavik en augmentant l'accessibilité à la formation de sages-femmes inuit;
7. Offrir aux Nunavimmiut des services de sages-femmes inuit dans chacune des communautés pour le suivi pré- et postnatal, et dans certaines communautés pour les suivis, y compris les naissances.

2. SERVICES DE SAGES-FEMMES ACTUELS (2014)

2.1 SERVICES DE SAGES-FEMMES ACTUELS OFFERTS PAR LE CSTU

2.1.1 SITUATION ACTUELLE

Le service de sages-femmes du CSTU a commencé à être mis en place en 2008, pour devenir fonctionnel en 2009. Depuis 2012, les sages-femmes offrent un suivi complet pour les femmes résidant à Kuujjuaq. Le développement de ces services permet maintenant de desservir la clientèle de la côte d'Ungava.

2.1.2 QUALIFICATIONS DES CLIENTÈLES

Les sages-femmes du CSTU sont première ligne pour toutes les femmes enceintes du village de Kuujjuaq. Les femmes de Kangiqsualujjuaq, Tasiujaq, Aupaluk, Kangirsuk, Quaqtaq, et Kangiqsujuaq se rendent à Kuujjuaq dès la 37ième semaine de grossesse pour y donner naissance, et y demeurent jusqu'à leur congé des services sage-femme et leur retour dans leur village.

2.1.3 QUALIFICATIONS DES SERVICES

Activités actuelles par service de sages-femmes	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Suivi de grossesse				
Consultation prénatale et postnatale jusqu'à 6 semaines post-partum	x	x	x	x
Références et consultation sur place avec intervenants en périnatalité (nutritionniste, physiothérapeute, travailleuse sociale, psychologue, infirmière)	x	x	x	x
Services intégrés en périnatalité pour la petite enfance (SIPPE)	x		x	
Programme *Arctic Char*		x	x	x
Coupons périnatals (équivalent OLO)	x			

Activités actuelles par service de sages-femmes	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Accouchement				
Au centre hospitalier	x	x		
Au CLSC			x	x
Au domicile	x	x	x	x
Post-Partum				
Suivis jusqu'à 6 semaines, mère et bébé, par la sage-femme	x	x	x	x
Suivis à domicile (comprenant 3 visites au courant de la première semaine)	x		x	x
Support à l'allaitement	x	x	x	x
Santé reproductive				
Contraception		x	x	x
PAP tests et ITSS		x	x	x
Support équipe médicale et infirmiers				
Participation aux medevacs dans les villages	x	x	x	x
Participation aux schedevacs vers Montréal par vol régulier	x	x	x	x
Participation aux transferts par Challenger	x	x		

Activités actuelles par service de sages-femmes	CSTU	CSI		
	Kuujjuaq	Puvirnituq	Inukjuak	Salluit
Visite dans les communautés sans sage-femme		x	x	x
Référence et support obstétricale pour les médecins et infirmiers travaillant au CSTU.	x	x	x	x
Concertation et transferts des connaissances				
Réunion d'équipe interdisciplinaire (comité périnatale) hebdomadaire	x	x	x	x
Réunion d'équipe hebdomadaire	x	x	x	x
Participation au programme SIPPE et ETCAF	x	x	x	x
Formation sur place des sages-femmes inuit	x	x	x	x
Participation aux activités communautaires (Women Shelter, cuisine communautaire, etc.)	x	x	x	x
Participation activités diverses				
National aboriginal council of midwives (NACM)	x	x	x	x
Canadian association of midwives (CAM)	x	x	x	x
Nunavik Midwifery Working Group (NMWG)	x	x	x	x
Ordre des Sages-femmes du Québec (OSFQ)	x	x	x	x
Comité médecin dentiste pharmacien sage-femme	x	x	x	x
CSN		x	x	x
Regroupement les sages-femmes du Québec (RSFQ)	x			

Tableau 2 : Activités actuelles par service de sages-femmes (CSTU)

2.1.4 RESSOURCES HUMAINES

	Titre d'emploi nb (ETC)			
Établissement	Responsable sage-femme	Sages-femmes	Étudiante sage-femme	Sage-femme formation et village
CSTU	1	3	1	0

Tableau 3 : Ressources humaines du service de sages-femmes de Kuujjuaq (CSTU)

2.1.5 RESSOURCES FINANCIÈRES

Poste de dépenses	**2014-2015**
Salaires (avantages sociaux et charges comprises)	664 435,21$
Fournitures et autres charges	65 148,12$
Total	**729 583,33$**

Tableau 4 : Activités actuelles par service de sages-femmes (CSTU)

2.1.6 RESSOURCES MATÉRIELLES

Service consultation – Partie CLSC	
Espaces	Ressources matérielles / commentaires
Salle de consultation (2)	• 1 lit simple • 1 bureau • 3 chaises

Périnatal – Partie Centre Hospitalier	
Espaces	Descriptifs / commentaires
Salle d'accouchement	• 1 salle d'obstétrique-urgence • 1 lit mécanique • 1 lit girafe pour la réanimation néonatale
Bureau administratif	• Bureau avec postes de travail (Administratif)

Tableau 5 : Ressources matérielles du service de sages-femmes (CSTU)

2.1.7 RESSOURCES IMMOBILIÈRES

Le service sage-femme du CSTU est divisé en deux espaces, les locaux de consultations se situant dans un bâtiment accessible mais éloigné d'une quinzaine de mètres de l'espace réservé aux accouchements. L'espace se divise ainsi :

Usage	Espace m2
Côté consultation (ancien transit)	
Salle de consultation x2	**20**
Côté accouchements (service hospitalier)	
Bureau administratif (comprenant toilette)	**19**
Salle d'accouchement (salle pour urgences obstétricales)	**19**
Espace total	**58**

Tableau 6 : Ressources immobilières du service de sages-femmes (CSTU)

Les services actuels souffrent d'un manque d'espace. Ce manque d'espace entraine l'impossibilité d'agrandir l'équipe sage-femme au-delà de sa composition actuelle, et empêche également d'accueillir plus de femmes pour accoucher à Kuujjuaq plutôt qu'à Montréal. Ce manque de place impose également de limiter le nombre d'étudiantes inuit à former, ce qui met en péril la pérennité du service à long-terme.

Par ailleurs, les locaux utilisés au CSTU ne sont pas adaptés à un service de sages-femmes, comme le sont au contraire les maisons de naissance existant ailleurs dans la province.

Finalement, au-delà des problèmes pratiques liés à cette division de l'espace, il faut souligner que la salle d'accouchement se situe au cœur des services hospitaliers. Les risques d'infections nosocomiales sont donc particulièrement élevés.

2.2. SERVICES DE SAGE-FEMME ACTUELS OFFERTS PAR LE CSI

2.2.1 SITUATION ACTUELLE

Le service de sages-femmes du CSI a d'abord été mis en place à Puvirnituq en 1986, à la demande des femmes des 7 communautés de la baie d'Hudson. Deux autres services ont été ouverts, d'abord à Inukjuak en 1998 puis à Salluit en 2004. Il n'y a pas eu de nouveau développement depuis 10 ans.

2.2.2 QUALIFICATIONS DES CLIENTÈLES

Les sages-femmes du CSI sont première ligne pour toutes les femmes enceintes des villages d'Inukjuak, de Puvirnituq et de Salluit. Les femmes de Kuujjuaraapik, Umiujaq, Akulivik et Ivujivik se rendent à l'une des 3 maternités dès la 37ième semaine de grossesse pour y donner naissance jusqu'à leur retour dans leur village. Elles se rendent principalement à Puvirnituq où un hébergement temporaire (transit) est disponible pour les accueillir, contrairement à Inukjuak et Salluit ou elles sont hébergées dans des familles d'accueil (*boarding home*)

2.2.3 QUALIFICATIONS DES SERVICES

Activités actuelles par service de sages-femmes	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Suivi de grossesse				
Consultation prénatale et postnatale jusqu'à 6 semaines post-partum	x	x	x	x
Références et consultation sur place avec intervenants en périnatalité (nutritionniste, physiothérapeute, travailleuse sociale, psychologue, infirmière)	x	x	x	x
Services intégrés en périnatalité pour la petite enfance (SIPPE)	x		x	
Programme *Arctic Char*		x	x	x

Activités actuelles par service de sages-femmes	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Coupons périnatal (équivalent OLO)	x			
Accouchement				
Au centre hospitalier	x	x		
Au CLSC			x	x
Au domicile	x	x	x	x
Post-Partum				
Suivis jusqu'à 6 semaines, mère et bébé, par la sage-femme	x	x	x	x
Suivis à domicile (comprenant 3 visites au courant de la première semaine)	x		x	x
Support à l'allaitement	x	x	x	x
Santé reproductive				
Contraception		x	x	x
PAP tests et ITSS		x	x	x
Support équipe médicale et infirmiers				
Participation aux medevacs dans les villages	x	x	x	x
Participation aux schedevacs vers Montréal par vol régulier	x	x	x	x

Activités actuelles par service de sages-femmes	CSTU	CSI		
	Kuujjuaq	Puvirnituq	Inukjuak	Salluit
Participation aux transferts par Challenger	x	x		
Visite dans les communautés sans sage-femme		x	x	x
Référence et support obstétricale pour les médecins et infirmiers travaillant au CSI.	x	x	x	x
Concertation et transferts des connaissances				
Réunion d'équipe interdisciplinaire (comité périnatale) hebdomadaire	x	x	x	x
Réunion d'équipe hebdomadaire	x	x	x	x
Participation au programme SIPPE et ETCAF	x	x	x	x
Formation sur place des sages-femmes inuit	x	x	x	x
Participation aux activités communautaires (Women Shelter, cuisine communautaire, Maison de la famille, etc.)	x	x	x	x
Participation activités diverses				
National aboriginal council of midwives (NACM)	x	x	x	x
Canadian association of midwives (CAM)	x	x	x	x
Nunavik Midwifery Working Group (NMWG)	x	x	x	x
Ordre des Sages-femmes du Québec (OSFQ)	x	x	x	x
Comité médecin dentiste pharmacien sage-femme	x	x	x	x
CSN		x	x	x

Activités actuelles par service de sages-femmes	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Regroupement les sages-femmes du Québec (RSFQ)	x			

Tableau 7 : Activités actuelles par service de sages-femmes (CSI)

2.2.4 RESSOURCES HUMAINES

		Titre d'emploi nb (ETC)			
Établissement	**Localisation**	**Responsable Sage-femme**	**Sages-femmes**	**Étudiantes sages-femmes**	**Sage-femme en charge de la formation pour les 3 villages**
CSI	Puvirnituq	1	3,5	2	0
	Inukjuak	1	2	2	1
	Salluit	0	2	2	0

Tableau 8 : Ressources humaines par service de sages-femmes (CSI)

2.2.5 RESSOURCES FINANCIÈRES

Poste de dépenses	**2014-2015**		
	Puvirnituq	Inukjuak	Salluit
Salaires (avantages sociaux et charges comprises)	1 100 833,61$	580 094,91$	597 431,01$
Fournitures et autres charges	123 237,00$	60 664,00$	46 065,00$
Total	**1 224 070,61$**	**640 758,91$**	**643 496,01$**

Tableau 9 : Ressources financière par service de sages-femmes (CSI)

2.2.6 RESSOURCES MATÉRIELLES

Ressource	**Puvirnituq**	**Inukjuak**	**Salluit**
bureau/table	5	2	1
classeur	2	2	2
chaise	10	4	3
ordinateur	3	3	3
causeuse/canapé	1	1	0
Téléphone (incluant chambres de naissance)	7	3	3

photocopieur/fax	1	1	0
lit d'accouchement	1	0	1
lit simple	0	1	0
lit double	3	2	1
meuble à pharmacie	1	1	1
table de réanimation néonatale	1	2	1
moniteur de signes vitaux	1	0	0
centrifugeuse	1	0	0
étuve	1	0	0
réfrigérateur	1	1	0
congélateur	1	1	0
véhicule	1	1	1

Tableau 10 : Ressources matérielles par service de sages-femmes (CSI)

2.2.7 RESSOURCES IMMOBILIÈRES

2.2.7.1 PUVIRNITUQ

Usage	Espace m2
Dans CSI	
Bureau administratif	19,13
Espace cuisine	4,03
Espace bureau	9,39
Salle d'accouchement	19,17
Chambre de naissance avec salle de toilette (3 avec 2 toilettes)	50,9
Entreposage	9,42
Corridor/salle d'attente	55
Espace total	**167.04**

Tableau 11 : Ressources immobilières de Puvirnituq (CSI)

2.2.7.2 INUKJUAK

Usage	Espace m2
Dans CLSC d'Inukjuak	
Bureau administratif	15,95
Chambre de naissance x 2	21,57
Toilette dans une chambre de naissance	2,5
Salle de consultation	14,44
Espace total	**54.46**

Tableau 12 : Ressources immobilières d'Inukjuak (CSI)

2.2.7.3 SALLUIT

Usage	Espace m2
Dans CLSC de Salluit	
Bureau administratif	6,57
Chambre de naissance avec toilette	17.14
Salle commune (bureau et lit de consultation)	15,6
Espace total	**39.31**

Tableau 13 : Ressources immobilières de Salluit (CSI)

3. DÉVELOPPEMENT DES MAISONS DE NAISSANCE AU NUNAVIK (2015-2023)

Le réseau régional des maisons de naissance devrait d'abord s'appuyer sur les communautés offrant déjà des services de sages-femmes, soit Kuujjuaq en Ungava, et Puvirnituq, Inukjuak et Salluit en Hudson. La croissance rapide de la population au Nunavik implique également de considérer de futurs développement, et l'installation de services de sages-femmes dans des communautés qui n'en proposent pas encore.

Une maison de naissance est un espace d'accueil, un milieu de vie pour les femmes enceintes et leurs familles. C'est une maison au cœur de la communauté, un lieu physique distinct du domicile et du centre hospitalier, faisant partie du réseau public de la santé. Cette installation est prévue pour accueillir un nombre raisonnable de naissances par année, afin de lui conserver un caractère intime, familial et humain. On peut ainsi dire qu'une maison de naissance est une « Maxi-maison » et non un « Mini-hôpital ».

La maison de naissance demeure dans tous les cas un lieu où pratiquent exclusivement des sages-femmes et dans lequel tous les services et les soins doivent être offerts dans le respect du champ de pratique des sages-femmes. L'organisation de service sages-femmes s'articule autour de la maison de naissance. C'est le centre névralgique de la pratique. Les services se développent en fonction de la réalité et des besoins des milieux.

Une maison de naissance répond aux besoins de la communauté dans laquelle elle est installée. On y développe une vision sociale et citoyenne de la naissance. Ceci implique un partenariat avec les familles et les citoyens et citoyennes à toutes les étapes de la vie de la maison de naissance. Ce modèle est particulièrement favorable à la sécurisation des pratiques et valeurs inuit.

L'interdisciplinarité et la collaboration interprofessionnelle sont par ailleurs favorisées, afin de mieux répondre aux besoins de la clientèle par une continuité de soins dans la période prénatale et postnatale ainsi que durant la période cruciale de la petite enfance.

Une maison de naissance offre des services de première ligne. Les sages-femmes qui y travaillent assurent aux femmes et à leurs familles un suivi global, comprenant la grossesse, l'accouchement et le postnatal de la mère et de l'enfant, et ce, jusqu'à six semaines pour les femmes de la communauté. Les femmes admissibles et venant des villages liés à la maison de naissance seront transférées dès la 37ième semaine de grossesse, et seront suivies jusqu'à leur retour dans leur village, soit à la deuxième ou troisième journée post-partum.

Au-delà des services offerts en maison de naissance, à domicile, au Centre Hospitalier ou au CLSC, il sera important de mieux intégrer le futur réseau de services sages-femmes centré sur les maisons de naissance.

Certains services déjà en place, notamment celui de Salluit, pourraient prendre plus d'importance en devenant des maisons de naissance desservant des communautés de la baie d'Hudson et de l'Ungava, telles les communautés de Kangiqsujuaq ou de Quaqtaq.

Une telle organisation impliquerait des accords entre les différents Centres de santé, et potentiellement la mise en place de services d'hébergement temporaire (transit), mais permettrait une meilleure utilisation des ressources existantes.

3.1 DÉVELOPPEMENT DES MAISONS DE NAISSANCE DU CSTU

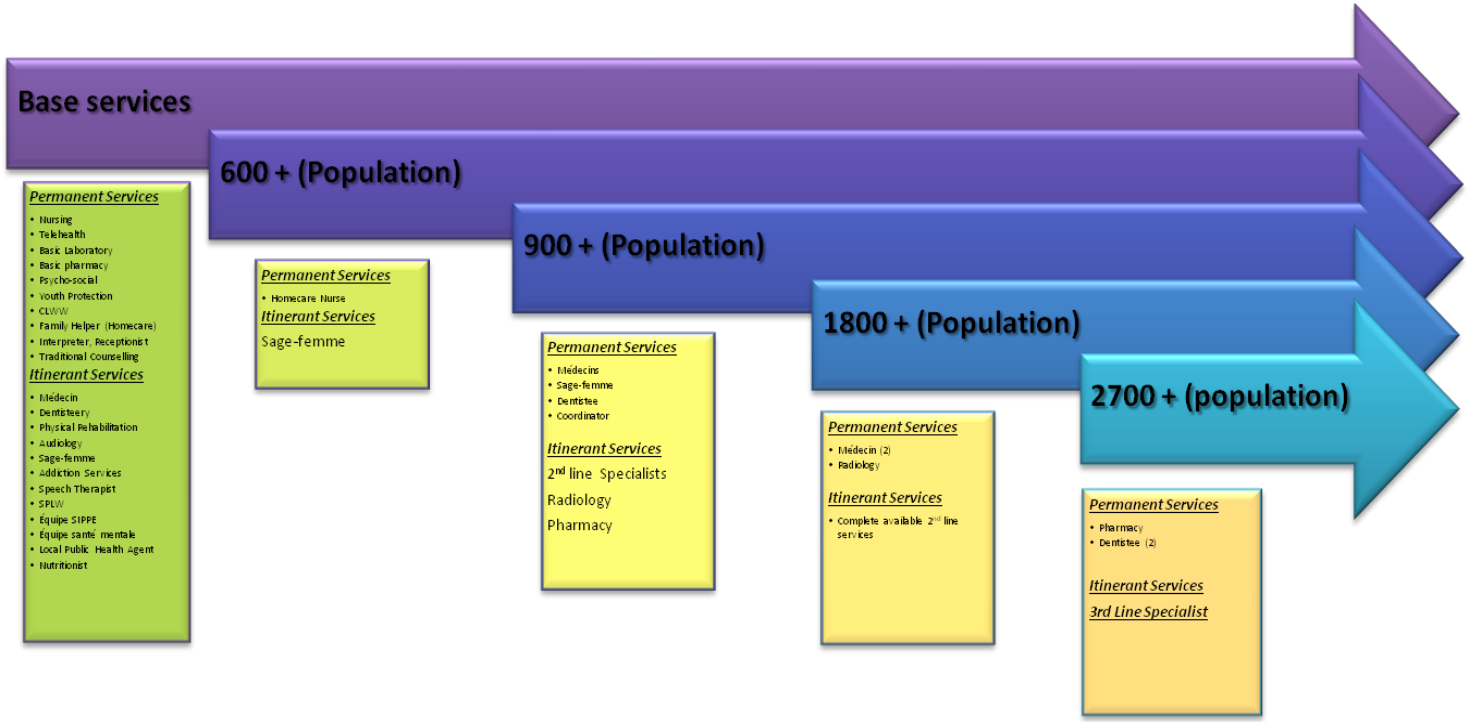
3.1.1 QUALIFICATION DES CLIENTÈLES

D'ici à 2023, il sera à prévoir en Ungava un maximum de 160 naissances par année, soit une augmentation de près de 54% par rapport à 2003 (**graphique 6**). Cette prévision implique dans un premier temps de pérenniser et d'élargir le service de sages-femmes actuellement en place à Kuujjuaq, desservant les 7 communautés de la baie d'Ungava. Il importe également de consolider la formation des sages-femmes inuit, initiée en 2013, actuellement limitée par manque d'espace. Cet objectif passe par l'établissement d'une maison de naissance à Kuujjuaq.

Une seconde maison de naissance est à prévoir dans la communauté de Kangiqsualujjuaq, dont la population va prochainement dépasser les 900 habitants. Ce seuil de 900 habitants a été retenu pour l'établissement de services de sages-femmes (**graphique 7**). Cette seconde maison de naissance viendra compléter le réseau des services sages-femmes de l'Ungava et permettra de pourvoir aux besoins grandissants de la population sur la période 2023-2033.

De manière à offrir un service suffisant et approprié à la hausse attendue de la population et du nombre d'accouchements assistés par des sages-femmes, la maison de naissance de Kuujjuaq devrait s'appuyer sur une équipe élargie si on la compare aux services actuels, et bénéficier d'un bâtiment spécifiquement consacré à sa mission, susceptible d'accueillir un centre périnatalité en collaboration avec les services SIPPE.

Graphique 7 : Répartition des services régionaux selon la population, Point de service CLSC, Nunavik 2014



3.1.2 QUALIFICATIONS DES SERVICES

3.1.2.1 LA PROGRAMMATION DES SERVICES ET DES ACTIVITÉS EN MAISON DE NAISSANCE

Activités à prévoir par maison de naissance	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Suivi de grossesse				
Consultation prénatale de première ligne pour toutes les femmes enceintes de la communauté de résidence	x	x	x	x
Accompagner les femmes venant des autres villages desservis par la maison de naissance dès la 37ième semaine de grossesse, et jusqu'au retour au village.	x	x	x	x
Références et consultation sur place avec intervenants en périnatalité (nutritionniste, physiothérapeute, travailleuse sociale, psychologue, infirmière)	x	x	x	x
Références et consultations aux centres spécialisés (échographie, amniocentèse, GARE, etc…)	x	x	x	x
Services intégrés en périnatalité pour la petite enfance (SIPPE)	x	x	x	x
Rencontres prénatales de groupe de préparation à l'accouchement naturel et à l'allaitement	x	x	x	x
Coupon prénatal (équivalent OLO)	x			
Accouchement				

Activités à prévoir par maison de naissance	CSTU	CSI		
	Kuujjuaq	Puvirnituq	Inukjuak	Salluit
Au centre hospitalier	x	x		
Au CLSC				
Maison de naissance	x	x	x	x
Au domicile	x	x	x	x
Post-Partum				
Suivis jusqu'à 6 semaines, mère et bébé, par la sage-femme	x	x	x	x
Suivis à domicile (comprenant 3 visites au courant de la première semaine)	x	x	x	x
Suivis des femmes issues des villages desservis par la maison de naissance jusqu'à leur retour dans leurs communautés	x	x	x	x
Halte - Support à l'allaitement	x	x	x	x
Santé reproductive				
Contraception		x	x	x
PAP tests et ITSS		x	x	x
Support équipe médicale et infirmiers				
Participation aux medevacs dans les villages	x	x	x	x
Participation aux schedevacs vers Montréal par vol régulier	x	x	x	x
Participation aux transferts par Challenger	x	x	x	x
Référence et support obstétricale pour les médecins et infirmiers travaillant aux CS	x	x	x	x

Activités à prévoir par maison de naissance	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Concertation et transferts des connaissances				
Réunion d'équipe interdisciplinaire (comité périnatale) hebdomadaire	x	x	x	x
Réunion d'équipe hebdomadaire	x	x	x	x
Participation au programme SIPPE et ETCAF	x	x	x	x
Visites dans les villages	x	x	x	x
Formation des sages-femmes inuit				
Formation sur place des sages-femmes inuit	x	x	x	x
Nunavik Midwifery Education College			x	
Participation activités diverses				
National aboriginal council of midwives (NACM)	x	x	x	x
Canadian association of midwives (CAM)	x	x	x	x
Nunavik Midwifery Working Group (NMWG)	x	x	x	x
Ordre des Sages-femmes du Québec (OSFQ)	x	x	x	x
Comité médecin dentiste pharmacien sage-femme	x	x	x	x
CSN		x	x	x
Regroupement les sages-femmes du Québec (RSFQ)	x			

Activités à prévoir par maison de naissance	CSTU	CSI		
	Kuujjuaq	Puvirnituq	Inukjuak	Salluit
Activités communautaires				
Réalisation du projet "Baby Book"	x	x	x	x
Rencontres prénatales	x	x	x	x
Rencontres coutures, crochet, etc.	x	x	x	x
Ateliers d'allaitement	x	x	x	x
Ateliers de transmission des habiletés parentales	x	x	x	x
Réalisation d'abdomen en plâtre	x	x	x	
Cuisine communautaire	x	x	x	x
Baby Shower	x	x	x	x

Tableau 14 : Activités à prévoir par maison de naissance

3.1.2.2 PROGRAMMATION DES SERVICES À DOMICILE

Les sages-femmes d'une maison de naissance permettent également les accouchements à domicile, en suivant le règlement en vigueur. Les sages-femmes se déplacent au domicile d'une personne résidant dans la même communauté que la maison de naissance.

3.1.2.3 PROGRAMMATION DES SERVICES EN CENTRE HOSPITALIER

Les sages-femmes permettent également les accouchements au centre de santé, selon les besoins des femmes enceintes. Ces accouchements demeurent sous la responsabilité des sages-femmes, en suivant les règlements en vigueur. Lors de certaines situations d'urgences et/ou de cas nécessitant un transfert de soins, l'accouchement doit avoir lieu au centre hospitalier et la sage-femme assiste l'équipe médicale et infirmiers selon les besoins.

3.1.2.4 PROGRAMMATION DES SERVICES EN CLSC

Les sages-femmes des maisons de naissance offrent également leur support aux villages :

- Support aux infirmières des villages;
- Visites régulières dans chaque village pour consultations, support et enseignement. Ces visites doivent se faire régulièrement, entre 2 et 4 fois par an, dans les villages où les sages-femmes ne sont pas présentes;
- Medevacs.

3.1.3 RESSOURCES HUMAINES

	Équipe Sage-femme (ETC)			**Équipe de soutien (ETC)**		
Communauté	Responsable service sages-femmes	Sage-femmes	Étudiantes sages-femmes	Assistante natale sur appel	Agente administrative	Préposé à l'entretien
Kuujjuaq	**1**	**5**	**2**	**3**	**1**	**1**

Tableau 15 : Ressources humaines à prévoir pour la maison de naissance de Kuujjuaq

3.1.3.1 L'ÉQUIPE SAGE-FEMME

L'équipe sage-femme de la maison de naissance de Kuujjuaq devrait être composée comme suit :

- 1 Responsable des services de sage-femme (RSSF);
- 5 sages-femmes ETC;
- 2 Étudiantes sages-femmes (2 ETC).

3.1.3.2 L'ÉQUIPE DE SOUTIEN

En plus des sages-femmes et de la responsable des services de sage-femme, l'équipe devrait être composée de :

- Assistantes natales sur appel (3 ETC);
- Agente administrative (1 ETC);
- Préposé à l'entretien ménager (1 ETC).

3.1.3.2.1 LES ASSISTANTES NATALES

Les assistantes natales relèvent de la responsable des services de sage-femme. Elles sont de garde et sur appel selon un horaire qui permet d'assurer une disponibilité aide natale 24/24, 7/7 jours.

- elles travaillent auprès de la clientèle;
- elles ont des tâches reliées à l'organisation des services et des activités déployés à la maison de naissance;
- elles assurent les services de buanderie.

3.1.3.2.2 L'AGENTE ADMINISTRATIVE

L'agente administrative travaille sous l'autorité de la responsable des services sage-femme. Ses fonctions sont les suivantes :

- composer et produire des documents pour la maison de naissance et la clientèle;
- contacter les clientes pour les aviser des rendez-vous;
- être en lien avec différents services administratifs du CSTU;
- être responsable de la récolte des données informatique (statistiques SIC+)
- être responsable de l'ouverture et de la fermeture des dossiers.

3.1.3.2.3 LE PRÉPOSÉ À L'ENTRETIEN

Le préposé à l'entretien ménager travaille sous l'autorité de la responsable des services de sage-femme. Ses fonctions sont :

- Assurer l'entretien journalier des locaux.

3.1.4 RESSOURCES FINANCIÈRES

Ressources Financières (Prévisions)	**2023**
Total	**1 241 231,51$**

Tableau 16 : Ressources financières à prévoir pour la maison de naissance de Kuujjuaq

3.1.5 RESSOURCES MATÉRIELLES

Consultations		
#	Besoins	Descriptifs / commentaires
1	Entrée	• Endroit pour manteaux • Endroit pour bottes
2	Salle d'attente/coin famille	• Chaises et tables • Télévision • Coin jeux pour les enfants • Coin bibliothèque et documentation
3	Accueil	• Poste d'accueil (ordinateur, téléphone) • Bureau agente administrative • Entrepôt pour documentation/papeterie
4	Archives	• Salle fermée ou les dossiers actifs des femmes enceintes sont accessibles • Bureau
5	Salle de consultation	• 2 salles avec les équipements médicaux nécessaires (lit simple, balance, etc…) • 1 salle de consultation pouvant être utilisée pour un accouchement si chambre des naissances non disponible • Espaces de rangement adéquats
6	Salle d'examen gynécologique	• Table d'examen • Tout le matériel pour les prélèvements sanguin ou autre • Réparation des déchirures du périnée
7	Bureau	• Étudiantes sages-femmes/documentation
8	Salle multifonction	• Salle de cours • Salle de réunion • Salle communautaire

9	Bureaux	• 1 bureau pour la responsable du service de sages-femmes • 1 bureau pour la sage-femme formatrice et des villages
10	Toilette	• 1 toilette pour les clientes • 1 toilette pour les sages-femmes

Accouchement		
#	Besoins	Descriptifs / commentaires
11	Chambre des naissances	• 3 chambres des naissances avec lit queen, baignoire, toilette, lavabo, armoire, tables de nuit • Favorise le calme nécessaire au travail, à l'accouchement, à l'attachement et à l'allaitement
12	Bureau de travail	• Bureau avec 1 poste de travail (ordi) et téléphone
13	Utilité souillée	• Nettoyage du matériel souillé avant la stérilisation au CSTU • L'utilité souillée comprend un espace de nettoyage avec cuve et un espace de stockage du matériel en attente de transfert vers l'unité de stérilisation du CSTU • Dépôt des linges et vêtements souillés • Emplacement matériel pour le service d'entretien
14	Utilité propre	• Stockage du matériel stérile reçu du CSTU. • Armoire chauffante pour linges de bébés et couvertures
15	Salle de lavage	• 1 laveuse • 1 sécheuse • Espace de rangement pour les draps/couvertures/serviettes
16	Entrepôt	• Matériel (I/V, seringues, etc…) • Espace pour chariot de réanimation • Espace pour le cardiotocogramme • Réfrigérateur • médicaments et espace pour préparation ATB
17	Cuisine	• Cuisine pour sages-femmes et familles (cuisinière, réfrigérateur, etc…) • Tables • Chaises • Fauteuil
18	Salle de repos	• Sofa pour s'étendre et se reposer • Table et chaise • Armoires pour vêtements
19	Salle de bain	• Exclusivement pour les sages-femmes avec douche, toilette et lavabo

Tableau 17 : Ressources matérielles à prévoir pour la maison de naissance de Kuujjuaq

3.1.6 RESSOURCES IMMOBILIÈRES

Des espaces doivent être prévus pour les bureaux de consultations, pour les réunions entre intervenants, pour les prélèvements sanguins et gynécologiques ainsi que pour les rencontres

de groupe. Les espaces pour les naissances doivent être en retrait afin de favoriser l'intimité des femmes en travail.

Usage	Espace m2
Côté consultation	
Agente administrative et accueil	15
Espace pour bottes et manteaux visiteurs	5
Salles de consultation (3)	45
Salle d'examen gynécologique et prélèvement sanguin	10
Bureau de la responsable sage-femme	15
Bureau pour la sage-femme formatrice/village	15
Salle de jeu enfants et famille (salle d'attente)	20
Bureau multifonction/documentation	15
Archives/Administration clinique	15
Salle de cours/salle de réunion/salle communautaire	25
Toilette (2)	20
Côté accouchements	
Chambres de naissances (3)	75
Bureau s-f (téléphone, ordi, etc…)	15
Salle de repos s-f	10
Utilités souillées/salle de lavage	10
Utilités propres	15
Entreposage Matériel, médicaments, frigo, chariot de réanimation n-né	25
Salle de repos / Cuisine pour le personnel et les familles	15
Salle de bain pour les sages-femmes	10
Total de la superficie	**375**
À cette superficie, un ajout de 25% correspondant à des facteurs de contingence inhérents (corridor, escaliers, etc.)	**93.75**
Espace total requis	**468.75**

Tableau 18 : Ressources immobilières à prévoir pour la maison de naissance de Kuujjuaq

D'autres critères devraient être considérés pour la localisation de la maison de naissance :

- accès extérieur direct;
- passage accessible et couvert de l'hôpital (Kuujjuaq)/CLSC (Kangiqsualujjuaq) afin d'assurer un transfert rapide et une accessibilité en cas d'urgence;
- espace de stationnement;
- mise en conformité des locaux pour permettre des accouchements;
- efficience budgétaire.

3.2 MAISONS DE NAISSANCE DU CSI: INUKJUAK, PUVIRNITUQ, SALLUIT

3.2.1 QUALIFICATION DES CLIENTÈLES

D'ici à 2023, il sera à prévoir en Hudson environ 260 naissances par année, soit une augmentation de près de 58% par rapport à 2003 (**graphique 6**). Cette prévision implique dans un premier temps de pérenniser et d'élargir les services de sages-femmes actuellement en place à Puvirnituq, Inukjuak et Salluit, desservant les 7 communautés de la baie d'Hudson. Il importe également de consolider la formation des sages-femmes inuit, en faisant d'Inukjuak un centre régional de formation. Conformément à la Politique de périnatalité 2008 – 2018 du MSSS, cet objectif passe par l'établissement de maisons de naissance à Inukjuak et Salluit, dans un premier temps, puis à Puvirnituq.

Une quatrième maison de naissance pourrait être à prévoir dans la communauté de Kuujjuaraapik, dont la population devrait dépasser les 900 habitants dans les 10 prochaines années (problème statistique, vérification en cours ISQ). Ce seuil de 900 habitants a été retenu pour l'établissement de services de sages-femmes (**graphique 7**). Cette quatrième maison de naissance viendra compléter le réseau des services sages-femmes de l'Hudson et permettra de pourvoir aux besoins grandissants de la population sur la période 2023-2033.

De manière à offrir un service suffisant et approprié à la hausse attendue de la population et du nombre d'accouchements assistés par des sages-femmes, ces maisons de naissance devraient s'appuyer sur des équipes élargies si on les compare aux services actuels, et bénéficier d'un bâtiment spécifiquement consacré à sa mission.

3.2.2 QUALIFICATIONS DES SERVICES

3.2.2.1 LA PROGRAMMATION DES SERVICES ET DES ACTIVITÉS EN MAISON DE NAISSANCE

Activités à prévoir par maison de naissance	**CSTU**	**CSI**		
	Kuujjuaq	**Puvirnituq**	**Inukjuak**	**Salluit**
Suivi de grossesse				
Consultation prénatale de première ligne pour toutes les femmes enceintes de la communauté de résidence	x	x	x	x
Accompagner les femmes venant des autres villages desservis par la maison de naissance dès la 37ième semaine de grossesse, et jusqu'au retour au village.	x	x	x	x
Références et consultation sur place avec intervenants en périnatalité (nutritionniste, physiothérapeute, travailleuse sociale, psychologue, infirmière)	x	x	x	x
Références et consultations aux centres spécialisés (échographie, amniocentèse, GARE, etc…)	x	x	x	x
Services intégrés en périnatalité pour la petite enfance (SIPPE)	x	x	x	x
Rencontres prénatales de groupe de préparation à l'accouchement naturel et à l'allaitement	x	x	x	x
Au centre hospitalier	x	x		
Au CLSC				
Maison de naissance	x		x	x
Au domicile	x	x	x	x

Post-Partum				
Suivis jusqu'à 6 semaines, mère et bébé, par la sage-femme	x	x	x	x
Suivis à domicile (comprenant 3 visites au courant de la première semaine)	x	x	x	x
Suivis des femmes issues des villages desservis par la maison de naissance jusqu'à leur retour dans leurs communautés	x	x	x	x
Halte - Support à l'allaitement	x	x	x	x
Santé reproductive				
Contraception		x	x	x
PAP tests et ITSS		x	x	x
Support équipe médicale et infirmiers				
Participation aux medevacs dans les villages	x	x	x	x
Participation aux schedevacs vers Montréal par vol régulier	x	x	x	x
Participation aux transferts par Challenger	x	x	x	x
Référence et support obstétricale pour les médecins et infirmiers travaillant aux CS	x	x	x	x
Concertation et transferts des connaissances				
Réunion d'équipe interdisciplinaire (comité périnatale) hebdomadaire	x	x	x	x
Réunion d'équipe hebdomadaire	x	x	x	x
Participation au programme SIPPE et ETCAF	x	x	x	x
Visites dans les villages	x	x	x	x
Midwifery Education Program				

Formation sur place des sages-femmes inuit	x	x	x	x
Nunavik Midwifery Education College			x	
Participation activités diverses				
National Aboriginal Council of Midwives (NACM)	x	x	x	x
Canadian Association of Midwives (CAM)	x	x	x	x
Nunavik Midwifery Working Group (NMWG)	x	x	x	x
Ordre des Sages-femmes du Québec (OSFQ)	x	x	x	x
Comité Médecin Dentiste Pharmacien Sage-Femme	x	x	x	x
CSN		x	x	x
Regroupement les Sages-Femmes du Québec (RSFQ)	x			
Activités communautaires				
Réalisation du projet "Baby Book"	x	x	x	x
Rencontres prénatales	x	x	x	x
Rencontres coutures, crochet, etc.	x	x	x	x
Ateliers d'allaitement	x	x	x	x
Ateliers de transmission des habiletés parentales	x	x	x	x
Réalisation d'abdomen en plâtre	x	x	x	x
Cuisine communautaire	x	x	x	x

Baby Shower	x	x	x	x

Tableau 19 : Qualification des services à prévoir pour les maisons de naissances du CSI

3.2.2.2 PROGRAMMATION DES SERVICES À DOMICILE

Les sages-femmes d'une maison de naissance permettent également les accouchements à domicile, en suivant le règlement en vigueur. Les sages-femmes se déplacent au domicile d'une personne résidant dans la même communauté que la maison de naissance.

3.2.2.3 PROGRAMMATION DES SERVICES EN CENTRE HOSPITALIER

Les sages-femmes permettent également les accouchements au centre de santé, selon les besoins et des facteurs de risque des femmes enceintes. Ces accouchements demeurent sous la responsabilité des sages-femmes, en suivant le règlement en vigueur. Lors de certaines situations d'urgences où les médecins partagent la responsabilité, l'accouchement doit avoir lieu au centre hospitalier et la sage-femme assiste l'équipe médicale et infirmière selon les besoins.

3.2.2.4 PROGRAMMATION DES SERVICES EN CLSC

Les sages-femmes des maisons de naissance offrent également leur support aux villages :

- En offrant leur service à proximité des CLSC d'Inukjuak et de Salluit, les soins seront dispensés en collaboration avec l'équipe en CLSC.
- Références aux services spécialisés dispensés en CLSC.
- Support aux infirmières des villages;
- Visites régulières dans chaque village sans permanence sage-femme pour consultations, support et enseignement. Ces visites doivent se faire régulièrement, entre 2 et 4 fois par an, dans les villages où les sages-femmes ne sont pas présentes;
- Medevacs.

3.2.3 RESSOURCES HUMAINES

3.2.3.1 LES ÉQUIPES

	Équipe Sage-femme (ETC)			**Équipe de soutien (ETC)**		
Communauté	Responsable service	Sage-femmes	Étudiantes Sage-Femmes	Assistante sur natale appel	Agente administrative	Préposé à l'entretien
Puvirnituq	**1**	**4,5**	**3**	**2**	**1**	**1**
Inukjuak	**1**	**3**	**3**	**2**	**1**	**1**
Salluit	**1**	**2**	**3**	**2**	**1**	**1**

Tableau 20 : Ressources humaines à prévoir pour les maisons de naissances du CSI

3.2.3.2 LES ASSISTANTES NATALES

Les assistantes natales relèvent de la responsable des services de sage-femme. Elles sont de garde et sur appel selon un horaire qui permet d'assurer une disponibilité aide natale 24/24, 7/7 jours.

- elles travaillent auprès de la clientèle, font la surveillance des signes vitaux lorsque nécessaire;
- Elles prodiguent des conseils aux parents sur divers aspects tels que l'allaitement, la nutrition, les premiers soins au bébé, etc.;
- elles ont des tâches reliées à l'organisation des services et des activités déployés à la maison de naissance;
- elles assurent les services de buanderie.

3.2.3.3 L'AGENTE ADMINISTRATIVE

L'agente administrative travaille sous l'autorité de la responsable des services sage-femme. Ses fonctions sont les suivantes :

- composer et produire des documents pour la maison de naissance et la clientèle;
- contacter les clientes pour les aviser des rendez-vous;
- être en lien avec différents services administratifs du CSI;
- être responsable de la récolte des données informatique (statistiques SIC+);
- être responsable de l'ouverture et de la fermeture des dossiers;
- Soutient l'organisation des activités périnatales et sociales, surtout de groupes.

3.2.3.4 LE PRÉPOSÉ À L'ENTRETIEN

Le préposé à l'entretien ménager travaille sous l'autorité de la responsable des services de sage-femme. Ses fonctions sont :

Assurer l'entretien journalier des locaux

3.2.4 RESSOURCES FINANCIÈRES

Ressources Financières (Prévisions)	**2023**
Total	**3 725 809,21$**

3.2.5 RESSOURCES MATÉRIELLES

Ressource	Puvirnituq	Inukjuak	Salluit
bureau/table	11	9	8
classeur	4	4	3
chaise	22	10	8
ordinateur	12	11	10
causeuse/canapé	2	2	2
téléphone	18	14	13

photocopieur/fax	2	2	2
lit d'accouchement (pour salle d'examen gynécologique)	1	1	1
Lit d'accouchement (pour salle d'accouchement)	1	0	0
lit simple	4	3	3
lit double	3	2	2
meuble à pharmacie	1	1	1
table de réanimation néonatale avec lampe chauffante	0	1	1
Unité de réanimation néonatale	1	0	0
moniteur de signes vitaux	1	1	1
centrifugeuse	1	1	1
étuve	1	1	1
réfrigérateur	2	2	1
congélateur	2	2	2

Armoire chauffante	1	1	1
véhicule	1	1	1

Tableau 21 : Ressources matérielles à prévoir pour les maisons de naissances du CSI

3.2.6 RESSOURCES IMMOBILIÈRES

Des espaces doivent être prévus pour les bureaux de consultations, pour les réunions entre intervenants, pour les prélèvements sanguins et gynécologiques ainsi que pour les rencontres de groupe. Les espaces pour les naissances doivent être en retrait afin de favoriser l'intimité des femmes en travail.

Usage	**Espace m2**		
	Puvirnituq	**Inukjuak**	**Salluit**
Côté consultation			
Agente administrative et accueil	15	15	15
Espace pour bottes et manteaux visiteurs	5	5	5
Salles de consultation	(3X15) 45	(2x15) 30	(2x15) 30
Salle d'examen gynécologique et prélèvement sanguin	15	15	15
Bureau de la responsable sage-femme	15	10	10
Bureau pour la sage-femme formatrice/village	10	15	10
Salle de jeu enfants et famille (salle d'attente)	20	20	
Bureau multifonction/documentation	1	1	1
Archives/Administration clinique	15	15	15
Salle de cours/salle de réunion/salle communautaire	25	25	25
Toilette	10	10	10
Côté accouchements			
Chambres de naissances	(3x25) 75	(2x25) 50	(2x25) 50
Bureau s-f (téléphone, ordi, etc.)	(2x 10) 20	10	(1x10) 10
Salle de repos s-f et travailleuses post-natales	(15 x 2) 30	15	15
Utilités souillées/salle de lavage	15	10	10
Utilités propres	10	10	10

Entreposage Matériel, médicaments, frigo, chariot de réanimation n-né	15	10	10
Salle de repos / Cuisine pour le personnel et les familles	20	20	20
Salle de bain pour les sages-femmes	7	7	7
Total de la superficie	367	297	272
À cette superficie, un ajout de 25% correspondant à des facteurs de contingence inhérents (corridor, escaliers, etc.)			
Espace total requis	458,75	371,25	340

Tableau 22 : Ressources immobilières à prévoir pour les maisons de naissances du CSI

D'autres critères devraient être considérés pour la localisation de la maison de naissance :

- accès extérieur direct;
- passage accessible et couvert de l'hôpital (Puvirnituq)/CLSC (Inukjuak et Salluit) afin d'assurer un transfert rapide et une accessibilité en cas d'urgence;
- espace de stationnement;
- mise en conformité des locaux pour permettre des accouchements;
- efficience budgétaire.

4. PROTOCOLES DES MAISONS DE NAISSANCE (PARTENAIRES DU RÉSEAU DE LA SANTÉ)

4.1 POLITIQUES INTERNES AUX MAISONS DE NAISSANCE

4.1.1 COORDINATION DES SAGES-FEMMES: LA RESPONSABLE DES SERVICES DE SAGE-FEMME

À l'intérieur de la loi sur les services de santé et les services sociaux, le gouvernement a prévu la nomination de responsables des services de sage-femme (cf. Annexe 1).

4.1.2 REPRÉSENTATION DES SAGES-FEMMES: LE CONSEIL DES SAGES-FEMMES

Un conseil des sages-femmes doit également être implanté (cf. Annexe 2) dans chaque centre de santé.

4.1.3 L'INTÉGRATION DES SAGES-FEMMES AU RÉSEAU DE LA SANTÉ ET DES SERVICES SOCIAUX

Les sages-femmes sont des praticiennes de première ligne intégrées au réseau de la santé. Elles travaillent au sein des équipes enfance jeunesse famille et relèvent des services généraux au sein du CSTU. Au CSI elles font partie des services professionnels, et relèvent de la direction des services professionnels et hospitaliers. L'interdisciplinarité et la collaboration interprofessionnelle sont favorisées afin de mieux répondre aux besoins de la clientèle par une continuité de soins dans la période prénatale et postnatale ainsi que durant la période cruciale de la petite enfance.

Les sages-femmes réfèrent au besoin la femme enceinte aux services appropriés (nutritionniste, travailleuse sociale, psychologue, physiothérapeute), et valorisent le travail en interdisciplinarité centré sur les besoins de la clientèle (particulièrement la clientèle du programme SIPPE).

Le cadre actuel de travail des sages-femmes au Québec est défini dans la loi sur les services de santé et les services sociaux[3]. Il importe également de mettre en place des procédures de

[3] Loi sur les services de santé et les services sociaux http://www2.publicationsduquebec.gouv.qc.ca/dynamicSearch/telecharge.php?type=2&file=/S_4_2/S4_2.html (accédé le 12 décembre 2014).

collaboration et de fonctionnement, en fonction des services et partenaires existants sur chaque côte, et dans chaque communauté.

4.2 PROCÉDURES DE COLLABORATION ET LIAISON AVEC LE RÉSEAU DE LA SANTÉ

Ces procédures peuvent varier selon l'organisation régionale et locale du réseau.

4.2.1 PROCÉDURES DE COLLABORATION AVEC LES MÉDECINS SPÉCIALISTES

- Les médecins spécialistes viennent pour quelques jours quelques fois par an pour des consultations et évitent ainsi le transfert de plusieurs personnes vers Montréal.
- Pour toute situation de consultation et de transferts de soins : principalement avec les obstétriciens, gynécologues, les pédiatres ou la clinique GARE.
    - Des consultations avec d'autres spécialistes sont parfois requises (endocrinologues, cardiologues) que ce soit sur le territoire du CS ou à Montréal.
- La liaison du CSTU est en charge des ententes entre le CSTU et les spécialistes.
- Les services spécialisés du CSI sont en charge des visites nordiques des spécialistes.

4.2.2 PROCÉDURES DE COLLABORATION AVEC LES MÉDECINS OMNIPRATICIENS

Pour la collaboration lors des urgences obstétricales, la participation aux comités périnatals, pour la prescription de certains médicaments ou pour l'obtention d'un retrait préventif. En référence après 6 semaines post-partum pour le suivi médical du bébé.

4.2.3 PROCÉDURES DE COLLABORATION AVEC LES INFIRMIERS/INFIRMIÈRES

Au département des CS, lorsque les sages-femmes assistent une femme qui accouche ou également lorsqu'il y a consultations ou transferts aux médecins. Les infirmières assistent également les sages-femmes lorsque l'accouchement est imminent et que la sage-femme est seule. Les infirmières spécialisées en santé communautaire, en ITSS, collaborent aussi avec les sages-femmes.

4.2.4 PROCÉDURES DE COLLABORATION AVEC LE PERSONNEL DES PLATEAUX TECHNIQUES

Le personnel du laboratoire et de la radiologie (échographie obstétricale) selon le règlement sur les examens et analyses qu'une sage-femme peut prescrire, effectuer ou interpréter dans l'exercice de sa profession.

4.2.5 PROCÉDURES DE COLLABORATION AVEC LES AMBULANCIERS

Avec le département pour les transferts urgents ou non urgents. Un appel direct par la sage-femme suffit pour obtenir une ambulance pour tout transfert.

4.2.6 PROCÉDURES DE COLLABORATION AVEC LES SERVICES INTÉGRÉS EN PÉRINATALITÉ ET PETITE ENFANCE (SIPPE)

Avec l'équipe 0-5 ans des CS pour les services intégrés en périnatalité et petite enfance (SIPPE) auprès de la clientèle. Le programme SIPPE est appliqué au Nunavik auprès de toute la clientèle 0-5 ans Le service sage-femme collabore et participe au programme.

Dans une perspective à long terme, les SIPPE contribuent à la diminution de la transmission intergénérationnelle des problèmes de santé et des problèmes sociaux dont l'abus et la négligence envers les enfants. Les SIPPES ont pour objectifs premiers :

- Maximiser le potentiel de santé et de bien-être des mères, des pères, des bébés à naître et des enfants de 0-5 ans étant dans une situation qui les rend vulnérables;
- Inclure la naissance et le développement des enfants dans un projet de vie porteur de réussite pour les parents, tout en renforçant le pouvoir d'agir des familles et des communautés dans toutes les sphères de la vie (personnelle, familiale, sociale, culturelle, économique et politique).

4.2.7 PROCÉDURES DE COLLABORATION AVEC LA LIAISON

La liaison est responsable de l'entente entre le CS et les CH de référence. La liaison établit les modalités de communication lors des transferts (en période prénatale, périnatale et postnatale) des clientes entre le service sages-femmes et l'équipe de spécialistes des CH de référence.

C'est par la liaison que les rendez-vous avec les spécialistes venant au CSTU pour consultations (gynécologue, psychiatre, pédiatre, etc…) sont organisés à la demande des sages-femmes. Au CSI, la liaison est assurée par une infirmière par village. Les services spécialisés s'occupent des visites de spécialistes au nord, et coordonnent les rendez-vous.

La liaison est aussi responsable des visioconférences.

4.2.8 PROCÉDURES DE COLLABORATION AVEC LE SERVICE AUX PATIENTS

Le service aux patients permet de transporter les femmes enceintes à leur demande. Il permet également le transport des sages-femmes de garde appelées comme support au service de sage-femme.

4.2.9 PROCÉDURES DE COLLABORATION AVEC LA PHARMACIE

La pharmacie accepte les prescriptions des sages-femmes selon le règlement sur les médicaments qu'une sage-femme a le droit de prescrire.

4.2.10 PROCÉDURES DE COLLABORATION AVEC SERVICE DES TRANSPORTS (TMS)

La possibilité pour les sages-femmes de réserver les billets d'avion pour les clientes, soit pour Montréal soit pour leur retour dans leur village en post-natal.

5. PROGRAMME RÉGIONAL DE FORMATION DES SAGES-FEMMES INUIT

Depuis 1986, le Centre de Santé d'Inuulitsivik a initié un service de sages-femmes, à la demande des femmes des 7 communautés de la Baie d'Hudson. Ce service débuta à Puvirnituq. Depuis, deux autres services sage-femme ont vu le jour, à Inukjuak en 1998, et à Salluit en 2004.

Un programme de formation des sages-femmes inuit a donc vu le jour dans chacun de ces services de sage-femme de la Baie d'Hudson. Ce programme compte, à ce jour, une dizaine de sages-femmes inuit diplômées. Ce programme a depuis été reconnu internationalement comme un modèle d'enseignement et de pratique pour le Nord et les régions éloignées.

En 2008, le Ministère de la santé et des services sociaux a élaboré un règlement sur les normes d'équivalence de diplôme et de la formation aux fins de la délivrance d'un permis par l'Ordre des sages-femmes du Québec, permettant la reconnaissance de la formation des sages-femmes inuit comme équivalente au programme existant à l'UQTR. Ce programme est conforme aux obligations contenues dans la CBJNQ (annexe 3).

La formation des sages-femmes inuit au CSTU de Kuujjuaq a été initiée le 26 août 2013. Aujourd'hui, le manque d'espace ne permet pas de former plus d'une étudiante à la fois. Le déploiement de maisons de naissances permettrait de rendre cette formation plus accessible, et de mieux former la relève locale.

La maison de naissance est un espace de formation pour les sages-femmes inuit en devenir. Elle permet ainsi aux étudiantes :

- De poursuivre des cours afin d'obtenir les connaissances nécessaires à la pratique sage-femme;
- D'observer et pratiquer des accouchements spontanés physiologiques et pathologiques;
- De développer le jugement clinique indispensable à une pratique sage-femme hors centre hospitalier et en région éloignée;
- D'acquérir la confiance et les habiletés nécessaires à la progression de cet art.

Les sages-femmes, en plus de leurs responsabilités cliniques, agissent comme enseignante et préceptrice auprès des étudiantes et participent à la formation de la relève.

Les infirmières, les médecins résidents et internes peuvent parfois effectuer des stages d'observations, ce qui contribue à leur éducation sur la physiologie de la grossesse, de l'accouchement et du post-partum.

Les sages-femmes participent également activement à la mise à jour des connaissances en collaborant aux activités d'enseignement des infirmières et médecins (NRP, intégration des nouvelles infirmières, etc.)

6. PROCESSUS D'ÉVALUATION DES SERVICES DE SAGES-FEMMES, DU PROGRAMME RÉGIONAL DE FORMATION DES SAGES-FEMMES INUIT ET DES MAISONS DE NAISSANCE

Durée : 10 ans

Objectifs	Activités	Responsable
Implanter une maison de naissance à Kuujjuaq	-Proposer des plans -Participer aux travaux des plans et du code du bâtiment	RRSSSN RSSF-CSTU RRSSSN
Intégrer les locaux de la maison de naissance	-Installer les locaux, le matériel et les fournitures dans la partie consultation et accouchement	RSSF CSTU
Implanter une maison de naissance à Inujkuak et à Salluit	- Proposer des plans -Participer aux travaux des plans et du code du bâtiment	RRSSSN RSSF-CSI-chef SSF RRSSSN
Consolider la formation des sages-femmes inuit en démarrant l'école de sage-femme à Inukjuak	-Collaborer avec le CSI pour participer au programme de	RSSF

	formation et de la future école de sage-femme -Augmenter le nombre d'étudiantes sages-femmes inuit	Sages-femmes du CSI CSTU et CSI
Implantation de service de sage-femme dans les autres communautés desservies par les CS	-Former des sages-femmes inuit venant de chaque communauté -Suivis pré et post partum dans chacun des villages par des sages-femmes inuit locales	RSSF CSTU RRSSSN
Implantation d'une maison de naissance dans tous villages desservis par les CS assurant une présence permanente d'un médecin (Kangiqsualujjuaq, Kangiqsujuaq, Kuujjuaraapik)	-Développer et mettre en place une maison de naissance -Mettre en place et débuter la formation de sages-femmes inuit locales -Faire les suivis prénatals et post natals de toutes les femmes enceintes du village -Accouchement dans les villages pour les femmes répondant aux critères d'admissibilités et par le comité périnatal	RSSF CSTU-CSI Chef MDN RRSSSN

	-Assister l'équipe des médecins et infirmières à leur demande pour toute urgence ou autre	

Tableau 23 : Processus d'évaluation des services de sages-femmes

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8. ANNEXES

ANNEXE 1 : LOI SUR LA SANTÉ ET LES SERVICES SOCIAUX : ARTICLES RELATIFS À LA RESPONSABLE SAGE-FEMME

Article 208.1

Un responsable des services de sage-femme doit être nommé par tout établissement qui exploite un centre local des services communautaires où exercent des sages-femmes. Cette personne doit être une sage-femme.

Article 208.2

Sous l'autorité du directeur général, le responsable des services de sage-femme doit :

1. surveiller et contrôler la qualité des actes posés par les sages-femmes pour l'établissement;

2. élaborer des règles de soins que doit appliquer la sage-femme et qui tiennent compte de la nécessité de rendre des services adéquats et efficients aux usagers ainsi que de l'organisation et des ressources dont dispose l'établissement;

3. assumer les fonctions prévues au premier alinéa de l'article 225.3, le cas échéant.

Article 208.3

Sous réserve de ce que prévoit le règlement pris en vertu du paragraphe 13° de l'article 505 et sous l'autorité du directeur général, le responsable des services de sage-femme doit:

1 s'assurer de la distribution appropriée des services de sage-femme dispensés pour l'établissement;

2 coordonner les services de sage-femme en fonction des besoins de l'établissement;

3 assumer les fonctions prévues à l'article 225.4, le cas échéant;

4 assumer toute autre fonction prévue au plan d'organisation.

ANNEXE 2 : LOI SUR LA SANTÉ ET LES SERVICES SOCIAUX : ARTICLES RELATIFS AU CONSEIL DES SAGES-FEMMES

Article 225.1

Un conseil des sages-femmes est institué pour chaque établissement public qui exploite un centre local de services communautaires et qui a conclu, avec au moins cinq sages-femmes, un contrat de services en vertu des dispositions de l'article 259.2.

Ce conseil est composé de toutes les sages-femmes qui ont conclu un tel contrat avec l'établissement.

Article 225.2

Malgré l'article 225.1, l'établissement peut, sur recommandation conjointe des sages-femmes qui ont conclu un contrat de services avec l'établissement et du conseil des médecins, dentistes et pharmaciens de cet établissement, désigner ce conseil pour exercer les fonctions du conseil des sages-femmes prévues à l'article

Article 225.3. Dans un tel cas, les sages-femmes qui ont conclu un tel contrat font partie du conseil des médecins, dentistes et pharmaciens et trois d'entre elles, nommées par ces dernières, siègent au comité exécutif de ce conseil si un tel comité est formé. Elles prennent part aux délibérations de ce conseil et du comité exécutif, le cas échéant, mais n'y ont droit de vote que pour les questions relatives à ces fonctions.

Article 225.3

Conformément aux règlements de l'établissement, le conseil des sages-femmes est responsable envers le conseil d'administration :

1 de contrôler et d'apprécier de manière générale la qualité et la pertinence des actes posés par les sages-femmes pour l'établissement;

2 de faire des recommandations sur les règles de soins applicables à ses membres;

3 de faire des recommandations sur la distribution appropriée des services dispensés par ses membres;

4 de faire des recommandations sur les qualifications et la compétence d'une sage-femme qui adresse une demande au conseil d'administration en vue de conclure avec l'établissement un contrat en vertu de l'article 259.2;

5 de faire des recommandations sur les obligations qui doivent être rattachées à l'exercice de la profession de sage-femme conformément à un contrat conclu en vertu de l'article 259.2;

6 d'assumer toute autre fonction que lui confie le conseil d'administration.

Le conseil des sages-femmes doit faire un rapport annuel au conseil d'administration concernant l'exécution de ses fonctions et les avis qui en résultent.

En l'absence d'un conseil des sages-femmes et dans le cas où l'article 225.2 ne reçoit pas application, le responsable des services de sage-femme exerce les fonctions prévues au premier alinéa.

Article 225.4

Conformément aux règlements de l'établissement, le conseil des sages-femmes ou, en l'absence d'un tel conseil, le responsable des services de sage-femme est responsable envers le directeur général de donner son avis sur les questions suivantes :

1 l'organisation scientifique et technique du centre local de services communautaires;

2 les moyens à prendre pour évaluer et maintenir la compétence des sages-femmes;

3 toute autre question que le directeur général porte à son attention.

Article 225.5

Le conseil des sages-femmes peut adopter des règlements concernant sa régie interne, la création de comités et leur fonctionnement ainsi que la poursuite de ses fins. Ces règlements entrent en vigueur après avoir été approuvés par le conseil d'administration.

Article 225.6

Les responsabilités du conseil des sages-femmes sont exercées par un comité exécutif formé d'au moins trois sages-femmes désignées par le conseil et du directeur général.

Le comité exécutif exerce tous les pouvoirs de ce conseil.

ANNEXE 3 : ARTICLES DE À LA CONVENTION DE LA BAIE JAMES ET DU NORD QUÉBÉCOIS RELATIFS À LA FORMATION DES SAGES-FEMMES INUITES

« Article 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 :

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 »

Social marketing analysis of factors influencing smoking behaviours in NUNAVIK

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KEY MESSAGES

The main goal of this social marketing analysis was to gain a better understanding of factors influencing smoking behaviours in Nunavik. This information was deemed necessary to develop a multi-component action plan on tobacco control and prevention that addresses the specific needs of the Nunavik population. The results of this analysis represent opinions of wide variety population representatives, including youth, pregnant women, parents and health care workers (both smokers and non-smokers). As such, we feel these results can be used to identify some of the tobacco prevention actions needed on the ground.

Factors influencing smoking in the general population

Although smoking undoubtedly retains a certain role in establishing social links, we can safely affirm that **most Nunavimmiut appear to be fully aware of the risks it poses to health**. In fact, many smokers would like to quit (or at least reduce their) smoking, and health is mentioned as their main motivation to do so. Yet, one **significant barrier to quitting remains the lack of cessation counselling** (i.e. support beyond prescription of NRT), and supportive counselling should be provided in Inuktitut, use visual aids and provide concrete advice on what can be done to fight cravings and "keep busy".

Similarly, the importance of protecting others against the dangers of SHS also seem to be well understood in the region, as **most smokers seem to find it "normal" to smoke outside**; there might only be a need to remind people that such precautions also apply to smoking in other contexts like in cars, above the stove and in the furnace room.

Factors influencing smoking in pregnant women and parents of young children

Again, most parents interviewed were well aware of the **importance of not exposing children to SHS by smoking outside**. In addition, the risk of smoking in pregnancy appears to be well known, and considered particularly saddening by many. A few knowledge gaps appear to remain, however, as there might be a need to clarify the risk of SHS to unborn babies (and hence the importance of protecting pregnant women from SHS) and the risk of smoking with a baby in the amauti.

Yet, pregnant women and young parents who are unable to stop smoking on their own may benefit from **specific interventions that are better adapted to their needs**; potential useful suggestions included combining group cessation counselling with other activities such as traditional handcrafts, walking clubs, stress management workshops, as well as using harm reduction approaches (i.e. trying to reduce if quitting is too difficult).

Factors influencing smoking in Youth

Youth smoking was also described as quite saddening, and the importance of tobacco prevention in school was often mentioned as a way to address what is seen as a worsening situation. This appears to be congruent with the fact that non-smoking teachers were often reported as positive role models by youth interviewed.

It needs to be recognized, however, that such programs need to go beyond teaching the negative impact of smoking on health (which is again quite well known), but rather help youth develop skills to react to peer pressure, cope with stress and other negative emotions, as well as provide community-based activities to boredom at bay.

The need for a comprehensive tobacco prevention strategy

Based on the key findings mentioned above, we feel a comprehensive tobacco prevention strategy is necessary in order to achieve the following objectives:

1. **Improving access to culturally safe tobacco cessation services for all:** This should include universal tobacco screening and offer of tobacco cessation counseling for all smokers, as well targeted approaches to better address the needs of pregnant women and young parents.
2. **Preventing tobacco use in Youth**: This would be achieved using a combination of community/school-based programs, regional policy enforcement to limit tobacco access for minors, as well as judicious use of social media campaigns.
3. **Reducing exposure to second hand smoke especially amongst children**: This may require information campaigns promoting the new legislation on smoke free cars, as well as specific reminders on the dangers of SHS exposure inside the home for unborn babies and small children.
4. **Promoting community awareness:** This would include funding and implementing long-term, high-intensity, mass-media campaigns using strategic messages developed with representative of the target audiences.
5. **Measuring process and success**: Surveillance and evaluation measures are also necessary to continue to inform and guide our actions, as the strategy unfolds.

1 INTRODUCTION

In the last 50 years, Canada has witnessed a slow but stable decrease of its smoking prevalence, from almost 50% to less than 20%. However this trend has not been observed among Aboriginal populations in Canada, where the smoking prevalence has remained consistently 2 or 3 times higher than that of the general population, with some regions showing smoking prevalence rates of 50% or more (First Nations Information Governance Centre, n.d.; Kelly-Scott & Smith, 2015; Orisatoki, 2013).

Smoking is also very common in Nunavik where nearly three out of four adults report smoking daily (Plaziac & Hamel, 2007). This represents one of the highest smoking prevalence in the country, even among Aboriginal groups in Canada (Bernier, Pepin, Cree Board of Health and Social Services of James Bay, & Institut national de santé publique du Québec, 2008; Statistics Canada, 2013). While it is well known that psychological distress and socio-economic vulnerability factors largely explain the higher rates of smoking among Aboriginal populations in general (Watt, 2012; Wong, 2016) the specific reasons for such high smoking rates in Nunavik have never been thoroughly studied.

The Public Health Department of the Nunavik regional board of health and social services of Nunavik (NRBHSS) has recently obtained funding as part of Health Canada Federal Tobacco Control strategy to develop and deploy a multi-component action plan on tobacco control and prevention. However, as most health behaviours, smoking is highly influenced by cultural and social norms; it is thus essential that interventions being implemented are well adapted to the specificities of the Nunavik's context.

In order to guide the development of this action plan, the NRBHSS has requested the collaboration of the Aboriginal health team of the *Institut national de santé publique du Québec* (INSPQ) to conduct a social marketing analysis of the determinants influencing tobacco behaviour in Nunavik. The present report summarises the methodology and main findings of this analysis. First a brief description of the situation will be given, followed by an overview of the current tobacco interventions available in Nunavik. The definition and rationale of using a social marketing approach will then be given, along with the methodology used for this analysis. The results and the proposed recommendations for intervention planning will conclude the document.

This work would not have been possible without the contribution of many people, and we would like to convey to them our deep appreciation for their many valuable contributions. First, we are grateful to Christine Stich, PhD, Tobacco control expert from the INSPQ, for all her insightful advices on the present document. We also send our sincere thanks to our dedicated interviewers, Kathy Snowball, health promotion agent from the NRBHSS, and Phillip Alexandre Bourgoin, consultant. Finally, and undoubtedly most importantly, we would like to extend our most profound thanks to all our participants who graciously accepted to spend time sharing their stories, experience, and opinions about tobacco in Nunavik. *Narkurmimarialuk!*

2 CONTEXT

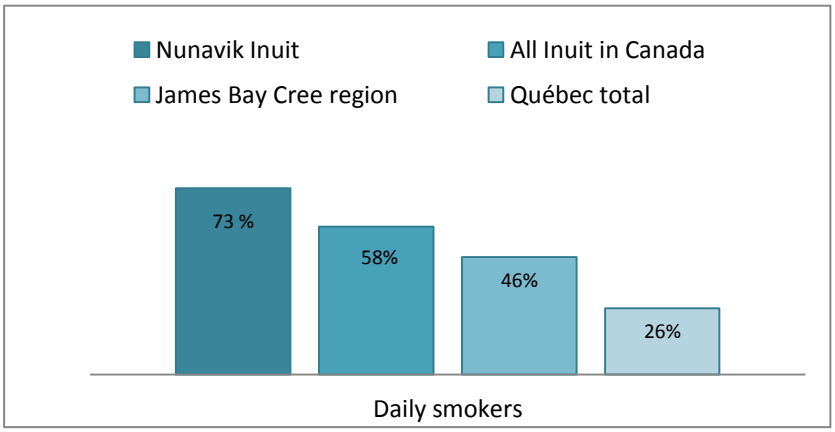
2.1 Current state of the situation

2.1.1 SMOKING PREVALENCE

Smoking is very common in Nunavik. According to the most recent regional survey (conducted in 2004), nearly three out of four adults reported being daily smokers (Plaziac & Hamel, 2007). This proportion is significantly higher than the one observed for Québec's general population at the time; in fact, it is also higher than the one observed in other Aboriginal populations in the country (figure 1). In addition, Nunavik's smoking prevalence has shown no significant change from the one observed in the region in 1992 (Plaziac & Hamel, 2007).

The good news is…
Despite the high smoking rate in Nunavik, most smokers are not heavy smokers.

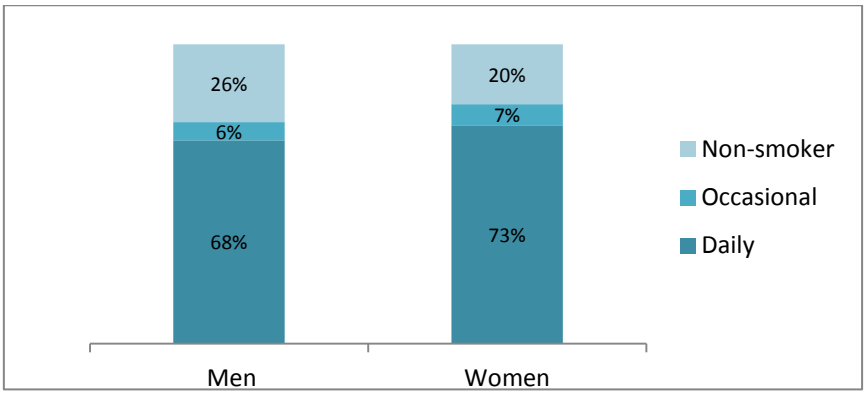
Figure 1: Prevalence of daily smokers



Source: Statistics Canada, 2003; Statistics Canada & Social and Aboriginal Statistics Division, 2006

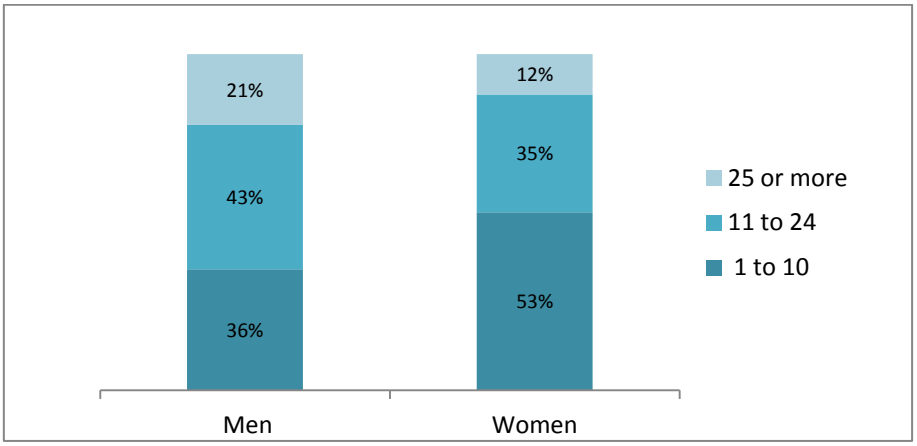
As depicted in figure 2, women tend to smoke slightly more frequently than men; however, they tend to smoke a smaller quantity of cigarette daily (figure 3). Almost nine out of ten daily smoking women smoke less than 25 cigarettes per day, with more than half smoking less than 10 cigarettes a day (figure 3). The smoking status by gender contrast with what is usually observed in general Canadian population that is men tends to smoke more frequently than women (Statistics Canada, 2016a).

Figure 2 : Smoking status by gender (Nunavik, 2004)



Source: Plaziac & Hamel, 2007

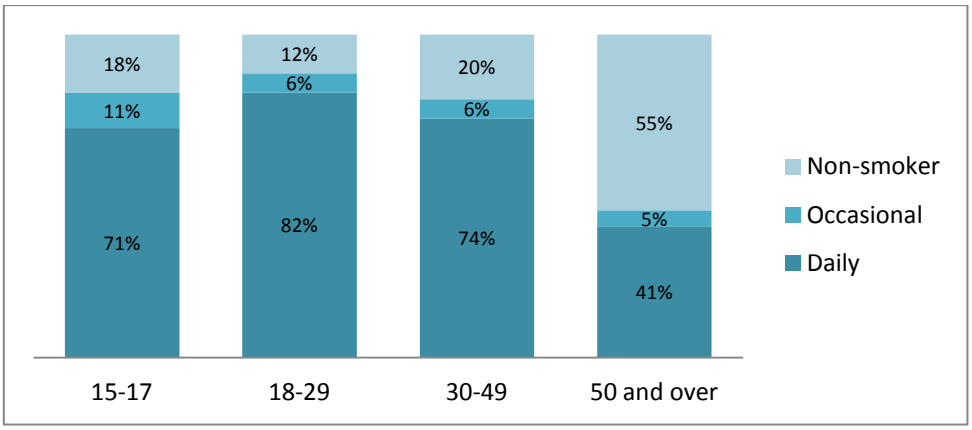
Figure 3 : Number of cigarettes smoked by gender among daily smokers (Nunavik 2004)



Source: Plaziac & Hamel, 2007

Young adults (18-29 years old) are the population showing the highest proportion of daily smokers (Figure 4). This trend appears to be a little different than what is observed in other Inuit populations; in Nunavut in 2012, for example, smoking rates in youth were lower than that of the older groups[1] (12 to 24; 51% vs. 25 to 44; 71%) (Statistics Canada, 2016b). Yet, youth smokers in Nunavik tend to be light or moderate smokers (Plaziac & Hamel, 2007). In contrast, adults of 50 years old and over tend to smoke significantly less than other age groups (Figure 4); but when they do, however they tend to be heavier smokers (Figure 5).

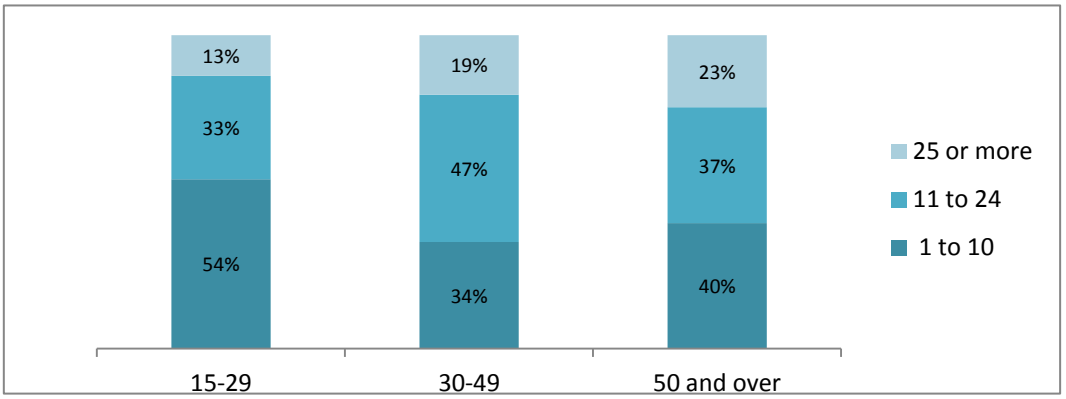
Figure 4 : Smoking status by age groups (Nunavik, 2004)



Source: Plaziac & Hamel, 2007

[1] The comparison between the two populations should be interpreted with caution because the Nunavut statistics were collected at a different time period and are presented using different age groups than the ones from Nunavik.

Figure 5 : Number of cigarettes smoked by age groups among daily smokers (Nunavik, 2004)



Source: Plaziac & Hamel, 2007

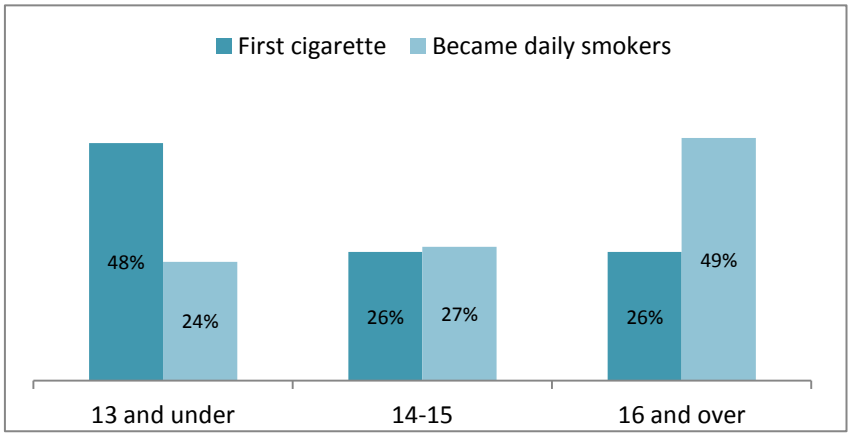
2.1.2 SMOKING DURING PREGNANCY

A high proportion of women smoke while pregnant in Nunavik: 65% reported smoking daily during their last pregnancy in 2004 (Plaziac & Hamel, 2007) compared to 28% of pregnant women in the rest of the province in 2005 (Guyon, Chayer, Audet, April, & De Koninck, 2008). When pooling daily and occasional smokers, we notice that most pregnant women (82%) in Nunavik have smoked during their last pregnancy in 2004 (Plaziac & Hamel, 2007).

2.1.3 SMOKING INITIATION

Almost half of daily smokers reported smoking their first cigarette before the age of 14 (Figure 6), and one quarter had their first cigarette at 11 years old (Plaziac & Hamel, 2007). Moreover, half of daily smokers began smoking on a daily basis before the age of 16 (Plaziac & Hamel, 2007). In addition, daily smokers tend to have had their first cigarette earlier than the ones smoking occasionally; almost half daily smokers compared to one third of occasional smokers had their first cigarettes before the age of 14 (Plaziac & Hamel, 2007).

Figure 6 : Age at first cigarette and of daily smoking (%) among daily smokers (Nunavik, 2004)



Source: Plaziac & Hamel, 2007

2.1.4 SECOND AND THIRD HAND SMOKING

Despite the very high proportion of smokers, restrictions to limit exposure to second hand smoke are very common in Nunavik. Approximately eight out of ten households impose such rules, especially in houses where there are young children present (Plaziac & Hamel, 2007). In almost half of the cases, smoking restrictions are applied in the entire house, whereas smoking was allowed under certain circumstances in one third of the households (Plaziac & Hamel, 2007). Indeed, it is very common in Nunavik to see people smoking outside their house regardless of the ice cold weather. Third-hand smoke is a concern that has gained some attention in the last years, and research has recently showed its negative impact on health; up to now, no data is available on this topic in Nunavik.

> ***The good news is…***
> *Nunaviummuit are very cautious about not exposing others, especially children, to cigarette smoke thus restriction of smoking inside houses and cars are very common and well respected.*

2.1.5 SMOKING CESSATION

According to the 2004 Nunavik health survey data, almost half of daily smokers and two thirds of occasional smokers attempted to quit smoking in the year preceding the survey (Plaziac & Hamel, 2007). For the majority of people indicated not having used any specific cessation method was used; they simply tried to quit on their own, and nicotine replacement therapy was used by only 20% of those having attempted to quit (Plaziac & Hamel, 2007). The most common reason for wanting to stop smoking was personal health.

2.2 Factors influencing smoking

2.2.1 POOR LIVING CONDITIONS

Studies have long established the correlation between high unemployment, low income and high smoking rates (CCNA, 2013). Hence, the high prevalence of smoking in the region could be explained, at least in part, by the fact that many Inuit families lack access to adequate income, employment opportunities, safe housing, or nutritious, affordable food (RRSSSN, in collaboration with l'INSPQ, 2013). In addition, emerging evidence tends to demonstrate that, once controlled for low income and psychosocial distress, smoking rates in pregnant Aboriginal women are similar (or lower) than those observed in non-Aboriginal women (Watt, 2012).

> *Although many jobs are available in the region, Inuit occupy barely over half the full-time jobs. Unemployment rates are hence very high, reaching 27% in youth 15-24 years of age. In addition, more than one family in five fell below the low-income line in 2006 (double the Québec average) (RRSSSN, in collaboration with l'INSPQ,*

2.2.2 TOBACCO PRICE

Studies have also shown that easy access to cigarettes is one of the best predictors of a child becoming a regular smoker at a young age. For example, tobacco use in youth is particularly sensitive to price, as a 10% increase in price is associated with a 14% decrease in the prevalence of smoking in this age group (Wong, 2016). Yet, while tobacco products may be tax exempt for Status Indians living on reserve, these exemptions do not apply to Inuit populations; the price of cigarettes is therefore extremely high in the region, and does not appear to influence youth smoking as much as could be expected. The reasons for this are unclear.

2.2.3 SOCIAL & CEREMONIAL FUNCTION OF SMOKING

Smoking has also been reported as playing an important social function in some Aboriginal populations, symbolising belonging to a group and reinforcing the social bonds (Bottorff et al., 2010). It should be mentioned, however, that in contrast to First Nations, tobacco has never been used ceremonially in traditional Inuit culture. Indeed, tobacco does not grow in the Arctic, and smoking was brought up North by European settlers; hence smoking became widely accepted behaviors among the Inuit only from the 1960's on.

2.2.4 EFFICIENCY OF SMOKING CESSATION INTERVENTIONS

Experts have suggested that effective cessation "best practices" appear to be largely underutilized and under investigated in Aboriginal populations. Yet, emerging research on quit lines suggests that they "can be an effective addition to Aboriginal tobacco cessation strategies"(Hayward, Campbell, & Sutherland-Brown, 2007). Similarly, research shows that drug therapy is underused in this population, likely because they do not frequently consult physicians for smoking cessation (Wardman, Quantz, Tootoosis, & Khan, 2007). Finally, it is possible that mainstream anti-tobacco campaigns are unlikely to raise awareness among Aboriginal youth as these campaigns tend to target realities that Aboriginal youth do not easily relate to.

2.3 Health consequences of smoking in Nunavik

Smoking poses important risks to health, not only for smokers themselves, but also for non-smokers exposed to second and third-hand smoke. Tobacco smoke holds more than 7000 chemical substances, among which at least 69 are known to cause or contribute to cancer (U.S. Dept. of Health and Human Services, 2010). Smoking is thus estimated to increase the risk of developing lung cancer approximately 25 times and tobacco use could be responsible of as many as 90% of all lung cancer deaths (U.S. Dept. of Health and Human Services, 2010).

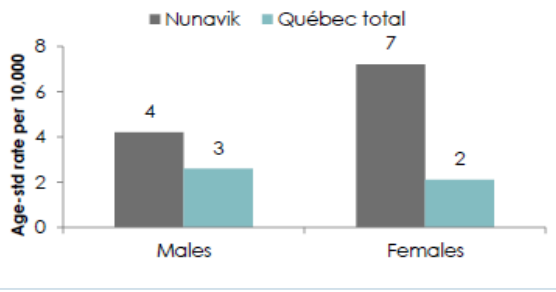
The good news are…

- *The earlier in life a person quits the greater the health benefits.*
- *Quitting smoking lowers the risk of smoking-related diseases and can add years to life (U.S. Department of Health and Human Services, 2010).*
- *The improvements in health are dramatic and start as soon as the person quit. For instance, after 48 hours, the chances of having a heart attack start to decrease and the sense of taste and smell begin to improve (The lung association, 2010).*

2.3.1 RESPIRATORY PROBLEMS

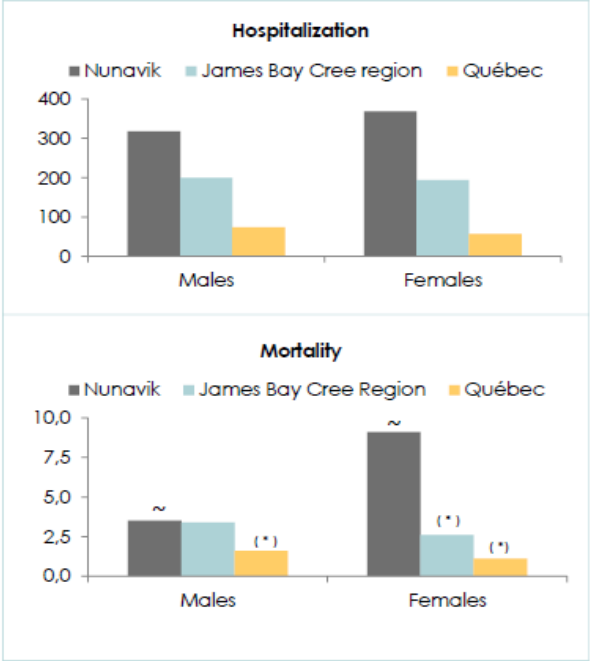
Widespread smoking causes serious consequence to population health, including lung cancer and respiratory diseases. Indeed, incidence rates of lung cancer in the region far exceed the provincial average (see figure 36). Furthermore, respiratory ailments are the leading cause of hospitalization in Nunavik (see figure 39), and as much as one death in four in the elderly in the region is attributable to some type of respiratory disease (see figure 39). Nunavik's mortality rates from respiratory disease are, however, comparable to those of the other Inuit regions and have been quite stable over the last two decades (RRSSSN, in collaboration with l'INSPQ, 2014).

Figure 36
Ajusted incidence rate for cancers of the respiratory system, Nunavik, 2004-2008



Source: Cancer registry

Figure 39
Age-adjusted mortality and hospitalization rates from respiratory conditions: Nunavik compared to the James Bay Cree region and Québec as a whole, 2005-2009



(*) indicates a statistically significant different between a region's rate and the Nunavik rate.
~ indicates a rate based on small numbers, and thus somewhat imprecise (coefficient of variation over 16.6%)

Tobacco is also known to contribute to the severity of active tuberculosis infections (Public Health Agency of Canada, 2010), increasing the risk of being infected (World Health Organization, 2009). Passive exposure to tobacco smoke has also been associated with increased risk of infection (Chiang, Slama, & Enarson, 2007). Moreover active and passive exposure have been shown to increase the risk of the transition from latent to active infection (Chiang et al., 2007).

The state of the situation of tuberculosis in Nunavik is preoccupying; while the incidence of active TB had declined between 1980 and 2003, rates have started increasing again since 2007. Not all communities are equally affected, but the young adults and young family with children appear to be most at risk (Nunavik regional board of health and social services, 2015). Another important contributing factor is undoubtedly the high rates of house overcrowding (see box) which increases SHS exposure as well as enables transmission of Tuberculosis (Nunavik regional board of health and social services, 2015).

*Almost half (49%) of Nunavik's population lives in an overcrowded dwelling (*RRSSSN, en collaboration avec l'INSPQ, 2014*).*

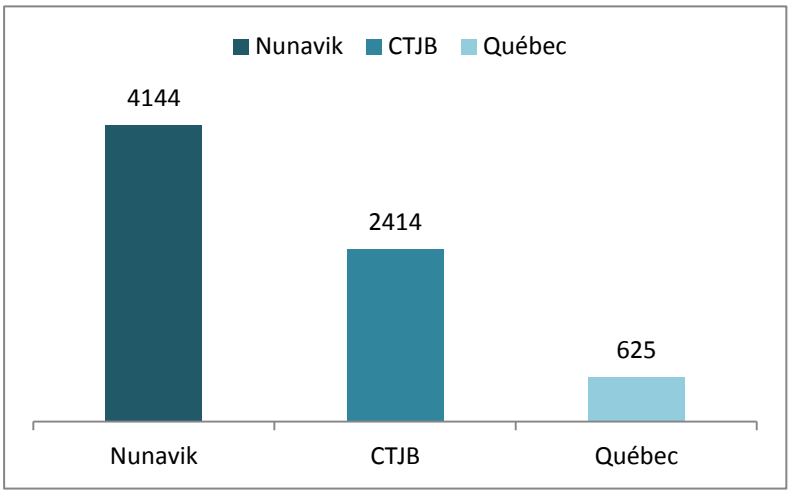
2.3.2 CONSEQUENCES OF SMOKING ON MATERNAL AND CHILD HEALTH

Smoking also poses risks to pregnancy and the health of newborns. Indeed, tobacco use in pregnancy increases the risk of preterm delivery, still birth, low birth weights and sudden infant death syndrome (SIDS). The regional infant mortality rate is very high relative to the rest of Québec (Infant mortality rate, 2005–2009 18 vs. 3 / 1,000 live births, corresponding to an annual average of 7 deaths); the leading causes of death at that age are perinatal conditions and sudden infant death syndrome (RRSSSN, en collaboration avec l'INSPQ, 2014).

The effects of passive smoking on the health of young children is also of great concern, as exposure to second-hand smoke has been linked to chest and ear infections (Health Canada, 2005). And indeed, respiratory diseases such as pneumonia and bronchiolitis are the leading causes of hospitalization for children in Nunavik in their first year of life, with rates that are far superior to those observed elsewhere in the province (see Figure 7).

Third hand smoke also poses a risk to the health of children, as tobacco smoke gets trapped in surrounding elements such as hair, skin, clothes (fur, especially) and toys (The lung association, 2012). Because they frequently put their hands in their mouth and also because they spend a long time indoors and on the floor, babies are particularly at risk through household dust pollution as well as contaminated objects and surfaces (Matt, 2004; Winickoff et al., 2009).

Figure 7: Crude Hospitalization rates (per 10,000) for children less than 1 year old (2007-2012)



2.4 Tobacco control and prevention interventions available in Nunavik

There are currently a certain number of tobacco prevention initiatives in Nunavik, and while some are already working quite well, many need to be reinforced. Evaluation of their efficiency has also been limited.

2.4.1 SMOKING CESSATION SERVICES

At the clinical level, nicotine replacement therapy (NRT) is available free of charge, but it needs to be prescribed by a doctor or a nurse at the Centre local de santé communautaire (CLSC). Still, as described earlier, NRT is very rarely used in the region, as most try to quit on their own. In addition, it appears that there currently is very little cessation counselling available in the communities; yet, a certain number of cessation counsellors had been trained in 2000, and a survey done in 2005 found that

65% of those who consulted them found them helpful (Gray & Fuller, 2015). However, none of them appear to be practicing anymore.

Quit lines are also available to smokers in Nunavik. The services are not based in the region; the English line comes from Québec city and the Inuktitut one, from Nunavut. However a recent evaluation reported that very few Aboriginal smokers use them and proposed to improving access and promoting the use of this service. (Gray & Fuller, 2015).

2.4.2 COMMUNITY-BASED ACTIVITIES

Since 2003, the public health department of the Nunavik regional board of health and social services holds an annual Quit-to-Win challenge. The main goal of this contest is to motivate people to become (or remain) smoke free. An evaluation conducted in 2015 found that the efficiency of this activity could be improved by 1) devoting more resources to its deployment, especially by extending the contest to youth at youth centers; 2) complementing the challenge with interventions which aim at creating favourable environments and improving access to smoking cessation support (Gray & Fuller, 2015).

Various information and education campaigns have also been put in place in the region over the years. Indeed numerous brochures and websites targeting Inuit populations have been developed, such as the "Smoking sucks, kick butt!" and the "Healing from smoking" programs. It is unclear, however, whether people are aware of these or have access to them.

2.4.3 SMOKING BANS AND OTHER PUBLIC POLICIES

Smoking restrictions in public buildings are well implemented in Nunavik, although the new 9-metre smoke-free zone may still require a little more time to be fully implemented. Also, the blue light campaign[2] aiming at promoting smoke-free households started in 2004 in three pilot communities, and it appeared to have been received very positively. This campaign is still going on in Nunavik, but it is not clear to which extent.

And finally, although in principle the region fully applies Quebec's Tobacco Control Act, whether the prohibition of cigarette sales to minors and the recent prohibition of smoking in vehicles are in fact well enforced remains unclear.

[2] The purpose of the blue light campaign is to promote smoke-free households by placing a blue light outside of each home that is smoke-free.

3 OUR MANDATE

The factors described above might provide some insight for Nunavik's high smoking rates. However, many questions remained unanswered or had been very little studied. To gain a comprehensive understanding of factors influencing smoking behaviours as well as approaches to smoking cessation appropriate for this population, these remaining needed to be assessed and addressed. Only then will we be able to develop tobacco control interventions including tobacco cessation "best practices" to a context in which smoking seems to be considered the "norm" and where individual, social and environmental factors might make it more difficult to implement such interventions successfully.

Thus, the regional board of health and social services of Nunavik (RRSSSN) had decided to conduct, in collaboration with the Institut national de santé publique du Québec, a thorough social marketing analysis of the tobacco related behaviour in Nunavik.

The main goal of this analysis was to better understand the values and attitudes of the population on smoking, so that we could get a better understanding of factors interfering with and facilitating smoke free life styles in Nunavik. It is thought that this information would help the planning of a comprehensive multi-level program aiming at preventing tobacco use and promoting smoking cessation as well as protecting non-smokers from second and third hand smoke in the region in the region.

This project was done in close collaboration with an advisory committee composed of stakeholders from the RRSSSN. All relevant elements of the project were discussed and decisions were taken in consultation with the advisory committee members. This was mainly done through regular phone meetings, especially during the preparatory phase of the project. Agendas and minutes of all phone conferences are available on request.

4 METHODOLOGY

4.1 The Social marketing approach

Social marketing uses marketing and advertising techniques to promote the adoption of healthy behaviours (cf. box below). Indeed, social marketing is now widely recognised as "an effective framework for behaviour change interventions and can provide a useful 'toolkit' for organisations that are trying to change health behaviours" (Gordon, McDermott, Stead, & Angus, 2007).

> **Social marketing is commonly defined as...**
> "the application of commercial marketing technologies to the analysis, planning, execution and evaluation of programs designed to influence the voluntary behaviour of target audiences in order to improve their personal welfare and that of society."
> (Andreasen, 1995)

Yet, while social marketing and public health interventions both aim at promoting the health of individuals, social marketing specifically targets the modification of voluntary behaviours (Andreasen, 1995) and is hence not limited to improving knowledge or awareness.

The use of commercial marketing techniques involves a systematic analysis and planning process, including careful audience segmentation, as well as the definition of the ideal "marketing mix", as described below (Weinreich, 2011).

- Positioning the **product** means defining the exact behaviour which needs to be changed (in our case, smoking), as well as knowing your potential "competitors", which can either be an alternative behaviour or not adopting a specific behaviour.

- The concept of **price** in this case relates to what the person has to give up (or take on) in order to adopt a new behaviour; for instance, "prices" of giving up smoking include the nicotine withdrawal symptoms and having to adopt new strategies to deal with stress, for example.

- **Place** refers to the location where people usually adopt the behaviour, or where they can "access" support to the desired behaviour, such smoking cessation services provided by a CLSC, the schools or a quit line.

- And finally, **promotion** refers to the methods of promoting adequate health behaviour change messages, and involves a thorough analysis of the best communications channels to reach the target audience(s) selected.

Social marketing users should hence adopt a "social marketing mindset", in that they need to think about the problem and its solutions from the target audience perspective (Weinreich, 2011). In order to reach such an in-depth understanding of target audiences realities and contexts, an extensive consultation process should be undertaken, not only with representatives of the target audience but also with many other relevant key informants.

As such, social marketing is an approach that targets not only the individual adopting the behaviour, but also the professionals, organisations, and legislators (Weinreich, 2011). This multi-level approach is a key element of social marketing as it allows implementing a comprehensive set of coordinated interventions to specific audiences (Center for Diseaes Control and Prevention, n.d.).

4.2 Social marketing planning process

Although a multitude of reference documents exists on social marketing methodology, their founding principles are quite similar. This analysis was conducted using the guide proposed by the Center for Disease Control and Prevention (Centers for Disease Control and Prevention, 2010), which is composed of the following phases:

As indicated in the figure above, the present social marketing analysis includes the results of the first three phases of this model. The last three phases, will then be completed by the team of the Public health department of the NRBHSS.

4.2.1 Problem description

This first phase consisted in collecting and analysing the currently available information on smoking in Nunavik. This step usually helps to identify the missing information pointing out the information gaps, hence guiding the formative research phase. Many of the elements of the problem description have already been presented in the second section of this document, namely the state of the situation in terms of smoking prevalence in Nunavik, barriers to cessation, smoking consequences, as well as the interventions currently available in the region.

Other significant elements of the problem description were discussed with our advisory committee. This included the identification of our **main target populations** that is youth, pregnant women, parents of young children and adults. It was also proposed to **prioritize smoking prevention** when dealing with youth**, while smoking reduction and cessation seemed** to be more appropriate when intervening with pregnant women and adults**. Limiting second and third hand exposure** was mentioned to be of great importance when approaching parents of young children.

4.2.2 FORMATIVE RESEARCH

The formative research process hence involved the analysis of the information missing from the problem description (step 1), so as to identify the precise research questions and adequate methodology to answer them. The results of this step were then used to develop the intervention strategy (step 3).

Analysis of information gap and identification of research questions

Again, a process of reflection was completed in collaboration with the advisory committee members in order to better define the aspects of the behaviour to analyse. This has resulted in the development of comprehensive tables including all information gaps. From these, the following research questions were elaborated:

- What are the main factors influencing smokers' smoking behaviour? Which factors seem to interfere with quitting/reducing smoking behaviour?
- What are the main factors influencing non-smokers' tobacco free behaviour? What were important factors which helped them quit?
- What are the factors which appear to lead to exposure to second- and third hand smoke?
- Do these factors differ between the following sub-groups: Youth, adults, pregnant women or parents of young children?

Methodology

The type of research questions that were elaborated through this process warranted that a qualitative methodology be used, mainly through individual interviews. Two main documents had to be elaborated to conduct the data collection: the consent forms and the interview grid.

The consent forms were developed by applying the common rules of informed consent, but an effort was made to ensure an adequate literacy level. Three versions were developed: one for adults (cf. Annex 2), one for parents or guardians of youth between 14 and 17 years of age, and another one for youth between 14 and 17 years of age. All versions were approved by the lawyer of *the Institut national de santé publique du Québec*.

The interview grids were then developed in line with the research questions previously identified; these were structured 8 to 10 sections, depending on the target populations, as depicted in table 1. An informal pre-test was done to assess length, fluidity of questions and level of literacy. An example of the youth interview grid is available in annex 3. All versions are available on request.

The recruitment of both participants and key informants followed an opportunistic sampling method, mainly for practical and financial reasons. Three communities of different sizes were selected for the first round of interviews, that is two from the Hudson Coast, and one from the Ungava Coast. A total of 35 participants was recruited and interviewed, including nine youth, 8 pregnant women, 7 parents of young children and 11 adults. A total of 11 key informants from 5 communities was interviewed, representing staff from the school, the CLSC, the dental clinic, and the maternal child health services. Saturation of information was reached at the end of the interview period.

The interviews were conducted between April and July 2016. Two interviewers were available to conduct interviews in either English, French or Inuktitut. Most questionnaires were completed by interview, either in person or over the phone, depending on what was the most convenient for the participant. The questionnaire was self-administered for a few respondents only.

Table 1: Interview grids sections by target populations

Section	SMOKING Pregnant women Parents of young children Adults	SMOKING Youth	NON-SMOKING Pregnant women Parents of young children Adults Youth
1	Smoking	Smoking	Smoking
2	Second-hand smoke	Second-hand smoke	Second-hand smoke
3	Third hand smoke	Third hand smoke	Third hand smoke
4	Smoking behaviours	Smoking initiation	Smoking behaviours
5	Smoking cessation/reduction	Smoking behaviours	Smoking restriction
6	Smoking restriction	Smoking cessation/reduction	Perception
7	Perception	Smoking restriction	Social interaction
8	Social interaction	Perception	Communication channels
9	Communication channels	Social interaction	
10		Communication channels	

Information Analysis and interpretation

In order to structure the thematic analysis, the educational and ecological diagnosis step of Green's PRECEDE/PROCEED model was used (Renaud & Gomez Zamudio, 2002). This model categorizes factors known to influence behaviours, as either

- **predisposing factors,** related to the motivation to take action, such as knowledge, attitudes and beliefs,
- **facilitating factors** concern mostly environmental factors, such as rules regarding smoking in the house and in the car, and
- **reinforcing factors** , defined as incentives towards the behaviour that act as motivators in continuing the behaviour, such as the attitude of people surrounding the participant about their smoking.

The key informant information was mainly analysed to validate information collected from participants and also to identify the challenging aspects when intervening in smoking cessation and prevention.

5 RESULTS

The present section summarizes the information collected from interviewing all participants and key informants (KI). The first section will describe smoking behaviours of the respondents, as well as the factors that seem to influence it. Then behaviours surrounding smoking cessation and its determinants will then be presented. Lastly, interventions related to smoking will be discussed.

5.1 Smoking behaviours

The vast majority of smokers interviewed reported smoking every day, some up to half a pack a day. Some youth mentioned smoking during school breaks. Most smokers stated smoking outside, with only a few reporting also smoking in the furnace room.

Smokers tend to smoke within social contexts, as all participants reported smoking mostly with other people: partners, relatives and friends. Situation in which respondents seem to enjoy smoking most vary greatly but appear for the most part to be related to intake of food or drinks (coffee, tea or beer) or associated to a specific moment of the day, either mornings, evenings, or after lunch. However, some respondents stated smoking "out of habit" and not really enjoying it.

5.1.1 FACTORS INFLUENCING SMOKING BEHAVIOURS

Some consensual elements on adult smoking

"Everyone says smoking is bad, but nobody cares if I smoke"

All respondents but one had negative perceptions of smoking, saying it was "bad for health", "deadly", and "repulsive". Yet, most smokers thought that people around them were "mostly indifferent" about their smoking. In fact, most respondents said that it was their own business if they smoked.

"I want to smoke"

"I don't think I will (ever) stop smoking"

In addition, most smokers said that their smoking status had no impact on their social interactions. Yet, smokers reported living in households with a much higher proportion of smokers that non-smokers did, and this difference appeared to be more marked for youth smokers than for adult ones.

"…smokers spend time with smokers and that non-smokers have to find non-smokers to hang out with."

Many respondents seemed to believe that addiction and social norms are strong predisposing factors for smoking; in fact, most adult smokers admitted "cravings" was their main reason for smoking.

Smoking in Youth is perceived as particularly saddening

None of the youth respondents mentioned addiction as their main reason for smoking. In fact, when asked about what role smoking played in their life, most youth respondents answered "socializing" or "because everyone is doing it". In addition, other young people mentioned that being bored, stressed or mad seemed to bring on the need to smoke.

All respondents had very negative perception of very young people smoking, saying it was “very sad” or even “sickening” to see them smoking at such a young age, notably because their “lungs are still growing”. One parent mentioned seeing children as young as 8 years old using cigarette butts to smoke. Some reported that these children were “uneducated” or that “parents might not be strict enough”; as they thought that in many cases parents don’t even know that their child smokes.

> **“Kids pick up parent’s cigarettes butt and smoke it. “**
>
> ***“Young kids use cigarette butts to smoke! Adults should take care of it.”***
>
> ***“Youth start earlier and earlier to smoke, I want more prevention done at school. Show them the effect and what is in the tobacco and smoke! “***

Many adult respondents thought that youth perceived smoking as being “cool”. Yet, none of the youth interviewed answered that smoking was “attractive” or “cool”; many said “it smells bad”, and some even wondered whether it was legal. Many youth stated its negative health effects, in particular the risk of lung cancer. Surprisingly, only one youth declared that it is expensive.

Many youth mentioned buying cigarettes at the coop-store. Others access cigarettes form people in their network, parents, family members or friends

Smoking in pregnant women: a sensitive issue

The vast majority of respondents knew that there are risks associated with smoking during pregnancy, without giving details about the types of risk, mostly by saying “it is bad for the baby”.

> ***“...the baby inside of her is smoking as well.”***

A few mentioned hoping pregnant women would stop at least during their pregnancy and thought reasons for not quitting included lack of knowledge, being irresponsible, and lack of available counselling services in the community. On the other hand, some pregnant women who were smoking admitted being ambivalent about their smoking, and addiction was mentioned as one important reason for not quitting. One pregnant woman who was an ex-smoker mentioned:

> ***“...it is selfish to smoke while pregnant; it hurts the babies and I felt guilty after I saw the effect “.***

Key informants nevertheless suggested that at times the partner was not a positive influence on the pregnant woman, as she may want to change her lifestyle, but her partner did not support this change.

> ***“They are struggling like anyone else. And often they feel guilty.”***
>
> ***“We do not see much of the men in individual or group activities and they usually stay quiet. However, at home, we believe that men have a lot of influence on their partners.”***
>
> ***“When there is a partner, they often exercise a lot of influence. In many cases, the partner does not have a healthy lifestyle and he might feel challenged by the women’s desire to improve her behaviour regarding alcohol, drug and tobacco.”***

Smoking in parents: direct and indirect effects on their children

When asked about their thoughts on parents who smoke, many respondents declared the negative effects this would have on their children, namely because of second hand smoke (SHS) exposure, as well as the fact that they were providing a negative role model for them. A few also answered that smoking was expensive and wished parents would spend money on groceries rather than on cigarettes.

Again, lack of knowledge, addiction and lack of counselling support was mentioned by many as reasons for parents not to quit. Yet, as will be described in more detail in the following section, most parents in fact would like to quit or at least smoke less, and only a minority of parents interviewed told us they did not mind if they smoke as it was "their own business".

5.1.2 FACTORS INFLUENCING SMOKING OUTSIDE

The majority of smokers smokes outside

The vast majority of respondents have reported being aware about the risks of SHS. In fact, almost all respondents mentioned having rules limiting smoking in their house and that these rules were always followed. It seems that these rules were easy to follow, except perhaps, when the weather is very bad.

In fact, setting up rules restricting smoking inside was considered important for the vast majority of respondents interviewed (both smokers and non-smokers alike). Many even reported that there should be stricter enforcement of the smoke free distance from public building entrances.

> ***"Posters are posted about smoking bans close to building but the rules are not followed. We need more restrictions and enforcement."***

Many KI told us that, while smoking outside has become a habit in the region, most people do it without really knowing the precise effects of SHS on health. According to them, a few messages with respect to SHS still need to be reinforced, including its effects on the unborn baby, as well as the risks of exposing children to smoke when in cars, or when carrying them in the amauti. Yet, most respondents who owned a car told us that smoking was not allowed in their vehicle (and particularly not when children were present), and that this rule had been easy to put in place.

Barriers to implementing smoking restriction

There are some circumstances in which applying smoking restrictions inside are difficult; for example, when people smoke joints or other forms of drugs.

> ***"When they smoke cannabis joints, they smoke it inside. It seems as if the rule of smoking cigarettes outside does not apply to joints even if they mix tobacco with marijuana."***

> ***"Most of them don't' smoke inside. But people smoke weed inside. They could be open to smoke outside, however the fact that many people use stoves to smoke hashish makes it more difficult."***

Overcrowded housing conditions can also make imposing smoking restrictions inside the house very challenging.

> ***"The older generation is more reluctant to stop indoor smoking and with many people in the house it's hard to get them to stop smoking inside for the children and babies "***

> ***"If the pregnant woman lives at her parents' or somebody else's house, it would be difficult to change the rules. First and second pregnancies are often from young mothers living at somebody else's place which makes it difficult."***

Third hand smoke awareness: room for improvement

And finally, many mentioned also being aware of third-hand smoke (THS), referring to the bad tobacco smell of smokers' house and clothes (especially fur). To get rid of the smell, some smokers mentioned washing or changing their clothes; non-smokers said that they avoided places that smelled like cigarettes as much as possible for that reason. However, beyond the annoyance of the smell, only a few youths and parents reported being aware of the true risk associated with third hand smoke exposure.

5.2 Non-smoking behaviors

5.2.1 MOST NON-SMOKERS NEVER SMOKED

Most non-smoking respondents have never considered smoking, and a few non-smoking youth said they only tried it a few times, but had a negative experience. The main reasons reported for never smoking were related to health (wanting to "stay healthy", "live longer", and wanting to "stay active"). One respondent even said he got TB as a child and that smoking would make it worst.

Non-smokers also reported that smoking was not compatible with going on the land ("too many chemicals in cigarettes"). Also, the fact that parents and grandparents don't smoke or on the opposite that they were heavy smokes and sick from it seems to motivate some youth to stay smoke-free. Its prohibitive cost and its bad smell were also reasons for staying away from cigarettes.

General attitudes towards non smokers

Most respondents expressed very positive attitudes towards non-smokers (NS), mentioning being envious (or proud) of them, mostly because they were very healthy. Others added that NS were lucky either because they were saving money, they were able to taste food better, or because they did not suffer from addiction. Youth were also quite positive about non-smokers, mentioning that they were lucky and "must be happy"; one even specified being jealous and wanting to know how people succeeded to quit smoking. Only one person mentioned that NS were nonetheless still at risk of SHS.

Most non-smokers feel supported by families and friends

This was partly confirmed by non-smoking participants who told us that many people around them were supporting them to remain smoke-free. Only one participant said that some of her coworkers were pressuring her to smoke. Most non-smoking pregnant women also told us being supported to stay smoke-free, especially by their partners, family members and coworkers. Similarly, all non-smoking youth mentioned that everyone in their surroundings strongly encouraged them to keep up their non-smoking behaviours, parents and family members as well as their sports coach constituting important sources of support.

For most non-smoking respondents, being smoke-free appears to have favourably affected their relationships with others, as they felt having a positive impact on people and that people envied or praised them. One mentioned already having helped two people quit, and another thought people avoided smoking in front of them. Only one non-smoker said that occasionally people seemed "weird on her".

5.3 Quitting or reducing smoking

5.3.1 MOST SMOKERS HAVE TRIED QUITTING/ REDUCING

Almost all adult smokers interviewed mentioned having tried quitting smoking before.

> ***"I want to stop smoking! "***

Indeed, many smoking parents said they started considering quitting when they got children. Others said they would prefer to slow down than quit, because "it is easier" and it might eventually lead to quitting. Youth were less likely to have tried quitting before but were almost equally divided between those who said they would like to quit, and those who would rather reduce their smoking.

While none of the pregnant women who smoked said they would like to quit smoking, many said they would consider reducing their tobacco consumption during their pregnancy. However, many mentioned not knowing how to reduce the number of cigarettes they were smoking, and one admitted feeling she would not be able to do so.

Factors influencing smokers' intentions to quit

The main reasons provided by respondents who smoked for wanting to either quit or to reduce the number of cigarettes smoked related mostly to health: "because of breathing problems", being "too much affected by colds and cough", or , when pregnant, for the "baby's health". Youth respondents also reported wanting to be "better at sports", as well as because "it smelled bad". Many also mentioned the fact that smoking was too expensive. One respondent reported that seeing the "jar filled with water and smoke" experiment had motivated her to try to stop smoking.

> ***"The community health team came to school and showed a water jar with smoke. It smelled and looked disgusting, it had a strong impact on me."***

Partners, family members, children and to a lesser extent coworkers seem to be the people that put the most pressure on smokers to quit smoking or reduce the number of cigarettes smoked. Many young people stated being under particularly high pressure to quit or reduce, particularly from school staff, their teachers and their sports coach, followed by parents and other family members.

Quitting strategies

Most respondents had tried to quit on their own. A few had tried nicotine replacement therapy (NRT) patches. Many young respondents tried to quit supported by their physical education teacher. Only one adult mentioned having done it as part of Quit-to-Win challenge.

> *Key informants thought...*
> *One of the main weaknesses of the cessation support services is the lack of systematic follow-up.*

When asked what strategies they would use if they were to quit or reduce, many smokers actually admitted not knowing what would be helpful. Strategies mentioned by those who did quit smoking included finding another activity to take one's mind off smoking, such as sewing, exercising, playing video games, or eating, as well as finding friends and family members to quit with them; one person reiterated the importance of planning well so as to be supported. Interestingly, taking part in Quit-to-Win challenge and having more information about the impact of smoking on health and life expectancy was also mentioned as potential motivating factors (although, improvements to the program are clearly needed, see box below). A few youth thought that being supported by a teacher or having fun activities to do would also help.

Key informants told us that in order to improve the impact of the Quit-to-Win challenge, efforts should be devoted at improving...
- *Cessation support and follow up to clients*
- *The coordination between regional and local levels of services*

Although all respondents knew about NRT, (mostly the patch, and to a lesser extent, the gum), only a few said they would use it when trying to quit, in combination with counselling and the support from their partner. For those who said that they would not use any support, the main reasons included wanting to "do it on their own" or the fear of negative side effects of medication. Indeed, one respondent mentioned having tried NRT but did not like it because it was "uncomfortable to wear", it "made her feel unwell" and "causes bad breath".

"… other people reported having nightmares and other side effects from using NRT"

Respondents interested in using NRT generally said they could easily obtain it from the clinic and many felt that nurses and CLWW should be "prescribing it". It was also mentioned that counselling should be provided in Inuktitut. Youth, however, told us they would prefer to get it at school. Some parents also told us the family house would be another good place to access NRT.

Only a few respondents (youth mostly) appear to be aware of electronic cigarettes and other new smokeless tobacco products. They mostly had seen Qallunaat using them. Only one youth reported considering using e-cigarettes as a strategy to quit smoking.

Factors which appear to facilitate quitting

Most respondents who managed to quit smoking told us that they did not need to try many times before successfully quitting, usually once or twice, and many did it on their own; a few told us it took them more efforts, however. When asked about what seemed to have helped most, some mentioned eating more (especially junk or "very tasty" food), drinking a lot of water, sleeping more, going hunting, chewing gum, saving money, and being supported by family. One respondent explained that at first she had to avoid doing certain activities which she used to associate with smoking, like drinking coffee or tea, as well as going to parties.

Indeed, being around people who smoke was often reported as the most difficult situation when trying to quit smoking. The most common reasons for relapses mentioned were cravings, withdrawal symptoms, as well as smelling and seeing others smoking. While a few adults also mentioned being bored and having nothing else to do, youth reported relapsing because of feeling angry or stressed, or due to personal problems.

5.4 What could help people quit?

5.4.1 MOTIVATING PEOPLE TO QUIT

All respondents, smokers and non-smokers alike, were also asked for their suggestions on what they thought could help smokers quit. The following are some of the answers provided according to population subgroups.

To motivate **pregnant women** to stop smoking, it was suggested to offer a fitness challenge (with prices); the ladies enrolled could also act as support group. Providing adapted information about the dangerousness of smoking for their baby (using testimonies, for example) was also suggested. It was also mentioned that women's fear of gaining weight and moody swings such as getting angry were concerns when contemplating to quit

"It is very important to give information to pregnant women because their baby can be very sick from smoking during pregnancy like mine was."

For **adults** and **parents**, respondents mentioned the importance of being "concrete" in way to teach about the impact of tobacco use, using visual tools such as "the jar with water and smoke (bad look and smell)". Sharing testimonies of people suffering from health problem caused by smoking and of people that succeed in quitting, as a way of promoting positive role models were also thought to be useful. Non-smokers said that smokers should be reminded of the fact that "they can be who they want to be".

For smoking **youth**, it was suggested that fun activities should be offered to keep them busy; it would also be good to encourage friends to stop at the same time. Some arguments suggested were: stay healthy, smoking is bad for health and smells bad, save money. Reinforcing non-smoking role models was also suggested, either parents or teachers, as they are the people youth declared admiring the most.

Youth respondents were specifically asked whom they admired the most. Interestingly, smoking youths answered "teachers" while non-smoking youths, responded "parents".

Finally, in order to **reinforce rules for restricting smoking** in the house and in the car, many respondents seemed to believe that more information should be given about the negative consequences of SHS and THS, particularly to children; stickers and signs as well as posters could be used as well as sharing this information at school. Some participants also suggested reminding people that smoking outside is an easy thing to do, (easier than stopping smoking) and that it is also a good example for the kids. Lastly, the risk of setting a house on fire was mentioned as an argument to convince youth of the importance of quitting.

5.4.2 Preferred spokesperson and intervener

When asked about who they would see as a credible spokesperson to encourage smoke-free living, most respondents answered the clinic staff, such as nurses, community local wellness workers (CLWW) and addiction workers. Non-smoking role models with relevant testimonies were also frequently mentioned. Youth referred to a large extent to people from school, notably their physical education teacher or sports coach.

Finally, for the majority of respondents, the most helpful person to provide them with cessation counselling were people at the clinic, notably CLWW and nurses. Midwives and student counsellors were also mentioned, as well as dentists, doctors and "tobacco workers". From the information provided it is unclear by the respondents whether the smoking status of the intervener matters; however, some seemed to think counselling should be provided by non-smokers only, while others didn't seem to think this mattered much.

5.4.3 Preferred communication channels

When asked where respondents obtained information on the risk of tobacco use, **parents, pregnant women and adults** mentioned various sources including: friends and family, media (mostly social media – facebook & youtube –as well as TNI and CBC radio and to a lesser extent, television & web sites), cigarette pack warnings, as well as community health team and clinic. For **youth**, on the other hand, the school was reported as the main source of information about the risk of smoking, followed by social media, and the community gym. Most non-smoking youth also mentioned parents as an important source of information.

6 OVERVIEW OF THE MAIN RESULTS

6.1 Strengths and limitations of the methodology

The main goal of this social marketing analysis was to gain a better understanding of factors influencing smoking on behaviours in the Nunavik population. And although we feel that this study allowed us to improve our insights on the current state of the situation with respect to smoking in the region, caution must be used in the interpretation of the results.

Unlike quantitative surveys, qualitative methodologies as the one used here are not based on a large representative sample of participants. In fact, qualitative methodologies rather base their validity on the fact that the **opinions expressed by a large variety of participants reach saturation** (which means that interviews are pursued until no new information is gained). In addition, a great amount of collected information with the target population's members was corroborated through the interviews with the key informants, which give robustness to our results. However, we should caution the reader that the opinions documented in such interviews could reflect those of the most "health conscious" representatives of the population.

While our study external validity may be low, (i.e. we certainly cannot assert that the present results apply to the whole population of Nunavik), we can safely affirm that the results obtained do represent opinions of some representatives of the population. And as such, our results can be used to identify some of the tobacco prevention actions needed on the ground. In addition, the identification of these actions was based on strategies developed in similar contexts.

6.2 Factors influencing smoking in various populations – a summary

6.2.1 Factors influencing smoking in the general population

Although smoking undoubtedly retains a certain role in establishing social links, we can safely affirm that **most Nunavimmiut appear to be fully aware of the risks it poses to health**. In fact, many smokers would like to quit (or at least reduce their) smoking, and health is mentioned as their main motivation to do so. Yet, one **significant barrier to quitting remains the lack of cessation counselling** (i.e. support beyond prescription of NRT), and supportive counselling should be provided in Inuktitut, use visual aids and provide concrete advice on what can be done to fight cravings and "keep busy".

Similarly, the importance of protecting others against the dangers of SHS also seem to be well understood in the region, as **most smokers seem to find it "normal" to smoke outside**; there might only be a need to remind people that such precautions also apply in other contexts like in cars, above the stove and in the furnace room.

6.2.2 Factors influencing smoking in Pregnant women and parents of young children

Again, most parents interviewed were well aware of the **importance of not exposing children to SHS by smoking outside**. In addition, the risk of smoking in pregnancy appears to be well known, and considered particularly saddening by many. A few knowledge gaps appear to remain, however, as there might be a need to clarify the risk of SHS to unborn babies (and hence the importance of protecting pregnant women from SHS) and the risk of smoking with a baby in the amauti.

Yet, pregnant women and young parents who are unable to stop smoking on their own may benefit from **specific interventions that are better adapted to their needs**; potential useful suggestions

included combining group cessation counselling with other activities such as traditional handcrafts, walking clubs, stress management workshops, as well as using harm reduction approaches (i.e. trying to reduce if quitting is too difficult).

6.2.3 Factors influencing smoking in Youth

Youth smoking was also described as quite saddening, and the importance of tobacco prevention in school was often mentioned as a way to address what is seen as worsening situation. This appears to be congruent with the fact that non-smoking teachers were often reported as positive role models by youth interviewed.

It needs to be recognized, however, that such programs need to go beyond teaching the negative impact of smoking on health (which is again quite well known), but rather help youth develop skills to react to peer pressure, cope with stress and other negative emotions, as well as provide community-based activities to boredom at bay.

7 DISCUSSION & RECOMMENDATIONS

The need for a comprehensive tobacco prevention strategy

Based on the key findings mentioned above, we feel a comprehensive tobacco prevention strategy is necessary in order to achieve the following objectives:

1. **Improving access to culturally safe tobacco cessation services for all:** This should include universal tobacco screening and offer of tobacco cessation counseling for all smokers, as well targeted approaches to better address the needs of pregnant women and young parents.
2. **Preventing tobacco use in Youth**: This would be achieved using a combination of community/school-based programs, regional policy enforcement to limit tobacco access for minors, as well as judicious use of social media campaigns.
3. **Reducing exposure to second hand smoke especially amongst children**: This may require information campaigns promoting the new legislation on smoke free cars, as well as specific reminders on the dangers of SHS exposure inside the home for unborn babies and small children.
4. **Promoting community awareness:** This should include funding and implementing long-term, high-intensity, mass-media campaigns using strategic messages developed with representative of the target audiences.
5. **Measuring process and success**; Surveillance and evaluation measures are also necessary to continue to inform and guide our actions, as the strategy unfolds.

These five areas of action are not mutually exclusive, that is some of the measures proposed in one area might also be relevant in another one. When the detailed strategy will be elaborated, discussions with the partners will help in deciding the most relevant way to structuring it.

7.1 Improving access to culturally safe tobacco cessation services for all

There appears to be a large consensus among respondents that many smokers want to stop or reduce smoking, and that more counselling support is needed in the region. Such services should include both (1) increasing health care providers screening for smoking and (2) improving access to adapted cessation treatments and support.

7.1.1 SCREENING FOR SMOKING

Many respondents stated that health care workers could provide tobacco quitting counseling and indeed, research indicates that one of the best ways to initiate tobacco cessation support is by integrating systematic screening for smoking status into routine clinical care (Centers for Disease Control and Prevention, 2014). Computerized reminder systems are known to be useful, but a paper system using stickers indicating patients smoking status on charts, for example, could also be used in the short term in Nunavik.

Similarly, health care providers may benefit from using opportunistic “cues to action” (after a patient has just recovered from major health event, for example), as these constitute favorable windows of opportunity for screening and offering cessation support to patients who would otherwise be unwilling to consider quitting when feeling otherwise well (Meillier, Lund, & Kok, 1997).

7.1.2 IMPROVING ACCESS TO ADAPTED CESSATION TREATMENTS & SUPPORT

The lack of supportive follow up services was repeatedly identified as a strong barrier to quitting. Hence, improving access to adequate medication and counseling support should become a priority in the region.

For example, while many smokers reported being interested in trying nicotine replacement therapy to help them quit smoking, many stated being concerned about its side effects, notably nightmares; considering the importance of dreams in traditional Inuit culture this can understandably discourage many from trying it. Yet, it has been suggested that NRT side effects tend to be associated with inappropriate dosage or usage (Statistics Canada, 2011) This seems to be corroborated by the fact that many key informants expressed their interest in providing smoking cessation support, but admitted feeling unskilled to do it properly.

Hence, there appears to be an urgent need for **training new tobacco cessation counselors**. Choosing community champions (such as community workers, interpreters and other Inuit health care workers) would ensure counseling is provided in **Inuktitut**, as this appeared to be essential for many respondents. Also, **train-the-trainer programs** would help increase the sustainability of such services, as health care workers' high turnover rate may require that we re-train counselors on a regular basis. Finally, special attention may have to be given to counselors' non-smoking status, as this also seemed to be essential for many respondents interviewed.

Other evidence-based interventions suggested by respondents to improve tobacco cessation included the following:

- ***Accessibility of NRT***. Looking into the possibility of making NRT accessible outside clinics without prescription, (i.e. school, family house, youth centers…) (Wardman et al., 2007)

- ***Family interventions***. Some ex-smokers expressed the challenges to quitting created by the necessity of self-excluding oneself from social gatherings where most people smoke, it is thought that family/group interventions may help to counteract social pressures in such contexts (Thomas, Baker, Thomas, & Lorenzetti, 2015). Group support may also benefit from being integrated to other activities (such as sewing, beading, or exercising, for example) and this has been shown to work well in some Aboriginal contexts (Schwartz, 2005).

- ***Specific needs of pregnant women***: According to the information collected here, there seems to be a need to clarify the risks for babies' and pregnant women exposure to SHS, particularly in the context of Nunavik's high prevalence of sudden infant death syndrome (SIDS). However, considering the sensitive nature of smoking in pregnancy, we may need to consider creating pregnant women specific groups, couple interventions, as well as harm reduction approaches, where women are encouraged to reduce their smoking if quitting is not a feasible option for them (Schwartz, 2005).

7.1.3 SUPPORTING REGIONAL QUIT LINE CAPACITY AND OTHER MEDIA ALTERNATIVES

Quit lines are an interesting alternative to face-to-face individual counseling, as they have broad reach, can be tailored to diverse populations, and hence have been shown to increase quit rates (Hayward et al., 2007). Because quit line services are free, remove time and transportation barriers, and are confidential, they are one of the most accessible cessation resources (Hayward et al., 2007). For these reasons, telephone cessation support services (such quit lines) provided in Inuktitut and English should strongly be promoted.

Social media was reported as one of the favorite media channels used by respondent. These should be considered in the available cessation support options. For instance, social group under the form of an internet-based discussion forum could be put in place. This forum would aim at providing health information related to tobacco use, at accessing to virtual social support and also at acting as resources for other people (Donelle & Hoffman-Goetz, 2008).

7.2 Preventing tobacco use initiation in Youth

Our results indicated that most youth smoke mostly because everyone else does, or as a way to fight boredom, or other negative emotions such as stress or anger not one youth reported cravings as a reason for smoking. While most youth are still experimenting with tobacco use, only few might already be smokers (and thus addicted but not since very long), thus there is a great proportion who is not yet, which may indicate a good opportunity for intervention.

Evidence-based interventions recommended for prevention of tobacco use among youth revolve around three main strategies: school based programs, denormalization campaigns and reduction of access to tobacco products to minors.

7.2.1 SCHOOL BASED PROGRAMS FOR TOBACCO USE PREVENTION – WHAT WORKS?

The school was very often stated by respondents as a good place for providing intervention on tobacco prevention and cessation. Similarly, teachers, particularly physical education teachers seem to have a very strong influence on youth non-smoking behaviours, especially when relatives are smokers. For school-based tobacco prevention programs to be efficient, however, studies have shown that they must adopt an ecological approach by deploying activities aimed at students, parents, school, and community contexts.

These multi-level activities could take many forms. Following are examples of how they could be articulated.

- First, to reach **students**, adapted educational programs must be part of the school curriculum; these should use an approach based on social influences, focusing mainly on teaching students specific skills to resist peer pressure and social influences. In additions, evidence has shown that peer to peer interventions and programs addressing deceptive practices of the tobacco industry are quite efficient for youth (see denormalizing campaigns below).

- These students' education activities need to be complemented by protection activities aimed at **parents,** encouraging them to minimize SHS exposition for example.

- At the **school level**, specific smoke free policies and smoking cessation activities aimed at both staff and students offer a great potential for reducing youth smoking.

- Lastly, at the **community level**, support for community initiatives limiting tobacco access for youth should be provided by the regional health authorities (see section on access, 6.2.3).

7.2.2 DENORMALISATION CAMPAIGN

Denormalization of tobacco use to counter tobacco industry strategies has been shown to be quite efficient at deconstructing smoking as socially acceptable (Lalonde, Heneman, Institut national de santé publique du Québec, Direction du développement des individus et des communautés, & Institut national de santé publique du Québec, 2004). Such campaigns aim at informing the public on the strategies used by the tobacco industry to manipulate public opinion. This strategy was proven to be very powerful in youth because it sparks controversy and attracts the attention of the public on the responsibility of the tobacco industry. For these reasons, denormalization has been found useful in preventing youth smoking initiation, as well as for smoking cessation campaigns.

Other options also include the emergence of using digital videogame and gaming-based approaches have shown a significant potential of promoting healthy behaviors among youth and adolescent. Data are scarce on terms of smoking prevention and cessation interventions, but they may prove to be effective tools among a populations greatly familiar with these types of games (Hall, Mercado,

Anderson-Lewis, Darville, & Bernhardt, 2015). Finally, the recent "Short messages against tobacco" (SMAT) campaign of the Canadian Cancer Society might be interesting to propose in the region.

7.2.3 REDUCING ACCESS TO TOBACCO PRODUCTS FOR MINORS

Some of the people we interviewed brought our attention to the fact that youth tend to have relatively easy access to tobacco products (through smoking discarded cigarette butts, for example). Reducing access to tobacco products for youth (and more specifically for minors) seems coherent with the scientific evidence showing that efforts to mobilize communities to reduce the availability of tobacco products to youth are important in reducing youth smoking initiation.

The literature insists on the fact that strategies need first to focus on minimizing commercial availability of tobacco products, notably by enforcing laws prohibiting the sale of tobacco products to minors. While this regulation is in principle already in place in Nunavik, we may have to verify if it is well enforced. Increasing tobacco unit price through taxes is also known to be efficient in reducing tobacco use, mostly in youth and low socio economic status populations; however, cigarettes are already more costly in Nunavik than elsewhere in the province, and so this strategy may already be optimized.

The second aspect of this strategy consists in developing activities targeting families and friends, sensitizing them of the importance of limiting youth access to cigarettes; important messages may include not providing cigarettes to youth, as well as by making sure cigarette butts are cleaned up or in a locked ashtray so that they cannot be used by children to make their own cigarettes.

7.3 Reducing exposure to second hand smoke especially amongst children

Clean indoor air legislation prohibiting tobacco use inside public and private workplaces have been known to influence societal organizations and networks, as well as support individuals to make behavior choices consistent with tobacco-free norms (Zhang, Cowling, & Tang, 2010). According to the information collected, this appears to be already well in place in Nunavik. The protection of children's health was the argument most often used in support of smoke free areas and appeared to generate the most traction in producing consensus. It is also a strong motivator for tobacco cessation for parents.

Perhaps a few messages still needing reinforcement include the following:

- Reminding mothers that smoking while carrying their baby on their back is likely to expose the child to SHS and THS.
- Reminding the general public of the importance of not smoking in the car.
- Smoking in the furnace room or over the stove ventilation also needs to be reiterated as insufficient to protect other household members from SHS, as is smoking cannabis inside.

7.4 Promoting community awareness

Funding and implementing long-term, high-intensity, mass-media campaigns using strategic messages are also an essential intervention for tobacco prevention, as they are powerful tools to influence social norms (Smedley, Syme, Institute of Medicine (U.S.), & Committee on Capitalizing on Social Science and Behavioral Research to Improve the Public's Health, 2000). Communication campaigns can also help in enhancing the capacity of communities to act through promoting community participation (Smedley et al., 2000), for instance by advocating for public policies that encourage people to quit tobacco smoking.

To be efficient however, a coordinated communication plan should be elaborated and messages need to be developed in consultation with representative of the target audiences, and messages need to be carefully pre-tested (Lalonde et al., 2004). A fair amount of respondents have mentioned about the power of testimonies and suggested to use it in order to motivate people to take action.

Additionally, effective campaigns must meet the following criteria (Lalonde et al., 2004):

- ***Duration***: Research indicates that campaigns should be frequent and long enough to sensitize the target audience, i.e. at least 6 to 12 months. However, for an impact on beliefs and attitudes, the duration must be at least 12 to 18 months. Finally, to observe an impact on behaviour, the media campaign should last at least 18 to 24 months (Lalonde et al., 2004).

- ***Audience segmentation***: To be efficient, it is important to target youth at critical stages of their social development (i.e. 6th , 7th and 8th grade) (Lalonde et al., 2004).

- To have high impact, ***messages' content*** must :
    - Present smoke-free lifestyles in a realistic fashion, by using popular role models; role models, however, are only useful if they have credible stories to tell, (such as of having lost loved ones, for example), and they should refrain from using moralistic or authoritarian tones.
    - Propose alternatives to smoking (practice sports) as a way to promote pride and self-control.
    - Messages which seem not to work so well with teens, on the other hand, are those which present smoking as a « personal choice », emphasizing for example that not smoking can be "cool".

- ***Communication channels***: it is best to use a vast array of communication channels (radio, print media, posters, as well as social media). In our context, a combination of radio and social media would appear to be essential to catch the intended audience.

7.5 Measuring process and success

Implementation of these strategies needs to be followed by timely evaluations, not only to be able to follow their impact on tobacco prevalence, but also to assess the quality of implemented activities.

A process evaluation should be developed alongside the planning of the interventions. This type of evaluation focuses on the implementation process; it aims notably at determining how well interventions have been implemented and at documenting whether interventions have been deployed as expected. It also identifies the barriers and the facilitators of the implementation. An evaluation committee should be formed to discuss more precisely the elements that have to be assessed through this evaluation as well as how it should be articulated.

An impact evaluation aimed at determining whether intervention has achieved the desired effect; in this case it consists notably in closely following the prevalence of tobacco smoking in Nunavik. These surveillance-type activities should be done once implementation is complete. Systematic and regular data collection could be planned in order to timely follow smoking prevalence. However it could also be decided to use the data that are already collected through different surveys in the region. This last option would provide data that are far apart in time but would need no human and financial investments. A small committee should be formed to discuss the most relevant option for this specific situation.

Lastly, it is important to include these activities in the budget of the interventions. It is usually recommended that 10% of the program budget be set aside for such evaluations activities.

8 CONCLUSION

The information synthesized in the present analysis is far from being exhaustive, as it was based on interviews conducted with a limited number of respondents in a few communities only. The information collected, however, allowed us to identify some trends in Nunavimmiut attitudes towards smoking.

Smoking remains very common among Inuit population living in Nunavik, and as a result, tobacco is a leading contributor to the burden of disease in the region; it not only affects adults and elderly through high rates of lung cancers and other respiratory conditions, but it also causes important health problem in newborns, infants, and young children.

Yet, tobacco control "best practices" do exist and they have contributed to drastically reducing tobacco use in the rest of the province. In previous years, the Public Health Department of the Nunavik Regional Board of Health and Social Services has indeed implemented most of the provincial tobacco control strategy, but with limited success. In fact, some strategies have been a great success (many Nunavimmiuts now smoke outside, and NRT are readily available in all communities), but others have been difficult to implement and maintain (intensive cessation support services are very still very difficult to access).

It was hence felt that a socially or culturally relevant evidence was needed, one that would help gain a better understanding of the factors that directly or indirectly promote (i.e. perpetuate) smoking behaviours in various subpopulations of the region, so as to better inform the development of culturally and contextually relevant programs that would enable Nunavimmiuts to quit smoking, and remain tobacco free.

The aim of this social marketing analysis was, therefore, to explore the perceptions of smokers and non smokers, as well as important key informants such as health care professionals and teachers, on the individual and contextual factors that are associated with smoking in the region. The stories shared during the interviews confirmed that although smoking is still part very much of a certain "norm" in the region, most smokers do wish to quit, but are missing concrete cessation support services to help them do so. We were also able to explore the some of the needs of specific sub-groups, such as Youth and pregnant women, and obtain a better understanding of the extensive array of factors directly and indirectly influencing smoking in these groups.

This information will be useful in planning multilevel interventions, which will include the development of intensive health service smoking cessation programs. Our data suggests however, that programs are also needed to target the social and environmental factors perpetuating smoking in the region.

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Annexe 1

Consent forms

Institut national de santé publique Québec

Social marketing analysis on
Tobacco prevention and cessation approach
Information's sheet
Consent form for consultation interview
Adults (18 years old and over)

1) Why should we do a consultation on tobacco?

Where do we plan to do consultation?
Puvirnituq, Akulivik, Tasiujaq and Kuujjuaq

As you may certainly know, Tobacco use is still an important challenge in Nunavik. For this reason, the Department of Public Health from the Nunavik Regional Board of Health and Social Services (NRBHSS), is currently revising its actions and strategy in regards to tobacco.

Which target audience's do we plan to consult?
- ✓ **youths**
- ✓ **pregnant women**
- ✓ **parents of young children**
- ✓ **adults**

In order to develop, plan and implement prevention, reduction and cessation interventions that are adapted to Nunavik socio-cultural context, a social marketing analysis is being conducted. This process aims to:

- Better understand the attitudes, beliefs and behaviors of Nunavimmiut in regards to tobacco use and interventions.
- Identify the best ways to reach people by way of tobacco intervention.
- Put forward recommendations in terms of tobacco related interventions.

2) Who is responsible for this consultation?

To do this consultation, the Nunavik Regional Board of Health and Social Services asked the collaboration of the Institut national de santé publique du Québec (INSPQ). Hence, the person responsible of this consultation is **Isabelle Duguay**, planning, programming, and research officer at the INSPQ.

3) As a participant, what will I have to do?

The participant will have to take part in **one individual interview**, lasting about **45 minutes**. You will have the choice to do your interview in **English, Inuktitut or in French.**

4) What will you do with my answers?

Your answers will always be kept in a secure location. Also, your answers, as well as the one of all participants, will be analyzed in order to identify common elements that will help us to make relevant recommendations in term of tobacco interventions.

1

Institut national de santé publique Québec

5) Are there any risks in participating to this evaluation?

To the best of our knowledge, this interview should not involve any risks. However, if some participants need assistance, we will provide them the resource they need.

Your participation in this interview is extremely appreciated and fundamental. Indeed, it will provide us information that will help to make appropriate recommendation regarding what should be done to address adequately tobacco problematic.

To thank you for your time, we will give you a small compensation.

6) Will my answers be kept confidential?

YES, all your answers will be confidential. In the exercise of their functions, each members of this team has to strictly respect confidentiality.

7) Do I have to answer all questions?

NO, you can decide not to answer to one or to many questions; that is totally fine.

8) Can I withdraw from the interview?

YES, the participation is voluntary; you can withdraw from the interview anytime. The results of this consultation will be a compilation of all answers. No identification will be possible.

9) To whom can I talk to if I have questions during this consultation?

Isabelle Duguay, B.Sc.Inf. Planning, programming and evaluation officer, INSPQ	514-864-1600, ext:3512 Isabelle.Duguay@inspq.qc.ca

10) How can I agree to participate in this consultation?

By filling in the consent form, a copy must be kept by the evaluation team and another copy will be for you to keep in case you need to subsequently refer to it.

2

Institut national de santé publique Québec

Social marketing analysis on
Tobacco prevention and cessation approach
Consent form for consultation interview
Adults (18 years old and over)

Please check (V or x) the appropriate box and sign this consent form.

	YES	NO
• **I have carefully read or have been explained in detail the information sheet**		
• **I understand the information described above**		
• **I have obtained answers to my questions to my satisfaction**		
• **I freely consent to take part in this consultation by participating to an interview**		
• **I have been given a copy of this form**		

_____
My name

_____ _____
My signature Date

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

_____ _____
Intervener signature Date

3

Annexe 2

Consultation questionnaire for Social marketing analysis on Tobacco prevention and cessation approach

Date:
Community:

Specification of Participant	
Category	Target populations
	Youth Smoker

PREAMBLE

- **Project goal**
  To propose relevant recommendations aiming at developing, planning and implementation of **tobacco prevention and control intervention** adapted to Nunavik socio-cultural context

- **Interview objectives**
  To learn about knowledge, perceptions, attitudes, and behaviour of Nunavimmiut regarding smoking and tobacco interventions.

  Main themes
  1. Smoking, second and third hand smoke
  2. Initiation to smoking
  3. Behaviours
  4. Smoking restrictions
  5. Perceptions
  6. Social interactions
  7. Communications channels

- **Start up instructions**
  Approximate length
  Consent to be signed

- **Ask if the person has any questions**

REMINDER FOR INTERVIEWER
When discussing delicate subject such as sudden infant death syndrome (SIDS), keep in mind that the participant might have been through what you are discussing, therefore you should adopt an empathetic attitude to avoid feeling of guilt from participants.

QUESTIONS

1. SMOKING

1.1. What do you **know** about **smoking**?

1.2. Do you believe **your health** is at **risk** from **smoking**?

1.3. Do you know if there is a **link** between **smoking during pregnancy** and the **health of the baby**?

1.4. Do you **think** people know about **Sudden Infant Death Syndrome** (also known as **cot death** or **crib death** what is the name in Inuktitut?) and what **cause** it?

1.5. How **dangerous** do you think **smoking is compared to alcohol and cannabis**?

1.6. Are you **aware** of **smokeless cigarette**, **electronic cigarette** or any other new tobacco products?

2. SECOND HAND SMOKE

2.1. Do you think people know about **SECOND HAND SMOKE**?

2.2. DO you know **where** can you get in contact with **second hand smoke**? (house, cars, cabin...)

2.3. Do you believe your **friends** or **family members** are at **risk** from second hand smoke?

3. THIRD HAND SMOKE

3.1. Recently, it was discovered that there might be some risks linked to smoke present on clothes, furniture and other things that has been in contact with cigarette smoke. This is called **third hand smoke**. Were you **aware of it**?

YES	Go to 3.2
NO	Go to 4

3.2 Do you believe your **friends** or **family members** are at **risk** from third hand smoke?

4 INITIATION TO SMOKING

4.1 **How old** were you when you **first tried** to smoke a **cigarette**?

4.2 Can you tell us **how it happened** (context)?

4.3 **Who** provided the cigarette (friend; family member, …)?

4.4 **Where** were you?

4.5 **With whom** (friends, family members, …)?

4.6 **How old** were you when you **smoked** your **first complete cigarette**?

4.7 Can you tell us **how it happened** (context)?

4.8 Do you **smoke every day**? Every **week?**

YES	Go to 4.9
NO	Go to 4.10

4.9 **How old** were you when you **started** to **smoke regularly**?

4.10**Why** did you **start smoking**?

5 BEHAVIORS

5.1 **Where** do you smoke?

5.2 **When** do you smoke?

5.3 **With whom** do you smoke?

5.4 **How** do you have **access** to **cigarettes/tobacco?** (store, friends, older family members, parents, …)

5.5 When do you **most need** a cigarette? Why?

5.6 When do you most **enjoy** smoking? Why?

5.7 Did you **ever try** to **quit** smoking?

YES	Go to 5.8
NO	Go to 5.11

5.8 **For what reasons** did you try to **quit**? (Money, health, child, odour, pregnancy...)

5.9 Did you use any **support** to **quit**?

YES	What **type** of **support?** (intervener, nicotine replacement therapy, support from friends or people around you)
	What was the **most helpful**? (Counsellors, self-motivation, nicotine replacement therapy, support from family/friends...)
NO	Why?

5.10**Why** do you think you **relapsed**? (withdrawal symptoms, stress, other smokers, ...)

5.11Would you **consider** to reduce **smoking**?

YES	Why?
	What could **make it easier** for you to reduce?
	What would be the **most difficult**?
	Would you **prefer** to quit or reduce smoking?
	Would it **be easier** to quit or reduce smoking?
NO	Why?

5.12Do you think **young smokers** would **prefer to stop** or to **reduce** smoking?

5.13How can **young smokers** be convinced **not to smoke** or **reduce** smoking?

5.14What are your **behaviors** regarding **other aspects of health**?

Physical activity/inactivity	
Eating habits /fast food	
Alcohol	
Drugs	
How do you manage your stress? (Physical activity, land, seeing friends…)	
What are your hobbies or social activities?	

6 **SMOKING CESSATION/REDUCTION** (depending on their previous answer)

6.1 What do you think could **help you to quit/reduce** smoking?

6.2 Is there any **support** available from the **CLSC/clinic**? At **school**?

6.3 What do you **know** about **nicotine replacement therapy**? (gum, patch, pill, vaporizer, …)

6.4 Do you know if **nicotine replacement therapy** is **safe** to use for **teenagers**?

6.5 If you were to quit/reduce…

What would be your **strategy**?	
Would you **use** any **support (...)**?	YES → which one? (counselling, nicotine replacement therapy, help line, …)
	NO → Why?

6.6 If you were to quit, would you be **interested** to use **nicotine replacement therapy**?

YES	Do you think it would be **easy** to **access** it? Why?
	What could **make it easier** for you to use it?
	What would be the **most difficult**?
	Which **intervener** should be prescribing it? (student counsellor, community worker, nurse, dentist, physician, …)
	Where would you prefer to have **access** to nicotine replacement therapy? (CLSC/clinic, school, family house, youth house/centre…)
NO	Why?

7 SMOKING RESTRICTIONS

7.1 How **many people** live in your **house**?

7.2 How **many** are **smokers**?

7.3 Are there any **rules** regarding smoking in your **house**?

YES	What are they?			
	Are they followed:			
	Always	**Most of the time**	**Sometimes**	**Never**
	Was it **easy** or **difficult** to put these rules in places? Why? Go to 7.5			

NO	Did anybody try to put in place any rules in your house?
	YES Why are these rules not in place anymore?
	NO Go to 7.4

7.4 Would you **like** to **put in place** these kind of **rules** in your house now?

YES	Why would you put in place rules regarding smoking in your house?
	Do you feel you can succeed in putting in place rules regarding smoking in your house?
	What would help you to put in place those rules?
	Do you think that people around you will provide support in putting in place rules regarding smoking in your house?
NO	Why?

7.5 Do you or your family **own a car**?

YES	Go to 7.6
NO	Go to 7.9

7.6 Do you **smoke** in the **car**? Other **passengers**?

7.7 Are there any **rules** regarding smoking in your **car**?

YES	What are they?			
	Are they followed:			
	Always	**Most of the time**	**Sometimes**	**Never**
	Was it **easy** or **difficult** to put these rules in place? Why? Go to 7.9			

NO	Did anybody ever try to put in place any rules in the car?
	YES Why are these rules not in place anymore?
	NO Go to 7.8

7.8 Would you **like** to **put in place** this kind of **rules** in your family **car** now?

YES	Why would you put in place rules regarding smoking in your family car?
	Do you feel you can succeed in putting in place rules regarding smoking in the car?
	What would help you to put in place those rules?
	Do you think that people around you will provide support in putting in place rules regarding smoking in the car?
NO	Why?

7.9 **How** can Nunavimmiut be **convinced** to **put in place rules** regarding smoking in their house or car?

8 PERCEPTIONS

8.1 What do you **think of smoking** in general?

8.2 Is it **attractive**?

YES	Why? (makes you look cool; makes you feel older, …)
NO	Why?

8.3 **Why** do you **think** you **smoke** (other smokers, stress, pleasure, etc.)?

8.4 What **role** does **smoking play in your life** (relaxation, socialization, etc.)?

8.5 What do you **think** of…

Youths under 14-year-old that smoke?	
Pregnant women who smoke?	
Parents of young children who smoke?	
Adult smokers?	
Non smokers?	

8.6 We are aware that often smoking is not the only challenge people face in their life. Among the following behaviors, can you identify the two behaviours that are the most important for a person to work on? And the two behaviors that are the least important?

	Important	**Not Important**
setting-up rules regarding smoking in the house/car		
smoking		
alcohol		
drugs		
stress		

8.7 Can you think of other challenges that could be more important to address than the one mentioned above?

9 SOCIAL INTERACTIONS

9.1 What is the **attitude/comments** of **people around you** about the fact that you **smoke**?

	Pressure to smoke	**Pressure to stop smoking**	**indifferent**
Boyfriend/girlfriend			
Friends/other students			
Your parents/family members			
Other persons living in your house			
School staff/teachers			
Sports coach			

9.2 Do you think that **smoking** has an **impact** on your **relationships/social interactions** with people of the same age? How?

9.3 **Who** has the **most impact** on your behavior and ideas? Who do you **admire** the most? (parents, teachers, friends, girlfriend/boyfriend, …)

10 COMMUNICATIONS CHANNELS

10.1**WHERE** do you get your **INFORMATION** about smoking?

10.2**Place in order,** 1 to 4, your **favorite source of information?**

Radio	**Website**	**Social Media on internet**	**Newspaper**	Is there any other source of information's that you like?

10.3What is your favorite?

Radio show? On which channel?	
Website?	
Social media on internet? (Facebook, youtube, Twitter, Snapchat, Instagram)	
Newspaper? Online or printed?	
Others	

10.4**Who** do you see as **credible spokesperson** for this issue? Does the fact that the spokesperson smoke is an issue or not?

10.5What type of worker do you see as the **most helpful intervener** for smoking prevention and support to quitting (student counsellors, community worker, nurse, dentist, physician, etc.)? Does the fact that the intervener smoke is an issue or not?

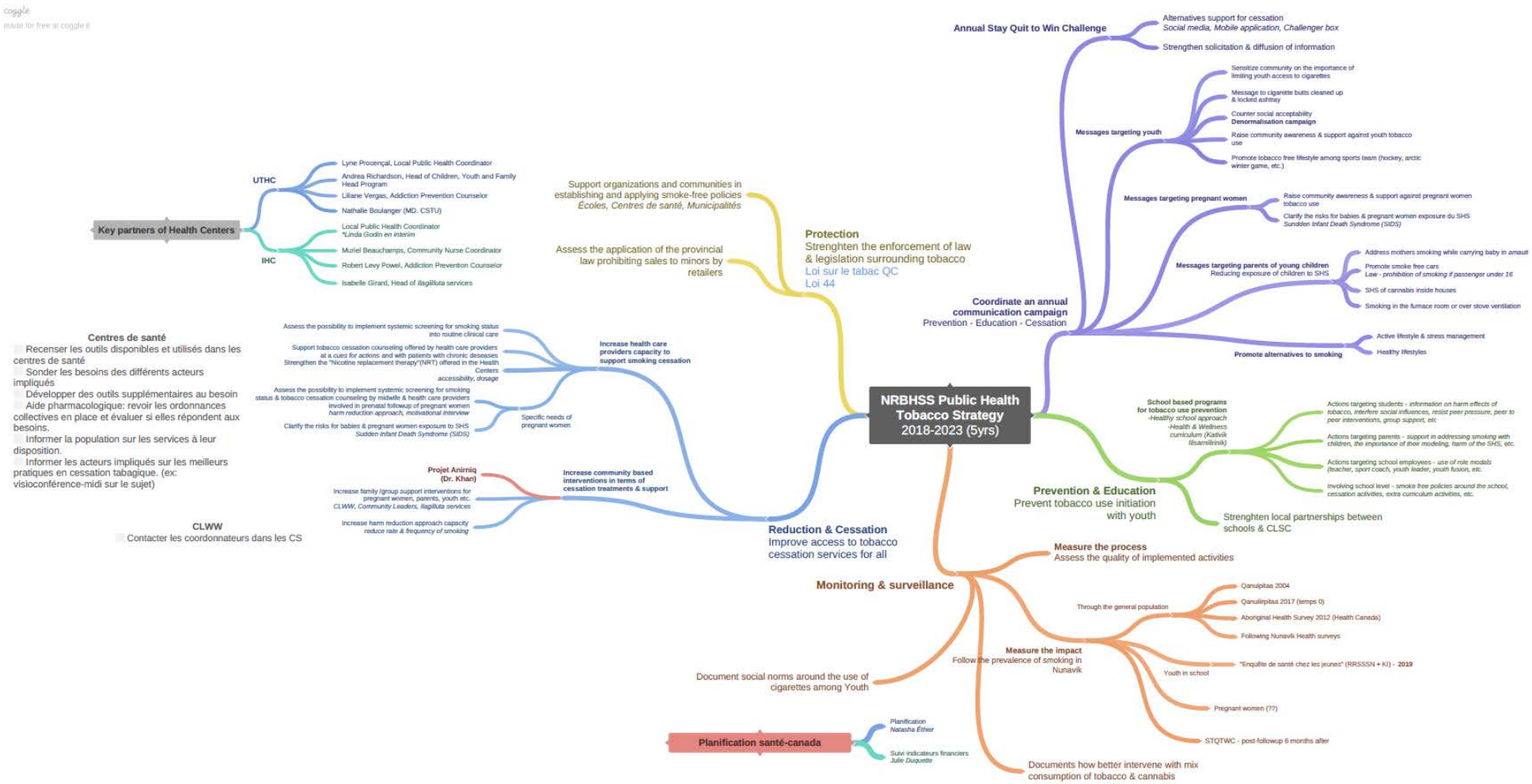
CONCLUSION

Is there **something else** you would like to add or that you consider important to share with us?

• Acknowledgements	
• Commitment (anonymity and others)	
• Invitation to focus group if needed	
• Handing in compensation	

Thank you

9.6 Mapping of planned initiatives for FTCS



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

REGIONAL PLAN OF ACTION FOR THE PREVENTION AND CONTROL OF TUBERCULOSIS, NUNAVIK

"Tuberculosis is a social disease with a medical aspect"
Sir William Osler (1849-1919)

Public Health Department

January 2014

ABBREVIATIONS USED

BCH	Bacillus Calmette-Guérin (vaccine)
CDC	Centers for Disease Control and Prevention
CIQ	Québec Immunization Committee
CLSC	Local Community Service Centre
CWW	Community Wellness Worker
DOTS	Directly Observed Treatment, Short-course
DPH	Department of Public Health
DTLC	Distance Teaching and Learning Center
FNIB	First Nation and Inuit Branch
HC	Health Center
HIV	Human Immunodeficiency Virus
INSPQ	*Institut national de santé publique du Québec*
KMHB	Kativik Municipal Housing Bureau
KRG	Kativik Regional Government
LTBI	Latent Tuberculosis Infection
MSSS	*Ministère de la santé et des services sociaux*
NRBHSS	Nunavik Regional Board of Health and Social Services
PHAC	Public Health Agency of Canada
SES	Socioeconomic Status
SHQ	*Société de l'habitation du Québec*
SI-PMI	Infectious disease protection information system
STBI	Sexually Transmitted and Blood Borne Infection
TB	Tuberculosis
THC	Tetrahydrocannabinol
WHO	World Health Organization

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1. INTRODUCTION

1.1 WHY A REGIONAL PLAN OF ACTION ON TUBERCOLOSIS IN NUNAVIK?

- The Nunavik region has the highest incidence of TB in Quebec.
- Overall incidence rates remain high and have been on the rise in recent years.
- The occurrence of community outbreaks has a significant impact on the community and health resources.
- Although improved diagnosis and treatment of active TB and latent TB infection (LTBI) have contributed to previous declines in the disease, recent trends also indicate the need to address the social and economic conditions that are known to be important determinants of TB at the population level.

A plan of action would reinforce other public health programs likely to have an impact on respiratory health.

1.2 WHAT THE REGIONAL PLAN OF ACTION PROPOSES

- A view toward elimination of TB with short- and medium-term objectives.
- A reference framework to identify the intervention sectors taking priority.
- A list of activities to undertake as well as a description of the roles and responsibilities of the authorities concerned.
- A coordination structure responsible for implementation of the plan.
- Follow-up to ensure monitoring of the plan's implementation.

2. CONTEXT

Tuberculosis is a contagious disease that spreads through inhalation of microdroplets carrying *Mycobacterium tuberculosis*. A transmission factor essential to the disease is therefore to have been in contact with an individual with active, contagious TB. Individuals who have had significant contact with a case of active, contagious TB will subsequently be likely to develop the disease or a latent TB infection that could evolve into an active form of the disease.

Since the advent of effective drug treatments for TB, emphasis of national TB programs has been on improving the delivery of effective TB treatment. The recognition of DOTS approaches to TB treatment as a highly cost-effective intervention by the World Bank in 1993 gave the World Health Organization (WHO) the impetus to promote this strategy as part of the primary health care agenda worldwide. In 2006, the WHO launched the STOP TB strategy, which emphasizes strengthening primary health care interventions and better addressing the needs of the vulnerable populations, the goal of this strategy being the elimination of TB (defined as an incidence of less than one case per million population) as

a disease of public health significance by 2050.

While the implementation of these clinical strategies has driven significant progress in TB control, the expected rate of world decline in TB incidence has not yet fully materialized in most regions. In fact, recent international reviews argue that in order to reach long-term TB control targets, current TB control efforts need to better address the risk factors and social determinants of the disease at a population level.

2.1 RISK FACTORS AND SOCIAL DETERMINANTS

Several analyses have revealed that the risk factors associated with TB differ according to the disease's stage of pathogenesis.

Factors contributing to exposure to the disease

The likelihood of having a contact with TB is determined by the underlying disease burden in the community. People living and working in environments where TB prevalence is particularly high are at higher risk of infection. The risk of exposure is also determined by the physical environment in which the contact takes place, encompassing the aspects of crowding, airflow and humidity, including health care settings. Also, certain practices are known to favour contact with infectious droplets, such as sharing bottles or cans used for smoking marijuana and hashish. The case source's level of infectiosity is also a determining factor in the transfer of the infection. That level is generally linked to the site of the disease in the source case (e.g., laryngeal TB) as well as age (children are not at high risk of being contagious) and the disease's stage of advancement: presence of cough, cavities, which translate into an abundance of mycobacteria in expectorations (positive smears).

Factors raising the risk of transition from latent infection to the active form of the disease

Risk factors important at this stage include those that affect the host defense against infection, such as HIV infection, malnutrition, tobacco smoke, drug use, indoor air pollution, alcohol abuse, silicosis, diabetes, malignancies, immunosuppressive treatment and a range of chronic systemic illnesses, as well as depression and stress. The inoculums (quantity of bacilli to which the individual is exposed) is also likely to have a role in rapid development of the disease after infection. That element can also prove to be a determinant in the acquisition of the infection.

In an updated analysis applied to 22 high TB-burden countries, the population-attributable risk factor for selective TB risk factors indicated that malnutrition (27%), smoking (23%), diabetes (6%), harmful alcohol use (13%) and indoor air pollution (26%) were important risk factors. Their relative importance in a community would depend however on the prevalence of exposure to the factor in the community and can thus differ.

Factors with an impact on diagnosis, treatment and consequences of TB

These are factors related to delays in diagnosis and start of treatment, inadequately treated chronic diseases and difficulties in ensuring complete treatment. Many of these factors are related to accessibility of health services competent in the area of TB and with the appropriate tools.

The relation between socio-economic status and TB is based on the fact that persons in low socio-economic groups tend to have greater exposure to some or all of the risk factors previously mentioned. Persons with low socio-economic status tend to have more frequent contact with persons with active tuberculosis, higher likelihood of crowded and poorly ventilated living and working conditions, more food insecurity, higher levels of smoking, lower levels of awareness, less power to act on existing knowledge concerning healthy behaviors and poor access to health care services.

Evidence from around the globe suggests that the determinants of TB are not purely biomedical. Rather, there is a growing base of evidence to substantiate the strong pathways between TB incidence and various social and economic determinants, including malnutrition, crowded housing and inadequate ventilation, low levels of sanitation, low socioeconomic status and poverty, alcohol and drug abuse, high levels of stress and poor health care access (Baker, Das, Venugopal and Howden-Chapman 2008; Clark et al. 2002; Clark and Cameron 2009; Grzybowski and Allen 1999; Long et al. 1999).

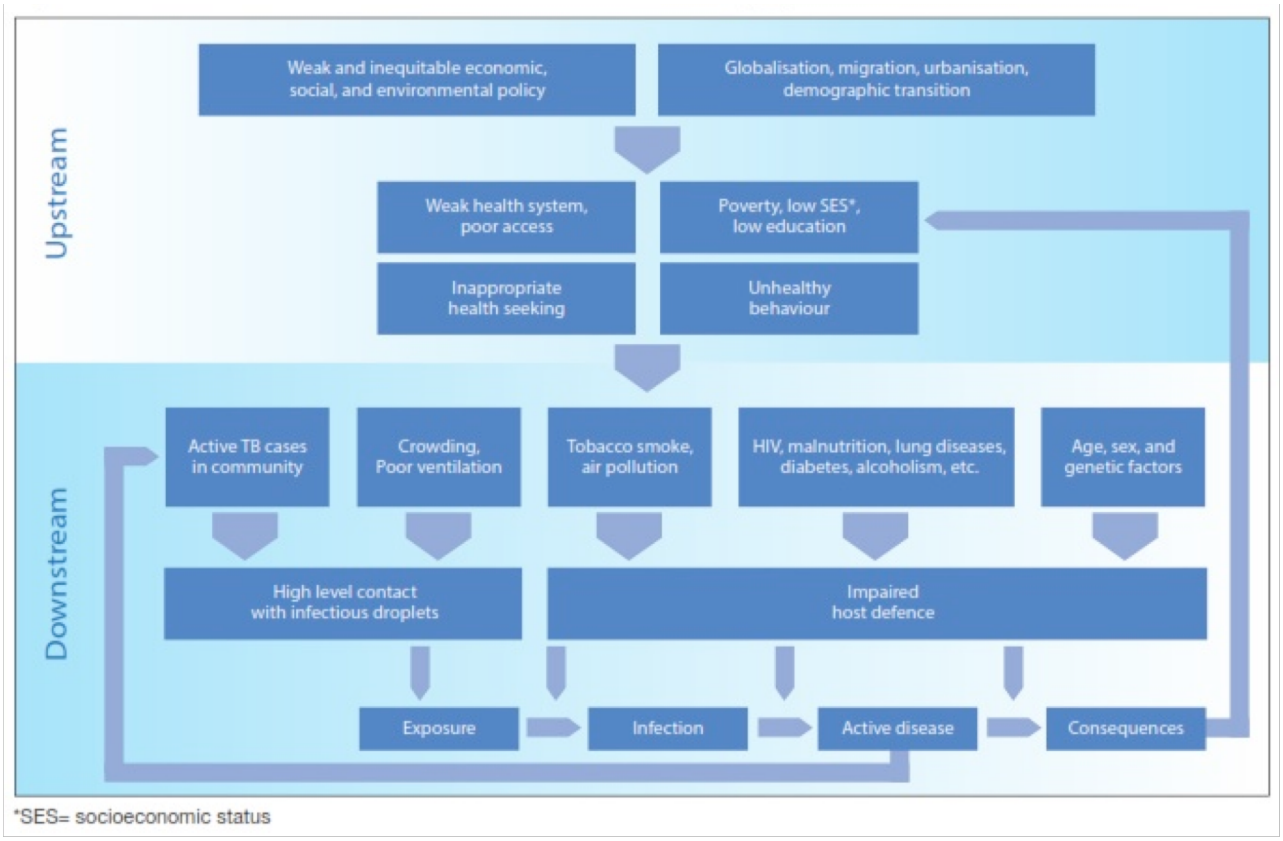
Several researchers have identified a positive relationship between household crowding and prevalence of TB in indigenous (Clark et al. 2002) and non-indigenous communities (Baker et al. 2008; Wanyeki et al. 2006).

Clark et al.'s (2002) study statistically examined the connection between household crowding and socioeconomic status and TB infection in First Nation communities in Canada. Wanyeki et al. (2006) also explored the association between TB and household crowding in Montreal; aboriginal peoples were not the focus of the study.

Source: Kulmann, K.C, et C.A.M. Richmond, "Addressing the persistence of tuberculosis among the Canadian Inuit population: The need for a social determinants of health framework", *The International Indigenous Policy Journal*.

The following figure reproduces the recently published WHO reference framework illustrating the interaction between the determinants and risk factors at various stages of the pathogenesis of TB:

Figure 1 – Framework for proximate risk factors and upstream determinants of TB



Factors contributing to the occurrence of outbreaks

In 2011, the Centers for Disease Control and Prevention (CDC) published a review of the outbreaks that occurred between 2002 and 2008 in the United States and in which the CDC intervened, in order to identify the contributing factors. The authors concluded that whereas outbreaks among immigrants were mostly associated with crowded living conditions and lack of access to health care, outbreaks involving mostly US-born persons were associated with substance abuse, homelessness and incarceration. One of the conclusions of this analysis was that the observed prolonged infectious period was the most common outbreak contributing factor.

In fact, persons reporting substance abuse are at particularly high risk of TB because of a combination of socio-behavioural and clinical TB risk factors. Not only do they tend to present higher prevalence of smear-positive status, often attributed to delayed diagnosis and pulmonary damage, but they are also more likely to experience prolonged infections

because of delay in seeking medical care. Transmission of infections is also favored by the fact that their sharing of drugs often occurs in poorly ventilated settings such as drug houses. Another characteristic is the difficulty of identifying the contacts of active cases as the patients often want to protect the names of person with whom they use drugs.

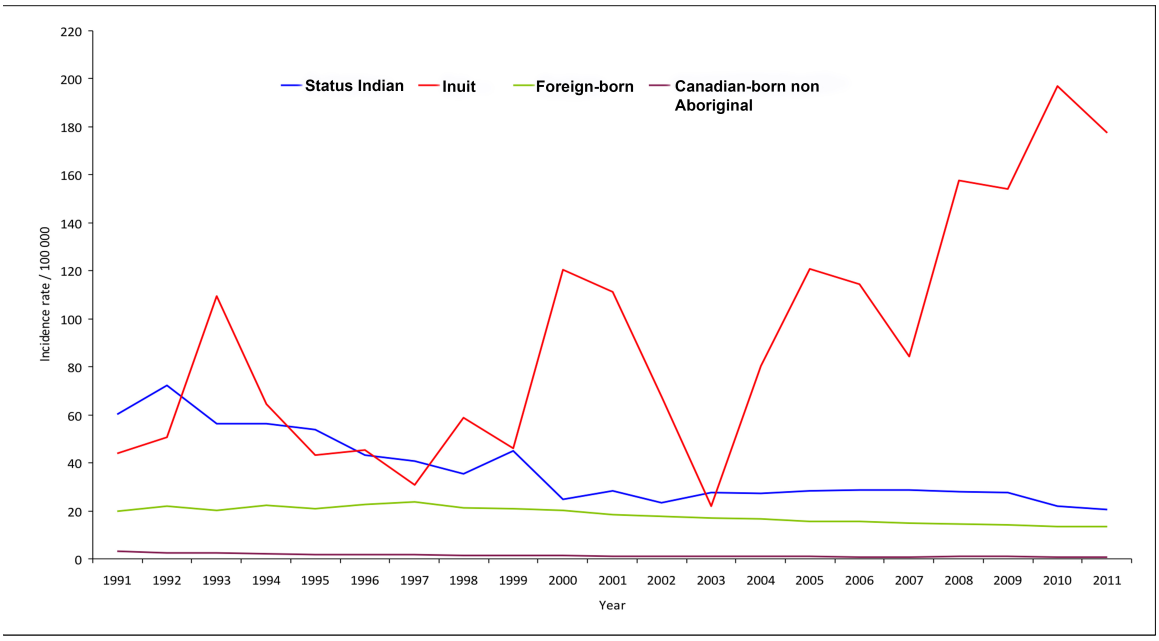
2.2 TUBERCULOSIS IN NUNAVIK

In Québec and Canada, TB was a major cause of morbidity and mortality throughout the first half of the 20th century. Thereafter, the incidence and mortality declined rapidly. Most TB cases in Canada now occur in two groups: the foreign born and members of aboriginal peoples.

Certain aboriginal populations continue to have an incidence of TB 10 to 20 times higher than the non-aboriginal Canadian-born population. There is however a wide variation in levels of disease and infection among aboriginal groups, and the Inuit population presents the highest incidence rate in the country (Figure 2).

The history of TB among the Inuit goes back to the time of their first contact with European settlers in the late 19th and early 20th centuries. Following rampant epidemics in the Inuit communities during the first half of the 20th century, dramatic declines were observed in the fifties and sixties. Four regions in Canada are the home of the majority of Canada's Inuit – Inuvialuit, Nunavut, Nunatsiavut and Nunavik – and out of those, the regions of Nunavut and Nunavik have recently reported increased incidence rates for the disease.

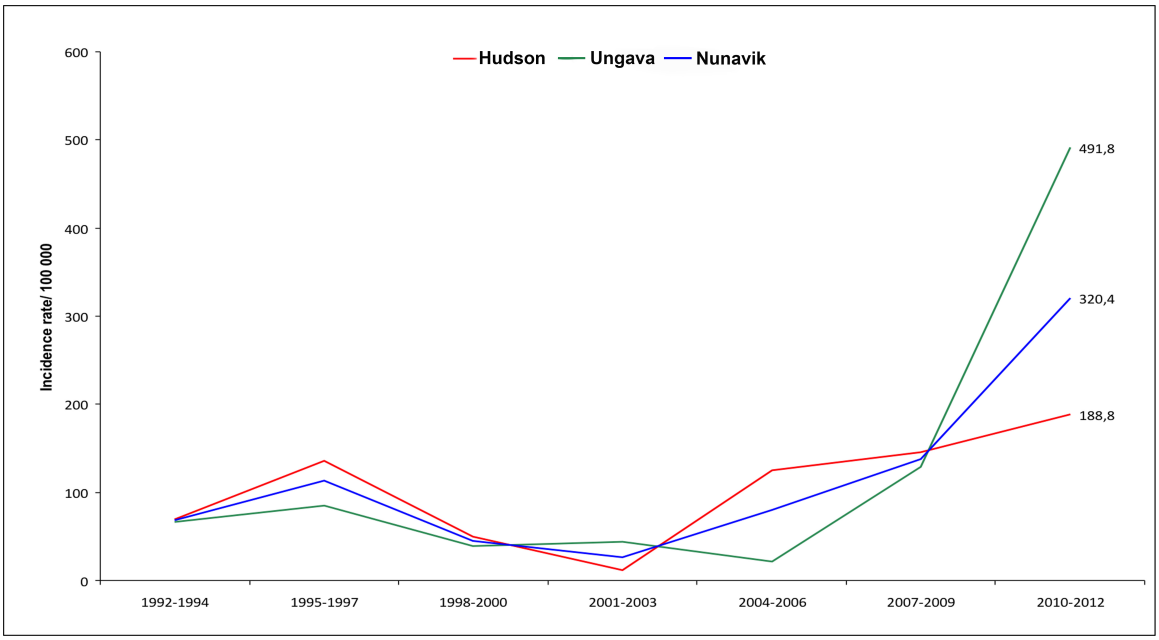
Figure 2 – Incidence rate of tuberculosis by origin, Canada, 1991-2011



- No data are available for Canadian populations before 1991.
- Not including individuals of mixed race or other aboriginals (such as non-registered Amerindians). Exact numbers of these populations are not available.
- Rates for 2011 are provisional and subject to change.

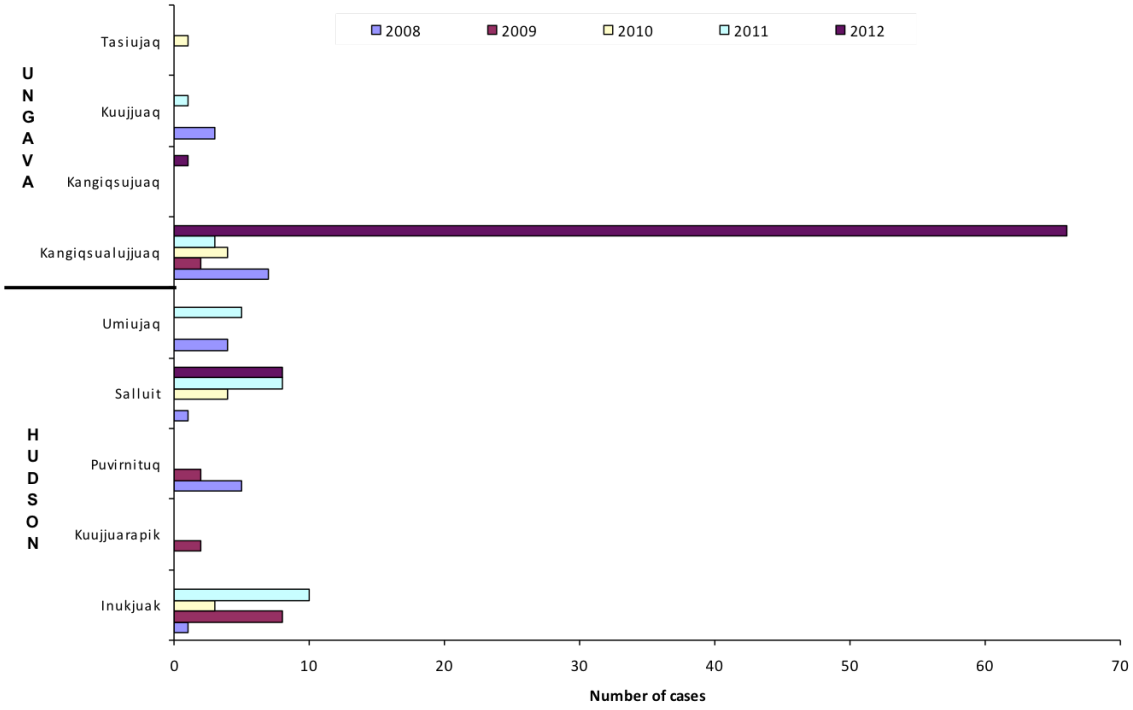
In Nunavik the incidence of active TB declined steadily from 1980 to 2003, from approximately 166 to 35 cases per 100,000 populations per year. Since 2007, however, the incidence of active TB in the region has been rising steadily, reaching a rate of 633.91 cases per 100,000 persons per year in 2012 (Figure 3). Neighbouring Nunavut has been observing a similar trend, reporting a rate of incidence of TB exceeding 300 cases per 100,000 persons in 2010.

Figure 3 – Incidence rate of tuberculosis sub regions and Nunavik, 1992-2012



In Québec, Nunavik is the region with the highest incidence of TB: 115.0 cases per 100,000 persons per year for the 2004-2007 period, compared to the rest of Québec (3.1 cases per 100,000 persons per year) and the Montréal region (7 cases per 100,000 persons per year). However, not all the communities have been affected; the distribution of cases per community over the past few years illustrates this (Figure 4). The current evolution of TB in Nunavik indicates that certain communities appear to be more at risk than others for the occurrence of active cases of TB. Further, in those communities at higher risk, there are social networks characterized by a greater vulnerability to TB and which may play an important role in the transmission of the disease.

Figure 4 – Cases of tuberculosis, Nunavik villages, 2008-2012 *



* Five communities did not report any cases of active tuberculosis between 2008 and 2012

A review of two recent outbreaks (one on the Hudson coast and the other on the Ungava) lead to the following observations:

- the persons most affected are those aged 15 to 35 years;
- source cases are often young persons who consult late and thus present with advanced cavitating pulmonary lesions as well as highly positive smears;
- gathering in poorly ventilated areas, either to consume drugs or to gamble, is a major risk factor for transmission;
- the high number of secondary cases in certain families also appears to be the result of the high rate of overcrowded housing prevalent in Nunavik. Among the risk factors identified in the literature, those present in Nunavik include the following:

Among the risk factors identified in the literature, those present in Nunavik include the following:

Factors related to exposure:

- overcrowded housing: the proportion of multi-family households is 13% compared to 0.8% for all of Québec. The average number of persons per private household is 4.1 compared to 2.3 for all of Québec;
- use of inhaled drugs (Santé Québec Inuit survey of 1992 and Qanuippitaa? 2004). In 2004, 60% of the Inuit (18 years and over) reported having consumed drugs during the preceding 12 months compared to 38% in 1992;
- prevalence of smoking: three out of four persons are smokers;
- food insecurity: close to 25% of the Inuit reported having experienced food insecurity during the year preceding the 2004 survey.

Factors related to health services:

- level of knowledge of the disease among the general population and among clinicians in particular. The disease is characterized as often evolving slowly and insidiously besides being relatively rare. In a context with a high prevalence of respiratory conditions, either as a consequence of tobacco smoking or other inhaled toxins or in relation to respiratory infections, suspecting the disease and diagnosing it early represent constant challenges;
- issues in adapting clinical practices to the cultural and organizational context. Turnover of clinical personnel and linguistic and cultural differences represent a challenge for the upgrade of knowledge and skills;
- challenges related to the duration of treatments and prevention. Treatment of the disease and elimination of the carrier state (latent TB infection) require regular and prolonged medication. The constraints are less onerous than during the days of sanatoriums, but patience and perseverance are always necessary;
- difficulties in epidemiological inquiries among contact cases in a context of activities considered or perceived as illicit (drug use, gambling, etc.). The full cooperation of the index cases is necessary to establishing and documenting the contact networks.

These factors contribute to the sometimes major delays in consultation as well as to late diagnosis of active, contagious TB, thus increasing the population's risk of exposure and the occurrence of secondary cases. The 2012 outbreak in Kangiqsualujjuaq is presently the subject of more in-depth research to evaluate the contribution of various factors to infection and development of the disease.

Moreover, it is pertinent to highlight certain elements of the regional epidemiology of TB, which demonstrates the rigour in historical management of the disease at both the population and the clinical levels:

a) rates of completed treatment (disease for which treatment is mandatory in Québec) and even prevention are very high;

b) very few cases (less than 1%) are resistant to any of the antibiotics routinely used to combat the disease, which greatly facilitates successful therapy and clinical follow-up for cases and contacts;

c) deaths attributable to the disease are rare, even though invasive cases (severe) occasionally arise;

d) to date, certain clinical conditions often linked to TB throughout the world have rarely been linked to the disease in Nunavik: HIV, severe diabetes in particular.

2.3 CONTROL OF TB IN NUNAVIK: THE PRESENT SITUATION

As elsewhere in Arctic Canada, from the end of the forties and especially during the fifties, Nunavik underwent massive intervention from the part of the federal government. The field of health was no exception: the fight against TB was then deemed a necessity given the extent of the epidemic among the Inuit population. In 1957, one adult Inuit in seven was in a sanatorium.

Around the end of the fifties and the early sixties, effective and safe anti-TB medications made it possible to follow up patients on an external basis as well as to carry out preventive efforts among contacts. That development, along with the advent of vaccines effective against certain severe childhood infections, accelerated the setup of nursing stations in the newly established communities. That model of service provision would prevail, especially on the Hudson coast, until the federal government's withdrawal from the field of health in 1980, following signature of the *James Bay and Northern Québec Agreement.*

At that time, the annualized practices of pulmonary X-rays, BCG and follow-up to cases and contacts were succeeded by public health protocols that made priorities out of early diagnosis of contagious cases, their isolation and treatment, the identification and evaluation of contacts and preventive measures destined for them, and the use of BCG among newborns and one-year-olds. Annual pulmonary X-rays were also abandoned for regular TB screening in the schools. A mass screening and prevention program for infected individuals was applied toward the end of the seventies on the Ungava coast and from 1983 to 1985 on the Hudson.

Those measures, combined during the eighties and nineties with a notable improvement in basic living and hygiene conditions, appear to have borne fruit, and the incidence rates of active TB then dropped to their lowest levels during the first decade of the new millennium, at 35 cases per 100,000 persons per year, a rate that is nevertheless 10 times higher than that for the rest of Québec for the same period. In 2004, upon the recommendation of the Québec immunization committee (*CIQ*), the administration of

BCG to newborns was abandoned, the benefits of that vaccine in terms of reducing the risk of invasive TB in children then being considered inferior to the risks of severe bcgitis, with deaths notably documented among First Nations children with innate or acquired immunodeficiency (HIV).

Since then, efforts to control TB have been focused principally on early identification and management, follow-up of cases of contagious TB, and evaluation and follow-up of individuals in significant contact with such cases, including the offer of preventive measures to infected persons (latent TB infection).

For the moment, Nunavik does not have a specific program for TB prevention and control with a precise objective. The 2012-2017 Québec provincial public health program indicates an objective of reducing TB incidence to 3.5 cases per 100,000 persons per year for Québec, but it does not include a specific objective for the region. However, the strategic plan of the Nunavik Regional Board of Health and Social Services (NRBHSS) aims for an objective of 10 cases per 100,000 for 2013 (NRBHSS Plan of Action 2010-2012, within the Strategic Regional Plan 2010-2016).

3. CONCLUSION: TIME FOR RENEWAL

The past few years have seen an unexpected turn in terms of the epidemiology of TB in Nunavik. The characteristics, in a way, reflect the consequences of several transitions that the population has undergone at many levels. Besides the efforts already deployed, we believe that community health services have an important role to play, as they constitute the front line of intervention. However, in line with the approaches recommended by TB experts worldwide, our opinion is that it is **necessary** to support a systematic, regional approach aimed at improving living conditions, an approach that particularly advocates action on the social and structuring determinants of TB.

Importance of addressing the population health determinants

The transmission of infection is fuelled by emerging environmental and social factors related in certain respects to those behind the outbreaks of the period from the thirties to the sixties: poverty and food insecurity, degradation of living conditions, use of products toxic to the respiratory tracts, notably tobacco and THC (tetrahydrocannabinol). Thus, a TB reduction action plan in Nunavik should emphasize the importance of mobilizing efforts toward improving the living conditions in the communities. This calls for effective and timely surveillance and identification of communities at risk as well as a systematic approach to address the determinants.

Importance of developing local competency

Recent events illustrate the difficulties and challenges in continuing to rely essentially on the early identification of cases and the interventions by the primary health care system for the control of TB. Health services in the North are characterized by a high turnover of health professionals, which requires continuous efforts to maintain awareness and competency in diagnosing and managing cases of active and latent TB infections.

Moreover, the presence of active TB cases in certain communities (and not others) calls for tailoring of intervention intensity according to local needs and for working with the most vulnerable groups.

Therefore, the overriding opinion is that a structured approach aimed at increasing community capacity for addressing TB should be introduced, at least in the communities currently affected by cases of TB. Given the social nature of the determinants of TB, an approach making use of local competencies in health would enable optimizing the health network's contribution to the control of TB, at least in those communities struggling with the disease repeatedly.

Based on the WHO's reference framework, three principal intervention strategies will therefore be proposed in the plan of action:

a) *Reinforcement of the front line health and social services system and local capacities*: interventions to maintain high-quality diagnostic and treatment of active cases of TB as well as of LTBI. This would include increased efforts to enhance community recognition of TB and participation as well as health-services capacity, establish criteria to identify communities at higher risk, implement, where appropriate, interventions for communities or groups at risk such as vaccination and screening, continuously update (and provide corresponding training) investigation, treatment and prophylaxis protocols, and enhance an outbreak-response plan;

b) *Optimization of public health programming aimed at reducing related risk factors*: interventions that strengthen public health programs that contribute to the prevention, treatment and management of malnutrition, smoking, diabetes, and alcohol and drug use. In the case of drug use, these include the adoption of environmental or harm reduction approaches that can decrease the risk of exposure to TB and other airborne transmissible conditions;

c) *Cross-sector interventions for action on the most distal determinants of the disease*: cross-sector interventions that address the upstream socio-environmental determinants such as housing, indoor air quality, food security, education and social, economic and political development. This includes seeking and supporting the commitment of all levels of government and community leaders.

Note that any actions on TB will have an impact on other respiratory conditions, which are notoriously prevalent in the region.

4. A REGIONAL PLAN AIMED AT REDUCING AND ELIMINATING TB IN NUNAVIK

4.1 PROPOSED VISION

Adhere to the WHO's vision.

Primary goal

Decrease and eliminate TB cases in Nunavik by 2040.

A step-by-step approach is proposed

By 2020: reduction in the annual incidence of active TB to 30 cases per 100,000 persons per year in Nunavik;

By 2030: 3.5 cases per 100,000 persons per year.

4.2 REGIONAL PLAN OF ACTION AND LOCAL PLAN OF ACTION

The Québec program for monitoring and controlling TB is based on the *Public Health Act* and the related ministerial regulations. Further, the TB intervention guide [*Guide d'intervention sur la tuberculose*] (2012 edition) serves as reference tool for all public health intervention following the declaration of a case of active TB in Québec.

The regional public health plan of action on TB constitutes our planning tool for adapting intervention on TB to the reality of the Nunavik territory. It is complemented by the local plans of action designed by the two health centres of the territory.

The regional plan aims to:

- better structure public health activities around essential public health functions: promotion of health and well-being, prevention and protection, and surveillance;
- identify regional and local responsibilities more clearly.

The strategic foundations are to:

- strengthen individual potential;
- support community development;
- support cross-sector actions favourable to health;
- support vulnerable groups;
- promote and support preventive clinical practice.

Based on a population approach and population responsibility, the regional and local plans invite the organizations and professional and institutional actors to act collectively on the determinants of health and to offer services that are accessible and better integrated.

4.3 PROMOTION OF HEALTH AND WELL-BEING

Principal strategies for action

- support for cross-sector action favourable to health and well-being;
- support for community development.

Objectives of intervention

1. Develop and consolidate regional and supraregional cross-sector partnerships with the goal of influencing decisions on the housing issue in Nunavik.
2. Raise and maintain the awareness of local and regional leaders on health determinants such as housing and respiratory diseases including TB.
3. Identify and promote effective use of harm-reduction measures in poorly ventilated spaces used for gatherings.
4. Maintain an optimal level of knowledge and mobilization in the communities at risk for TB.
5. Collaborate with public health programs that address risk factors associated with TB (food insecurity, nutrition, poverty, smoking, alcohol and other substance abuse, diabetes, HIV and other STBIs, etc.).

Expected results

By 2014:

- Adoption of harm-reduction measures to reduce exposure to TB in social gatherings in the prioritized communities.
- Health education initiatives on TB in the prioritized communities.

By 2017:

- Significant reduction of overcrowding rates in the prioritized communities.
- Adequate housing ventilation and air filtration in place in the prioritized communities.

Activities	Lead	Collaborators	Deadline	Comments/ follow-up / monitoring
Intervention 1: Strengthen cross-sector partnership to improve housing conditions in the region				
1.1 Define a strategy for mobilization and collaboration with the partners on the issue of housing.	NRBHSS DPH			Resolution adopted by Board, June 2013 Report from Acting regional Public Health Director, *Where we live matter*, June 2013
1.2 Implement the housing component of the Nunavik Plan	Makivik KRG KMHB	NRBHSS DPH Government of Quebec		
Intervention 2: Conduct media advocacy campaign on issues of overcrowding and respiratory disease in the region				
2.1 Establish a profile of respiratory infections in Nunavik in relation to environmental issues including housing	DPH	PHAC FNIB		
2.2 Develop a regional communication plan for maintaining awareness of TB among the regional and supraregional partners and the population	DPH			
Intervention 3: Promote harm reduction approaches in prioritized communities				
3.1 Identify and promote aeration and filtration systems to improve air quality in homes.	KMHB KRG SHQ INSPQ	INSPQ (environmental health) DPH		
3.2 Produce and circulate a brief summary of the state of knowledge and evidence on gathering places as factors of TB transmission	DPH	INSPQ		
3.3 Identify the main gathering places in the communities for application of measures for improving air quality and provide information on the risks of exposure	Municipalities CWW	DPH HCs CLSCs		
3.4 Support the Community Wellness Workers in harm-reduction efforts	HCs CLSCs	DPH		Role for nurses in infection prevention and control of HCs
Intervention 4: Mobilize prioritized communities towards prevention and control of TB				
4.1 Develop and offer educational initiatives on TB in prioritized communities	DPH HCs CLSCs	ACSP Schools Health Committees		
Intervention 5: Support public health actions on the risk factors related to TB				
5.1 Collaborate with the public health programs **targeting** the risk factors related to TB: HIV, diabetes, smoking, THC use and other determinants that have an impact on TB, such as nutrition and food security	DPH: see other public health program	Health Committees		

4.4 PREVENTION ET PROTECTION

Principal strategies for action

- promotion of and support for preventive clinical practice;
- reinforcement of individual potential;
- support for vulnerable groups.

Objectives of intervention

1. Support the organization of community services and local, front-line services in the application of clinical measures related to TB in Nunavik, notably:
    - rapid identification and efficient management of cases of active TB as well as contacts;
    - optimal follow-up of active cases under treatment as well as infected persons (LTBI).
2. Support community commitment and participation, **notably those at high risk**, in setting up local measures for the prevention and control of TB.
3. Optimize the regional plan in case of outbreak.

Expected results

By 2014:

- Update, in all CLSCs and HCs on the territory, of:
    - protocols for standardized clinical practices;
    - standardized monitoring tools;
    - a protocol for rapid and efficient response to outbreaks;
    - a TB-prevention program for health workers.
- Delivery of specific interventions in prioritized communities.
- Delivery of a regional communication plan that includes specific actions for prioritized communities.

Activities	Lead	Collaborators	Deadline	Comments/ follow-up / monitoring
Intervention 1: Support the organization of community services and local front-line services throughout the territory				
Design, update and circulate a reference document on TB for each HC and CLSC including: -The roles and responsibilities of various authorities; -The protocols to follow; -The follow-up and monitoring tools to use	DPH	HC CLSC	December 2013 (design) 2014 (circulation)	
1.2 Develop or **update** and circulation standard protocols for treatment and follow-up of active TB and LTBI	HC DPH	TB Experts	2013	
1.3 Develop training tools on TB which are easily accessible to the health professionals	HC DPH	INSPQ DTLC	2014	Link with training provided at the beginning of employment Link with the Regional Medical Department
1.4 Develop and implement an occupational health plan on TB for health workers	HC	DPH	2013	
Intervention 2: Implement specific measures for prioritized communities				
2.1 Identify the communities to be prioritized	DPH	HC CLSCs	2013 and on-going	
2.2 Develop and carry out epidemiological evaluations to identify, for each targeted community, the specific transmission factors, including vulnerable social networks	DPH	PHAC HC INSPQ	2013	Establish collaborative partnership
2.3 Establish consensus on the use of BCG	Quebec immunization committee	DPH MSSS-INSPQ	2013-2014	
2.4 Identify the required screening interventions	DPH	Experts	2013	
2.5 Set up and support a follow-up committee for prioritized communities	DPH	INSPQ HC CLSCs concerned	2013	
2.6 Develop and implement a specific clinical and community intervention plan for each prioritized community	DPH CLSCs	PHAC	June 2013	
2.7 Reinforce the role of the community nurses and CWW in the management and follow-up of TB in these communities	HC CLSCs			

Activities	Lead	Collaborators	Deadline	Comments/ follow-up / monitoring
2.8 Provide specific training for local interveners (physicians, nurses and community workers) of these communities	DPH	HC CLSC	2014	
2.9 Develop and implement a local communication plan for the prioritized communities	DPH	HC CLSC	2014	
2.10 Circulate timely surveillance reports on the TB situation for each prioritize community	DPH		Quarterly	
Intervention 3: Optimize a regional response in case of outbreak				
3.1 Identify the strengths and weaknesses of the response to the outbreak in Kangiqsualujjuaq	DPH	Montreal DPH HC CLSCs concerned	April to May 2013	Report done and distributed August 2013
3.2 Develop and adopt a response plan that identifies the mechanisms for coordination, communication and follow-up in case of outbreak in a community	DPH	HC CLSC Montreal DPH	2013	Support local skilled resources for outbreak investigation and follow-up Establish partnership with DPH of Montreal for access to public health capacity in TB outbreak control Regional mobilization plan for outbreak response

4.5 MONITORING, EVALUATION AND RESEARCH

Objectives of intervention

1. Consolidate the regional system for monitoring and following up TB.
2. Support research activities on TB in Nunavik.
3. Monitor the impact of the plan of action.

Expected results

By 2013:

- Identification of a system for monitoring and managing cases which responds to regional needs.
- Identification of follow-up indicators in the plan of action.

By 2014:

- Implementation of the system for monitoring and managing TB cases in the communities at risk.

Activities	Lead	Collaborators	Deadline	Comments/ follow-up / monitoring
Intervention 1: Optimize the regional system for surveillance and follow-up of TB				
1.1 Evaluate the needs for monitoring TB at the local, subregional and regional levels	DPH	PHAC HC CLSCs *MSSS (SI-PMI)* *INSPQ*	Spring 2014	
1.2 Create and maintain a regional and subregional TB and LTBI register	DPH HC CLSC	PHAC *INSPQ*	December 2014	
1.3 Revise and validate current tools for gathering information and monitoring	DPH	PHAC *INSPQ*	2014	
1.4 Design and maintain a computerized system for follow-up of TB and LTBI cases for the CLSCs, linked to the regional register (1.2) and compatible with the Panorama system	DPH	*MSSS* PHAC NRBHSS: informatics resources	2014	
1.5 Set-up activities for follow-up, evaluation and research to support implementation of the TB plan, including: Identification of indicators to monitor the plan of action Ongoing monitoring of the economic burden of TB and other preventable respiratory conditions Evaluation of interventions Monitoring of regional public housing and indoor-air quality issues, food security and nutrition	DPH	*INSPQ* University sector		

5. CONDITIONS FOR APPLICATION AND MANAGEMENT OF THE REGIONAL PLAN

The following conditions have been deemed necessary to successful application of the present plan of action. In effect, the actions and activities presented will only produce the expected effects to the extent where the plan is widely adopted and supported by all the regional and provincial authorities concerned with the problem of TB in Nunavik and in Québec.

For that purpose, we consider it essential to set up the following measures:

By 2013:

- setup of a Québec committee responsible for supporting and following up the objective of reducing and eliminating TB in Nunavik as well as a regional committee responsible for applying a regional plan of action on TB in Nunavik ;
- production of annual reports on the application of the measures in the plan of action on TB in Nunavik.

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9.8 Home and Community Care Service Delivery Plan

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Plan de prestation des services du Programme de soins aux personnes en perte d'autonomie du Nunavik

Novembre 2017

Santé Canda, DGSPNI, Programme soins à domicile et en milieu communautaire

Révisé le 23 janvier 2018 par : Michèle Béchard, infirmière conseil

Approuvé le 23 janvier 2018 par : Marie-Josée Lévesque, coordonnatrice intérimaire, programme de soins à domicile et en milieu communautaire

Élaboré par Justine Grenier, agente de planification et de programmation
en collaboration avec
Maxime Labrecque, chef du programme PPA, Centre de santé Inuulitsivik
et
Guy Bergeron, chef du programme PPA, Centre de santé Tulattavik de l'Ungava

Pour la Direction de la planification et programmation
Régie régionale de la santé et des services sociaux du Nunavik

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Liste des acronymes

CBJNQ : Convention de la Baie James et du Nord québécois
CHSLD : Centre d'hébergement et de soins de longue durée
CLSC : Centre local de services communautaires
CPEJ : Centre de protection de l'enfance et de la jeunesse
CRJDA : Centre de réadaptation pour les jeunes en difficultés d'adaptation
CSI : Centre de santé Inuulitsivik
CSTU : Centre de santé Tulattavik de l'Ungava
e-HRTT : « *Electronic Human Resource Tracking Tool* »
e-SDRT : « *Electronic Service Delivery Reporting Template* »
ETC : poste équivalent temps complet
FSA : « Family Social Aid »
MSSS : Ministère de la santé et des services sociaux du Québec
PDSB : Programme de déplacement sécuritaire des bénéficiaires
PPA : Personnes en perte d'autonomie
PSDMCPNI : Programme de soins à domicile et en milieu communautaire des Premières Nations et des Inuits
PSOC : Programme de soutien aux organismes communautaires
RAMQ : Régie de l'Assurance-Maladie du Québec
RRSSSN : Régie régionale de la santé et des services sociaux du Nunavik
SSNA : Services de santé non-assurés
SAPA : Soutien à l'autonomie de la personne âgée
TPO : temps partiel occasionnel
TS : Travailleur ou travailleuse sociale

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Introduction

Les établissements du réseau de la santé du Nunavik bénéficient d'un financement de la part de Santé Canada dans le cadre du « Programme de soins à domicile et en milieu communautaire des Premières Nations et des Inuits (PSDMCPNI) » afin d'optimiser les soins et services offerts à domicile pour les personnes le nécessitant.

Les soins et services offerts à domicile par le réseau de la santé du Nunavik sont regroupés dans le Programme de soins aux personnes en perte d'autonomie (ci-après, le Programme). Le présent plan de prestation des services se veut une description des objectifs du Programme et des modalités qui soutiennent son actualisation. Il est à noter que le plan de prestation des services en constante évolution, s'adaptant aux besoins des populations, aux ressources disponibles, ainsi qu'aux meilleures pratiques reconnues.

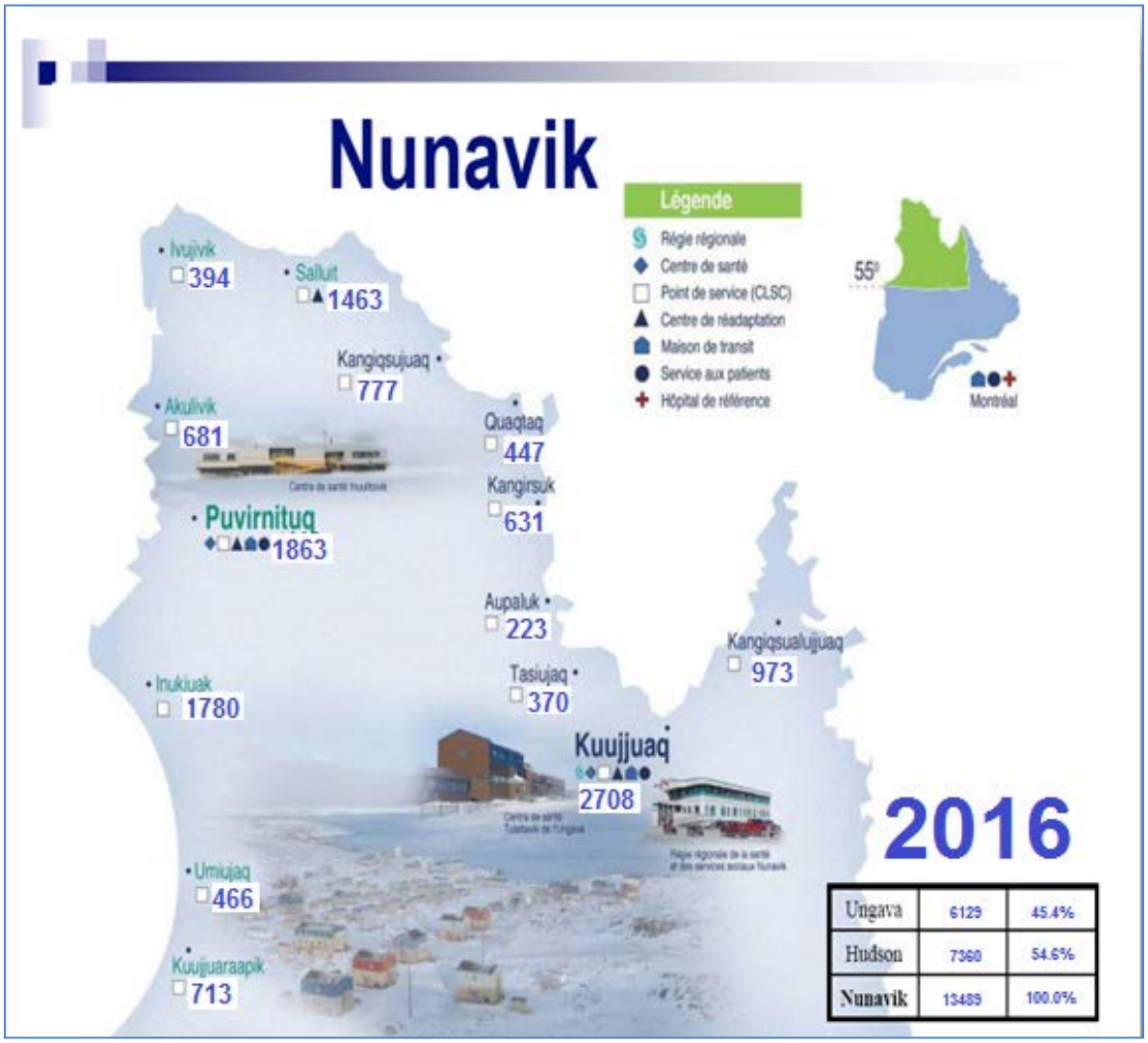
Avant d'entrer dans les détails spécifiques au Programme, il importe de bien décrire les particularités de la région. Nous verrons donc dans la prochaine section la situation géographique du Nunavik, son profil sociodémographique, l'état de santé de sa population et la structure de son réseau de la santé.

1. Description de la région du Nunavik

1.1 Situation géographique

Le Nunavik est un territoire inuit de plus de 500 000 kilomètres carrés, situé au nord du 55e parallèle. C'est la région la plus « nordique » du Québec, et aussi la plus isolée. En effet, seuls l'avion et le bateau, lorsque la navigation est possible, relient le Nunavik au reste du Québec. Au niveau local, ces deux moyens de transport (et la motoneige en hiver), permettent de se déplacer d'un village à l'autre.

Figure 1 : Carte du Nunavik



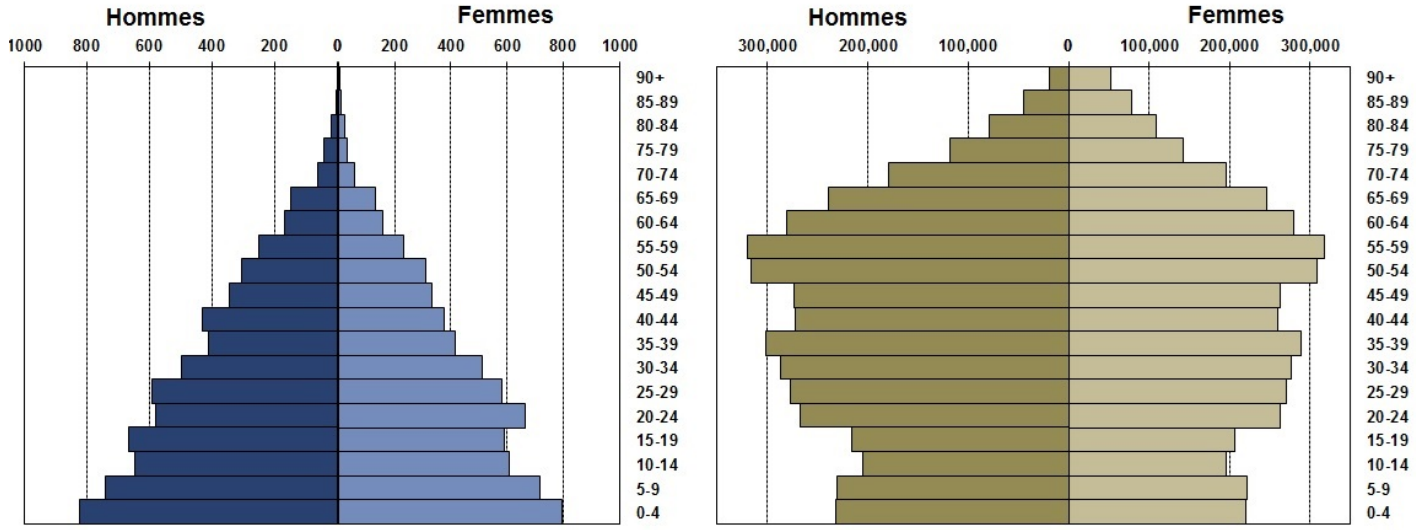
Source : INSTITUT DE LA STATISTIQUE DU QUÉBEC. Municipalités - Population totale, 1996-2016. [Document électronique]. http://www.stat.gouv.qc.ca/statistiques/population-demographie/structure/index.html

1.2 Portrait sociodémographique

Les quelques 13 500 habitants du Nunavik, dont plus de 91% sont Inuits, sont dispersés dans 14 villages le long de la baie et du détroit d'Hudson à l'Ouest, et de la baie d'Ungava à l'Est. Ces deux côtes, qui comptent chacune sept villages, forment les deux sous-régions du Nunavik. La densité de population est très faible, soit moins de 0,02 habitant par kilomètre carré[1]. Tel qu'il appert sur la carte ci-dessus, la répartition des habitants par village est grandement inégale, passant de près de 200 (Aupaluk) à plus de 2 700 (Kuujjuaq). Le tableau à la page suivante montre la répartition de la population selon les groupes d'âge dans chacune des communautés du Nunavik.

L'âge médian de la population du Nunavik est de 22,8 ans, soit environ la moitié de celui du reste du Québec (41,5 ans)[2]. Plus du tiers (34 %) de la population du Nunavik est âgée de moins de 15 ans, contre 16 % pour l'ensemble de la province[2]. Par ailleurs, la proportion des personnes âgées de 65 ans et plus, qui comptaient pour seulement 3 % de la population totale du Nunavik en 2011, devrait atteindre 8 % en 2031[2]. La figure suivante montre les différences dans la répartition des groupes d'âge au Nunavik, comparé à l'ensemble du Québec.

Figure 2 : Pyramides des âges, Nunavik et Québec, 2016



Nunavik, 2016 Québec, 2016

Source : INSTITUT DE LA STATISTIQUE DU QUÉBEC. Municipalités - Population totale, 1996-2016. [Document électronique]. http://www.stat.gouv.qc.ca/statistiques/population-demographie/structure/index.html

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Tableau 1 : Population des municipalités du Nunavik en 2016 par groupe d'âge

Nom de la municipalité		Groupe d'âge																			
		Total	0-4	5-9	10-14	15-19	20-24	25-29	30-34	35-39	40-44	45-49	50-54	55-59	60-64	65-69	70-74	75-79	80-84	85-89	90+
		n																			
Côte de l'Hudson	Kuujjuarapik	715	85	75	65	60	75	60	50	30	45	40	45	35	20	10	10	5	0	0	5
	Umiujaq	475	60	55	45	50	60	35	25	20	30	25	25	10	10	15	10	0	0	0	0
	Inukjuak	1,800	215	220	170	155	155	155	155	100	105	110	75	60	40	25	25	20	10	5	0
	Puvirnituq	1,875	240	210	210	195	170	140	155	110	105	80	70	60	45	45	15	10	10	0	5
	Akulivik	685	85	85	75	70	60	45	55	55	30	20	25	30	25	15	5	5	0	0	0
	Ivujivik	400	35	35	45	45	40	35	25	20	25	25	15	15	20	5	10	0	5	0	0
	Salluit	1,470	160	190	160	140	120	140	115	80	90	75	60	50	35	25	10	10	5	5	0
Côte de l'Ungava	Kangiqsualujjuaq	995	125	105	85	70	120	100	70	45	50	60	60	30	25	25	15	5	0	5	0
	Kuujjuaq	2,700	300	225	210	225	225	230	230	190	185	165	150	135	95	75	30	20	5	5	0
	Tasiujaq	355	55	40	30	50	35	25	20	25	20	15	10	10	10	5	5	0	0	0	0
	Aupaluk	210	20	20	25	15	20	35	25	10	10	5	10	10	0	5	0	0	0	0	0
	Kangirsuk	605	65	55	60	75	55	55	35	30	50	45	25	5	15	20	5	5	5	0	0
	Quaqtaq	455	60	50	30	40	55	50	35	30	20	5	25	20	10	10	5	0	10	0	0
	Kangiqsujuaq	790	95	90	70	75	85	70	55	55	40	45	35	30	25	15	5	0	0	0	0
	Total	13,530	1,600	1,455	1,280	1,265	1,275	1,175	1,050	800	805	715	630	500	375	295	150	80	50	20	10

Source : INSTITUT DE LA STATISTIQUE DU QUÉBEC. Population par groupe d'âge et sexe, 2001-2016. [Document électronique]. http://www.stat.gouv.qc.ca/statistiques/population-demographie/structure/index.html

1.3 État de santé

Comme son nom l'indique, le Programme de soins aux personnes en perte d'autonomie s'adresse aux personnes présentant des incapacités permanentes ou temporaires à se déplacer dans les établissements de santé pour recevoir leurs soins. La cause de ces incapacités peut être variée. Il existe malheureusement peu de données précises sur l'incidence et la prévalence au Nunavik des causes majeures d'incapacités (maladies, handicaps, déficiences, blessures, etc.).

Par ailleurs, l'enquête *Qanuipitaa ?* (« Comment allons-nous ? »), datant de 2004[3] a permis de documenter certains facteurs de risques associés à l'état de santé des Nunavimmiut, notamment liés aux maladies chroniques (maladies cardio-vasculaires, maladies respiratoires et cancer). En voici quelques-uns[4]:

- Près de 60 % des adultes présentaient un surplus de poids ou étaient obèses ;
- 5 % des adultes souffraient de diabète ;
- 89 % des Inuits ne suivaient pas les recommandations du Guide alimentaire canadien pour les fruits et légumes, et 94 % en ce qui a trait à la quantité de produits laitiers ;
- Trois adultes sur quatre (77 %) fumaient tous les jours ou occasionnellement ;
- 77 % des adultes buvaient de l'alcool de façon occasionnelle ou régulière, dont un quart affirmait avoir une consommation élevée d'alcool (cinq consommations ou plus) au moins une fois par semaine au cours de la dernière année.

De plus, un état de situation sur le cancer au Nunavik, complété en 2014, démontre que l'incidence du cancer est plus élevée dans la région, particulièrement pour les groupes d'âge plus jeunes, que dans le reste du Québec[5]. De plus, les infirmières de la région rapportent des taux importants de comorbidités, incluant un grand nombre de personnes avec des affections pulmonaires, qui affectent grandement l'autonomie des personnes et ainsi leurs besoins en soins et services à domicile.

[3] Une nouvelle enquête d'envergure, *Qanuilirpitaa ?* (« Comment allons-nous maintenant ? ») a été entamée à l'automne 2017. Les résultats de cette démarche devraient être disponibles au cours de l'année 2018.
[4] ANCTIL, M. (prepared by) (2008). Survey Highlights. Nunavik Inuit Health Survey 2004, Qanuippitaa? How are we? Quebec: Institut national de santé publique du Québec (INSPQ) & Nunavik Regional Board of Health and Social Services (NRBHSS).
[5] RRSSSN et CCSSSBJ (2014). Des soins et des services de qualité et culturellement adaptés pour les patients Inuit et Eeyouch atteints de cancer - État de situation, page 23.

1.4 Structure du réseau de la santé

La Convention de la Baie James et du Nord québécois (CBJNQ) et les conventions complémentaires ont établi les balises pour le développement des services de santé et des services sociaux sur le territoire du Nunavik. Sous la gouverne du système provincial québécois, l'organisation des soins de santé et des services sociaux est adaptée aux réalités de la région. De plus, la région bénéficie de certains programmes fédéraux spécifiques aux Premières Nations et Inuit, dont le PSDMCPNI et les services de santé non-assurés (SSNA).

Ainsi, le réseau de la santé du Nunavik est composé de trois (3) établissements : la Régie régionale de la santé et des services sociaux du Nunavik (RRSSSN), le Centre de santé Inuulitsivik (CSI) et le Centre de santé Tulattavik de l'Ungava (CSTU).

La RRSSSN a comme mandat d'adapter les programmes de services de santé et de services sociaux aux besoins de sa population et aux réalités de la région. En plus de l'organisation et de l'évaluation des programmes de services de santé et de services sociaux, la RRSSSN assure la gestion et l'utilisation efficace des ressources financières octroyées aux établissements de santé de la région du Nunavik.

Les deux centres de santé, soit le CSI pour la côte de l'Hudson, et le CSTU pour la côte de l'Ungava, assurent l'ensemble de la prestation des soins et services de santé et de services sociaux. Outre les services hospitaliers, les centres de santé assument les missions de centres locaux de services communautaires (CLSC), centres d'hébergement et de soins de longue durée (CHSLD), centres de protection de l'enfance et de la jeunesse (CPEJ), et centres de réadaptation pour les jeunes en difficultés d'adaptation (CRJDA).

Le Programme de soins aux personnes en perte d'autonomie s'inscrit donc dans le cadre de la mission CLSC des centres de santé. Tel que mentionné précédemment, le Programme souscrit aussi aux orientations ministérielles du Ministère de la santé et des services sociaux du Québec (MSSS). Le Programme fait partie intégrale du programme-service nommé « Personnes en perte d'autonomie » (PPA), qui est en fait l'ancienne appellation du programme du MSSS maintenant nommé « Soutien à l'autonomie de la personne âgée » (SAPA).

La prochaine section présente les détails du Programme.

2. Le Programme de soins aux personnes en perte d'autonomie

2.1 Vision, philosophie et énoncé de mission

La vision globale du Programme est de favoriser les services de proximité pour les personnes en perte d'autonomie, particulièrement en faisant du domicile la première option à considérer comme milieu de vie. De ce fait, l'engagement des proches-aidants est primordial et résulte d'un choix libre et éclairé. Aussi, lorsque le maintien à domicile n'est plus possible afin de garantir un environnement sécuritaire et sain, un milieu de vie substitut, le plus près possible du lieu privilégié par la personne et ses proches, peut être considéré.

Ainsi, le Programme repose sur une philosophie d'action qui implique que l'offre de services ne peut être considérée comme un simple « catalogue de soins » qui doivent nécessairement être offerts à la personne. Quatre (4) principes directeurs guident donc l'actualisation du Programme :

- La personne en perte d'autonomie nécessitant des soins doit pouvoir compter sur le soutien du réseau de la santé et des services sociaux pour lui assurer des services de proximité au sein de sa communauté ;
- Les soins aux personnes en perte d'autonomie s'inscrivent dans un continuum où les besoins et les choix des personnes sont placés au cœur de la planification, de l'organisation et de la prestation des services, afin d'assurer un accompagnement de qualité adapté à la condition de la personne, et ce, dans une approche collaborative ;
- Le maintien et l'accompagnement des personnes dans leur communauté, si elles le souhaitent et si leur condition le permet, doivent être privilégiés ;
- Le soutien accordé aux proches, aussi bien sur le plan physique que moral, s'avère incontournable puisqu'il constitue un élément fondamental de l'approche préconisée.

La mission du Programme est donc de pallier aux incapacités des Nunavimmiut afin de préserver et d'optimiser leur autonomie, par le biais de soins et services pertinents, sécuritaires, efficients, et de grande qualité, et ainsi favoriser le maintien dans le milieu de vie de leur choix le plus longtemps possible.

2.2 But et objectifs

Le but du Programme est donc d'établir les bases de la prise en charge des personnes en perte d'autonomie du Nunavik, de clarifier les mécanismes d'accès et les soins et services offerts. Les principaux objectifs du Programme sont donc :

- D'assurer un accès équitable aux soins et services dans chacune des communautés du Nunavik ;
- De fournir un accompagnement de qualité adapté à la condition de la personne, dans une approche de patient-partenaire ;
- De favoriser le maintien de la personne dans le milieu de vie de son choix, selon sa condition ;
- De soutenir les proches.

2.3 Aperçu du Programme

Les soins et services aux personnes en perte d'autonomie contribuent principalement à un grand objectif : le soutien à domicile. La notion de « domicile » se veut ici inclusive des milieux de vie substituts non-institutionnels, et implique donc que la personne peut demeurer dans sa propre maison, avec des membres de sa famille, dans une résidence pour aînés, ou tout autre milieu de vie qui n'offre pas les soins ou services nécessaires.

Ainsi, le soutien à domicile peut prendre diverses formes et est toujours modulé en fonction de la situation de la personne et de ses besoins, de son entourage et de son environnement. Le soutien à domicile repose sur une diversité de moyens, qui peuvent être regroupés en trois volets.

Le premier volet comprend les services destinés à la personne et ceux qui permettent d'agir sur son environnement immédiat, soit le noyau de base des services de soutien à domicile :

- Les soins et services professionnels (médicaux, infirmiers, réadaptation physique, services sociaux, etc.) offerts à domicile (ces services peuvent également être offerts en ambulatoire) ;
- Les services d'aide à domicile (aide domestique, soins d'hygiène, etc.) ;
- Les services de soutien aux proches-aidants (répit, dépannage, etc.) ;
- Le support technique requis à domicile (équipements, fournitures et aides techniques).

On peut aussi ajouter à ce volet l'adaptation du domicile, qui peut comprendre l'ajout de rampe d'accès pour fauteuil roulant, l'élargissement de cadres de portes, etc.

Le deuxième volet comprend les services au pourtour du domicile qui contribuent à l'objectif de soutien à domicile (comme les centres de jour, les activités de jour, les hôpitaux de jour, etc.), ainsi que les services généraux et spécialisés offerts en ambulatoire et en établissement par le réseau de la santé et des services sociaux.

Le troisième volet s'inscrit dans une perspective globale (sociétale) du soutien à domicile. Il regroupe les mesures relatives au logement, au transport adapté, à l'intégration sociale et professionnelle, les services municipaux, les mesures fiscales et les prestations destinées aux personnes ayant une incapacité et à leurs proches aidants, les mesures de conciliation travail-famille, etc.

Les soins et services aux personnes en perte d'autonomie faisant partie du Programme s'inscrivent donc spécifiquement dans le premier volet, avec quelques éléments complémentaires relevant du deuxième volet. Le Programme est évidemment offert en complémentarité des services généraux et spécialisés offerts par le réseau de la santé et des services sociaux. Les services offerts par le Programme seront expliqués plus en détails à la section 4 du présent document.

2.3.1 Profil de la clientèle du Programme

Le Programme de soins aux personnes en perte d'autonomie s'adresse à la clientèle de tout âge qui présente une ou des incapacités temporaires ou permanentes et qui doit recevoir une partie ou l'ensemble des services de santé ou de services sociaux requis pour assurer son bien-être ou sa santé à l'extérieur des installations du réseau de la santé.

La cause des incapacités peut être physique, psychique ou sociale. Ainsi, est éligible au Programme toute personne, peu importe son âge, qui rencontre les critères d'admissibilité et qui présente :

- Une altération temporaire ou permanente de son état de santé physique ou mentale ;
- Des incapacités provenant de maladies, de traumatismes, du processus du vieillissement ou d'une déficience physique, sensorielle, intellectuelle ou psychique ;
- Une période de perturbation ou de désorganisation dans l'accomplissement de ses rôles (personnes isolées socialement) ;
- Une situation de soins palliatifs et de fin de vie.

2.3.2 Critères d'admissibilité

Afin d'être admissible à recevoir des soins ou services du Programme, les conditions suivantes doivent être respectées :

- La personne demeure dans une des 14 communautés du Nunavik ;
- La personne nécessite un ou plusieurs soins ou services nécessaires à sa santé ou à son bien-être ;
- La personne ne peut se déplacer pour recevoir les soins et services nécessaires à sa santé ou à son bien-être ou encore il est jugé pertinent que la personne reçoive ses soins dans son milieu de vie. Plus spécifiquement, la personne doit être considérée comme « non-ambulatoire », c'est-à-dire qu'elle ne doit pas pouvoir se déplacer hors de son milieu de vie pour recevoir ses soins. Une personne qui nécessite de l'aide pour se déplacer n'est pas considérée comme non-ambulatoire, à moins d'être complètement isolée socialement. Le manque de transport n'est pas non plus un critère d'admissibilité au Programme ;
- Les soins et services nécessaires ne doivent pas être offerts par un autre programme ou une direction du centre de santé ;
- La personne est évaluée par un intervenant du Programme ;
- La personne accepte de participer au processus d'évaluation et à l'élaboration du plan d'intervention ;
- La personne accepte de recevoir les soins ou services établis ;
- Les soins ou services doivent pouvoir être dispensés de façon sécuritaire pour la personne, les proches et le personnel du centre de santé.

2.3.3 Cheminement de la demande et priorisation

Les demandes de soins ou services relevant du Programme peuvent provenir de la personne elle-même, d'un proche, d'un médecin, d'un professionnel de la santé et des services sociaux ou d'un autre établissement (par exemple, suite à une hospitalisation au Centre universitaire de santé McGill, à Montréal).

Les modalités de cheminement des demandes diffèrent selon les établissements, et peuvent aussi différer selon les communautés.

Ainsi, **au CSI**, il n'y a actuellement pas de mécanisme ou de formulaire spécifique pour adresser une demande de soins à domicile. Les demandes sont habituellement soumises directement aux infirmières du Programme (pour les communautés ayant une équipe dédiée) ou à l'infirmière-chef (pour les autres communautés).

Au CSTU, les demandes de soins ou services à domicile, verbales ou écrites, sont acheminées aux travailleuses sociales du Programme.

Compte tenu de la nature même des soins offerts par le Programme, toutes les demandes se doivent d'être analysées rapidement. Dans la mesure du possible, la prise de contact avec la personne s'effectue dans les 48 heures de la réception de la demande afin de débuter le processus d'évaluation.

Il est à noter que l'organisation actuelle des services et le nombre de demandes de soutien à domicile par communauté font en sorte que le personnel du Programme peut se mobiliser rapidement afin de répondre aux besoins de la clientèle. Il n'est donc pas nécessaire, présentement, d'établir des critères de priorisation des demandes.

2.3.4 Disponibilités des soins et services du Programme

Les soins et services du Programme sont essentiellement disponibles du lundi au vendredi, entre 9h et 17h.

Par ailleurs, certains soins ou services spécifiques au Programme, comme la relève à domicile et les soins de fin de vie, peuvent être offerts aux clients hors des heures régulières, advenant une situation particulière.

Aussi, les services de santé d'urgence sont disponibles dans toutes les communautés, avec des équipes de premiers répondants ou par les hôpitaux et les CLSC.

2.3.5 Droits et responsabilités du client

Les droits et responsabilités de la clientèle des centres de santé du Nunavik sont détaillés dans les codes d'éthique de chacun des établissements. En résumé, la personne qui reçoit tout soin ou service a le droit :

- De recevoir des soins de haute qualité, sécuritaires, efficients et respectueux;
- D'être partenaire dans la prise de décisions et la planification concernant ses soins, en collaboration avec ses proches ou toute autre personne de son choix;
- D'avoir un plan de soins qui tient compte de ses besoins en soins de santé ainsi que de ses besoins et objectifs sociaux, ainsi que de la capacité de ses proches à contribuer à ses soins ;
- De refuser les soins qui ont été recommandés.

En contrepartie, les clients du Programme ont les responsabilités suivantes :

- Agir comme un partenaire dans la prestation des soins, c'est-à-dire :
  - o fournir les renseignements requis et informer de tout changement dans son état qui pourrait avoir une incidence sur les soins ;
  - o contribuer à l'élaboration du plan d'intervention interdisciplinaire et le suivre, au meilleur de ses capacités ;
  - o être disponible lorsque vient le temps de recevoir des services à l'heure convenue ou informer de son absence ;
- Être courtois et respectueux envers les autres clients et les membres du personnel ;
- Fournir un environnement sécuritaire pour le personnel des centres de santé, notamment :
  - o isoler les animaux familiers dans une pièce à part au cours des visites, si on le demande ;
  - o ne pas fumer au cours des visites, si on le demande ;
  - o assurer que les accès à la résidence ne présentent aucun autre danger ;
- Faire bon usage de tout matériel ou équipement prêté par les centres de santé et le retourner dans les plus brefs délais lorsque requis ;
- Respecter les règlements et politiques des centres de santé.

Afin d'actualiser le Programme, les établissements du réseau de la santé se sont dotés d'une structure de gouverne, décrite à la prochaine section.

3. Structure de gestion du Programme

Afin d'assurer l'efficience et la qualité du Programme, une structure de gouverne régionale du Programme a été mise en place, composée d'un agent de planification et de programmation désigné au sein de l'équipe des affaires médicales et santé physique de la Direction de la planification et programmation de la RRSSSN et des chefs de programme PPA des centres de santé.

En conformité avec le mandat de la RRSSSN, mentionné au point 1.4 du présent document, le rôle de l'agent de planification et de programmation consiste à coordonner la mise en œuvre, le développement et le suivi des programmes pertinents. Ainsi, en étroite collaboration avec les chefs de programmes PPA, l'agent de planification et de programmation élabore et met à jour les cadres de références et plans d'action, en conformité avec les différentes exigences législatives et règlementaires, les orientations ministérielles, et les standards de pratiques reconnus. L'agent de planification et de programmation participe aussi aux mécanismes de suivi de l'entente, et veille à la saine gestion des ressources financières octroyées, en concertation avec ses collègues.

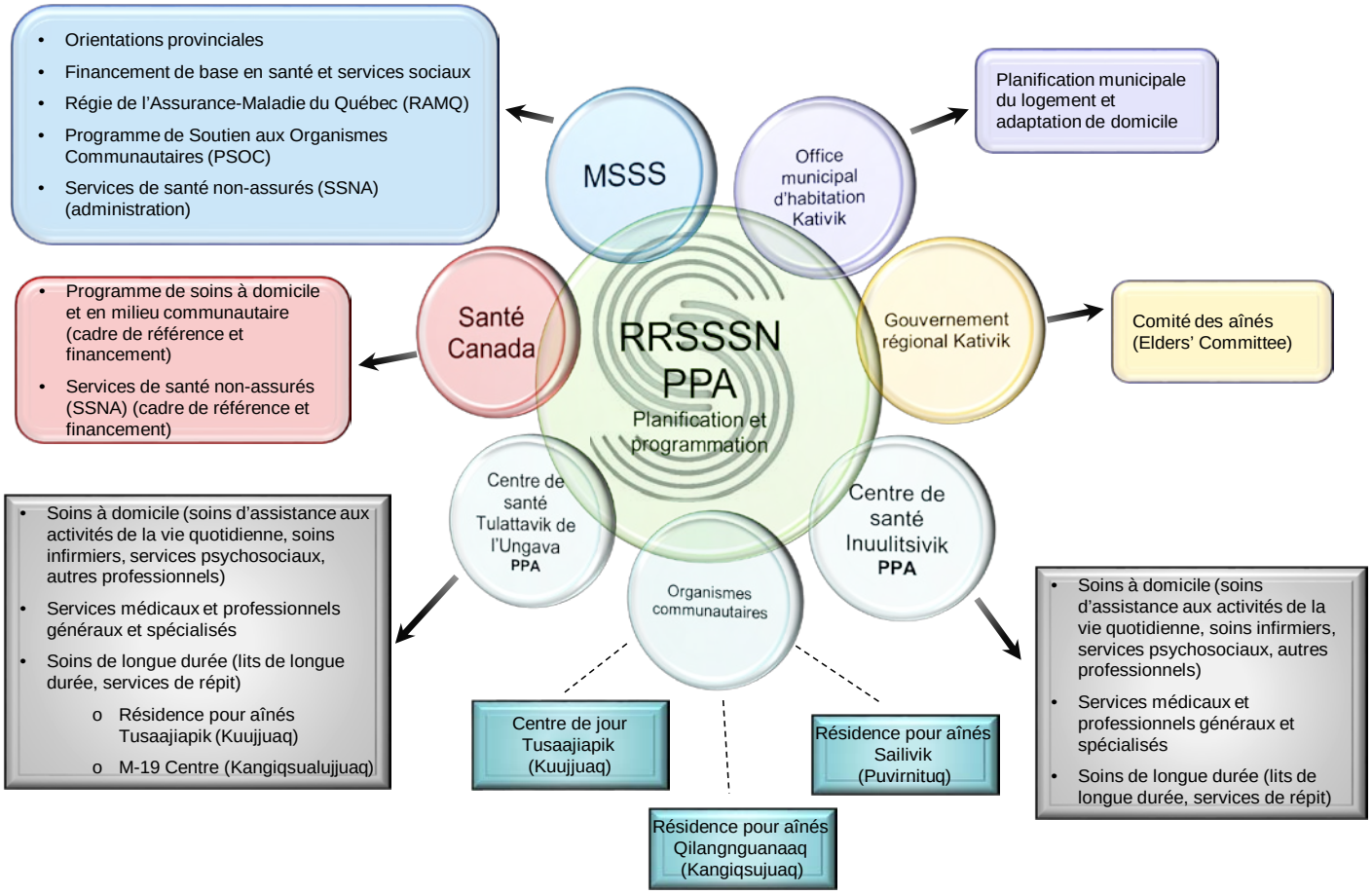
Les chefs de programme PPA des deux centres de santé assurent l'ensemble de la coordination clinique et l'actualisation des soins et services du Programme dans les différentes communautés. Ils sont aussi responsables de la gestion et de la supervision du personnel du Programme dans leurs établissements respectifs.

Au niveau régional, d'autres partenaires sont impliqués en ce qui a trait au soutien à domicile – en lien particulièrement avec le troisième volet mentionné au point 2.3, dont l'Office municipal d'habitation Kativik, le gouvernement régional Kativik, ainsi que certains organismes communautaires.

Le diagramme présenté à la page suivante présente, de façon simplifiée, l'architecture régionale du programme « Personnes en perte d'autonomie ».

Figure 3 : Architecture régionale du programme « Personnes en perte d'autonomie »

Architecture régionale du programme « Personnes en perte d'autonomie (PPA) »



Examinons plus spécifiquement la structure organisationnelle du Programme au CSI et au CSTU.

3.1 Centre de santé Inuulitsivik (CSI)

Rappelons que le CSI assure la prestation de soins et services sur la côte de l'Hudson, qui comprend les communautés d'Akulivik, Inukjuak, Ivujivik, Kuujjuaraapik, Puvirnituq, Salluit, et Umiujaq.

Le siège social du CSI, à Puvirnituq, comprend les services hospitaliers et un centre local de services communautaires (CLSC). Outre les services cliniques et de prévention, l'hôpital de Puvirnituq dispose de huit (8) lits de soins de longue durée. Les autres communautés de l'Hudson sont desservies par des points de services CLSC. Outre Puvirnituq, seuls les villages de Salluit et Inukjuak bénéficient d'une présence médicale en tout temps ; un médecin visite les autres communautés au moins une (1) semaine par mois.

Au CSI, les soins à domicile, sous la gouverne du programme « personnes en perte d'autonomie », relèvent de la direction des soins infirmiers. L'organigramme (simplifié) du CSI est disponible à l'annexe 1.

Le personnel dédié aux soins à domicile, sous l'autorité du chef de programme PPA, comprend une coordonnatrice, des infirmières, une thérapeute en réadaptation physique (TRP), et les « *Family Social Aids* » (FSA). Plus de détails concernant les rôles et services offerts par les différentes ressources humaines seront présentés dans la section des « Services offerts par le Programme » (page 22).

Au moment de la rédaction de ce document, seules les communautés de Puvirnituq, Salluit, et Inukjuak bénéficient de la présence à temps plein d'infirmières dédiées au Programme.

Certains soins et services offerts aux clients du Programme sont par ailleurs assurés par d'autres directions du CSI. Ainsi, certaines communautés n'ont actuellement pas d'infirmières dédiées aux soins à domicile ; la prestation des soins infirmiers à domicile est donc assurée par les infirmières des CLSC. De plus, les services d'ergothérapie et de physiothérapie, sont offerts aux clients du soutien à domicile par le biais de la Direction des services hospitaliers. Les services offerts par les intervenants psychosociaux, soient les travailleurs sociaux et les « *Community Workers* », sont assurés par la Direction des services sociaux.

Les ressources humaines du Programme sont financées par divers mécanismes, soit le PSDMCPNI, le budget de fonctionnement global de l'établissement, ou les fonds liés au plan stratégique régional (SRP).

On retrouve à la page suivante une figure représentant la structure organisationnelle des services à domicile offerts par le CSI, de même qu'un tableau qui présente le mode de financement des différentes ressources.

Figure 4 : Structure des services à domicile offerts par le CSI

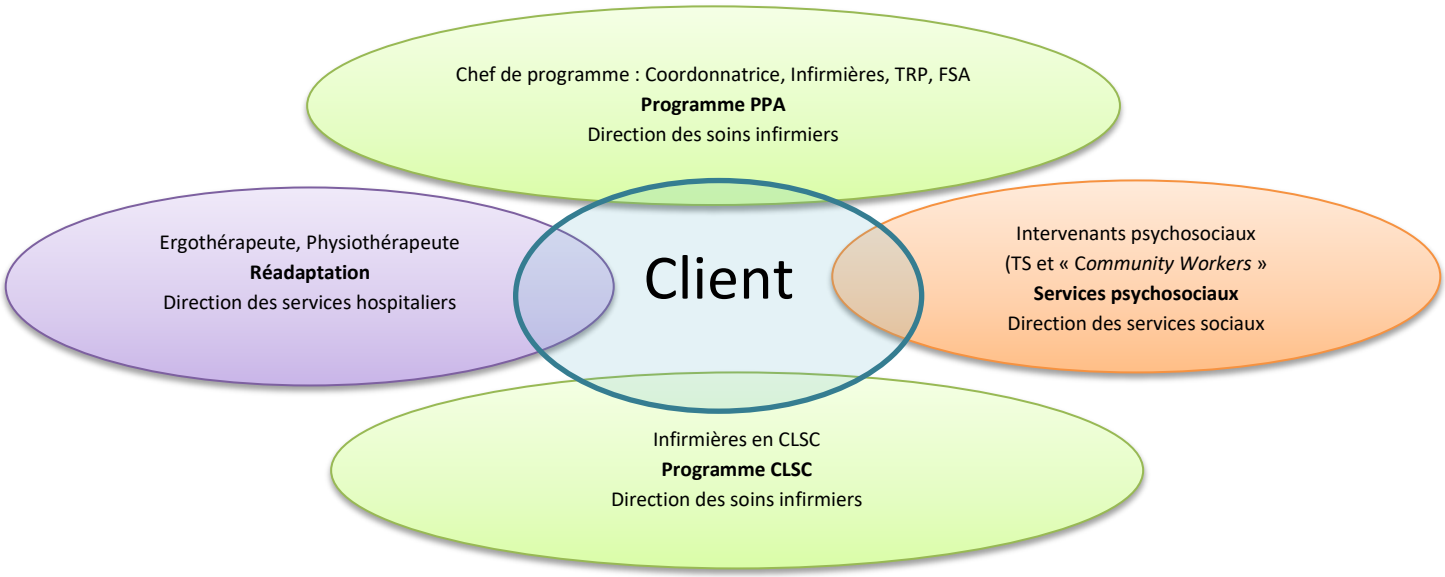


Tableau 2 : Mode de financement des ressources humaines, CSI, 2017

Titre d'emploi	Nombre de poste équivalent temps complet (ETC) dédié au Programme	Source de financement
Chef de programme	1	PSDMCPNI
Coordonnatrice	1	Budget global
Infirmières PPA	5	PSDMCPNI
« *Family Social Aids* »	4+	Budget global
Thérapeute en réadaptation physique	1	Budget global
Infirmières CLSC	0	Budget global
Ergothérapeute	0 (1 pour le CSI – multi-clientèle)	SRP
Physiothérapeute	0 (1 pour le CSI – multi-clientèle)	SRP
Intervenants psychosociaux	1	Budget global

3.2 Centre de santé Tulattavik de l'Ungava (CSTU)

Le CSTU assure la prestation de soins et services sur la côte de l'Ungava, qui comprend les communautés de Aupaluk, Kangiqsualujjuaq, Kangiqsujuaq, Kangirsuk, Kuujjuaq, Quaqtaq et Tasiujaq.

Le siège social du CSTU, à Kuujjuaq, comprend les services hospitaliers et un CLSC. Outre les services cliniques et de prévention, l'hôpital de Kuujjuaq offre dix (10) lits soins de longue durée. Les autres communautés de l'Ungava, soit Aupaluk, Kangiqsualujjuaq, Kangiqsujuaq, Kangirsuk, Quaqtaq et Tasiujaq, sont desservies par des points de service CLSC. Outre Kuujjuaq, seule la communauté de Kangiqsualujjuaq bénéficie d'une présence médicale en tout temps ; un médecin visite les autres communautés au moins une (1) semaine par mois.

Au CSTU, le Programme, sous la gouverne du programme « personnes en perte d'autonomie », relève de la direction des services communautaires. L'organigramme (simplifié) du CSTU est disponible à l'annexe 2.

Le personnel dédié au Programme est sous l'autorité du chef de programme PPA et comprend des infirmières, une équipe de réadaptation (ergothérapeute, physiothérapeute et TRP), des travailleurs sociaux (TS) et les « *Family Helpers* ». Plus de détails concernant les rôles et services offerts par les différentes ressources humaines seront présentés dans la section des « Services offerts par le Programme » (page 22).

Au moment de la rédaction de ce document, seules les communautés de Kuujjuaq, Kangiqsualujjuaq, Kangiqsujuaq, et Kangirsuk bénéficient de la présence à temps plein d'infirmières dédiées au Programme ; la prestation de soins infirmiers à domicile dans les autres communautés est donc assurée par les infirmières des CLSC, selon les besoins.

Comme pour le CSI, les ressources humaines du Programme sont financées par divers mécanismes, soit le PSDMCPNI, le budget de fonctionnement global de l'établissement, ou les fonds liés au plan stratégique régional (SRP).

On retrouve à la page suivante une figure représentant la structure organisationnelle des services à domicile offerts par le CSTU, de même qu'un tableau qui présente le mode de financement des différentes ressources.

Figure 4 : Structure des soins offerts à domicile par le CSTU

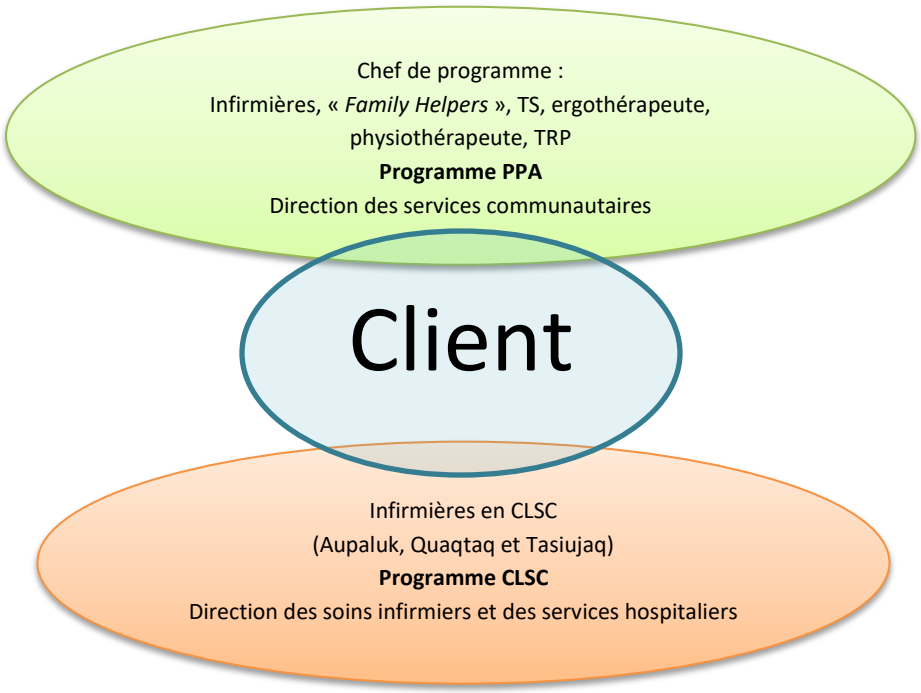


Tableau 3 : Mode de financement des ressources humaines, CSTU, 2017

Titre d'emploi	Nombre de poste équivalent temps complet (ETC) dédié au Programme	Source de financement
Chef de programme	1	PSDMCPNI
Infirmières dédiées	4.5	PSDMCPNI
« *Family Helpers* »	7+	Budget global
Travailleuses sociales	2	SRP
Thérapeute en réadaptation physique	2	1 - SRP 1 – PSDMCPNI (2017-2018)
Ergothérapeute	1	SRP
Physiothérapeute	1	SRP
Infirmières CLSC	0	Budget global

4. Services offerts par le Programme

Le cadre de référence du PSDMCPNI élaboré par Santé Canada identifie les services essentiels devant être dispensés dans les communautés, ainsi que des services complémentaires pouvant être offerts, selon les organisations et les ressources disponibles.

Tel que mentionné précédemment, les établissements de santé du Nunavik sont aussi régis par les lois, règlements et orientations ministérielles du MSSS. Conséquemment, certains soins ou services doivent être accessibles à toute la population, malgré leur caractère « complémentaire » dans le cadre du PSDMCPNI ; c'est le cas, par exemple, des soins palliatifs, qui font l'objet d'orientations précises au Québec depuis l'entrée en vigueur de la Loi concernant les soins palliatifs et de fin de vie, le 10 décembre 2015.

La prochaine section présente donc les services essentiels et complémentaires du Programme tels qu'indiqués dans le PSDMCPNI, tenant compte de l'organisation particulière des soins et services dans chacun des centres de santé et même de chacune des communautés du Nunavik.

4.1 Services essentiels

Les services essentiels devant obligatoirement faire partie du Programme comprennent : la gestion et supervision du Programme, les mécanismes d'évaluation des besoins du client, la gestion de cas, les soins infirmiers à domicile, les services d'assistance à la personne, la relève à domicile, les fournitures médicales, équipements médicaux et produits pharmaceutiques, ainsi que la cueillette d'information et de données.

4.1.1 Gestion et supervision

Certains mécanismes de gestion et de supervision du Programme sont décrits plus haut dans la section « Structure de gestion ». En complément des éléments déjà mentionnés, diverses modalités ont été mises en place afin d'assurer la qualité, la sécurité et l'efficience des soins et services offerts par le Programme.

De plus, les établissements du réseau de la santé du Nunavik sont aussi soumis aux lois, règlements et autres dispositions du MSSS qui dictent les règles concernant, entre autres, les processus de déclaration et de gestion des incidents et des accidents, l'autorisation de pratiquer et la supervision professionnelle des professionnels (infirmières, travailleurs sociaux, ergothérapeutes, physiothérapeutes, etc.).

Ainsi, différentes politiques et procédures, adoptées et mises à jour par les conseils d'administration des centres de santé, viennent encadrer les services offerts dans les établissements, incluant les soins à domicile. Chaque centre de santé possède donc son Manuel de politiques et procédures dont certaines sont en lien avec le Programme.

Il importe de rappeler que les chefs de programme PPA de chacun des centres de santé sont responsables de l'application du Programme au sein de leurs établissements respectifs. Ce sont donc eux qui s'assurent du bon fonctionnement du Programme, et assurent la gestion et la supervision des employés dédiés au Programme.

Aussi, **au CSI**, un poste de « Coordonnatrice PPA » a été créé afin d'assurer la coordination des services de soutien à domicile autres que les services professionnels. À cet effet, la coordonnatrice PPA est responsable de :

- La coordination des services de répit à l'hôpital ou à la résidence pour aînés *Sailivik* ;
- La gestion des prêts d'équipements ;
- La compilation des statistiques et l'entrée des données dans le e-SRDT ;
- L'organisation d'activités annuelles pour certains groupes de clients.

4.1.2 Évaluation des besoins du client

Pour obtenir des soins et services du Programme, tous les clients se doivent d'être évalués, afin non seulement d'établir leur admissibilité, mais aussi de bien cibler leurs besoins sur le plan bio-psycho-social. L'outil d'évaluation standardisé utilisé est l'« Outil d'évaluation multi-clientèle » (OEMC).

L'OEMC doit être complété par un professionnel de la santé, habituellement par une infirmière ou une travailleuse sociale. Dans la mesure du possible, l'évaluation doit être effectuée dans le milieu de vie du client. Au besoin, d'autres professionnels sont sollicités afin d'approfondir l'évaluation initiale.

Le client et ses proches participent activement à l'identification des besoins et des soins et services à mettre en place qui sont les mieux adaptés pour le client.

Suite à cette évaluation, les professionnels impliqués doivent rencontrer le client, en compagnie de ses proches (si le client le souhaite), afin d'établir un plan d'intervention et procéder à l'allocation des services. Le plan d'intervention peut être *disciplinaire* (un seul professionnel impliqué) ou *interdisciplinaire* (plusieurs professionnels impliqués), selon les besoins identifiés.

Le plan d'intervention détaille les objectifs et les résultats attendus, et identifie clairement le rôle et les actions de tous les partenaires impliqués. Le plan doit être réévalué périodiquement, au minimum une fois par année. Le plan est donc dynamique, et son suivi et sa mise à jour font partie intégrante des services du Programme.

4.1.3 Gestion de cas

Afin d'assurer la prise en charge et la continuité des soins et services, un gestionnaire de cas est assigné à chacun des clients.

Le gestionnaire de cas procède régulièrement à la réévaluation des besoins du client, à la mise à jour de son plan d'intervention et à l'organisation (ou réorganisation) de ses soins et services.

Le gestionnaire de cas coordonne aussi l'aiguillage et les liens avec les autres programmes, services, et ressources (incluant les partenaires externes), avec le souci constant d'optimiser la qualité et d'assurer la pertinence des soins et des services.

Le gestionnaire de cas est donc généralement le professionnel le plus significatif impliqué dans le plan d'intervention du client. **Au CSI**, le gestionnaire de cas est habituellement l'infirmière, alors qu'**au CSTU**, il s'agit de la travailleuse sociale.

4.1.4 Soins infirmiers à domicile

Les soins infirmiers sont la pierre angulaire du Programme. L'infirmière assume une responsabilité clinique continue et partagée avec l'équipe multidisciplinaire, le client, ses proches et les ressources de la communauté.

Les services offerts par les infirmières du Programme consistent principalement à :

- Évaluer et identifier les besoins de la personne et de ses proches ;
- Élaborer le plan thérapeutique infirmier (PTI) et participer activement à l'élaboration du plan d'intervention ;
- Prodiguer les soins requis, incluant la prise des signes vitaux, la surveillance de la prise de médication adéquate, les soins de plaie, l'administration des thérapies intraveineuses, les soins palliatifs et de fin de vie, etc. ;
- Transmettre l'information pertinente aux divers dispensateurs de soins et de services ;
- Enseigner au client et à ses proches comment participer aux soins ;
- Favoriser une approche de promotion des saines habitudes de vie et de prévention des maladies.

Toutes les infirmières au Nunavik sont membres de l'Ordre des infirmières et infirmiers du Québec (OIIQ).

Tel que mentionné précédemment, plusieurs communautés bénéficient d'infirmières dédiées aux soins à domicile, alors que d'autres en sont dépourvues. Lorsqu'une situation se présente dans une communauté qui n'a pas de personnel dédié, les infirmières des CLSC assurent la prestation de services.

La répartition des infirmières dédiées au Programme est comme suit :

- **Au CSI,** 4,5 postes équivalents temps complet (ETC) soit :
  - 1 ETC à Puvirnituq ;
  - 1 ETC à Salluit ;
  - 2 ETC à Inukjuak (dont 1 ETC « volant » qui dessert Umiujaq, Akulivik et Ivujivik, selon les besoins) ;
  - 0,5 ETC à Kuujjuaraapik;
  - Il est à noter qu'un ajout de 0,5 ETC devrait être annoncé sous peu, qui sera probablement assigné aux communautés d'Akulivik, Ivujivik et Umiujaq.
- **Au CSTU**, 4,5 ETC soit :
  - 1 ETC à Kuujjuaq ;
  - 1 ETC à Kangiqsualujjuaq ;
  - 1 ETC à Kangiqsujuaq ;
  - 1 ETC à Kangirsuk ;
  - 0.5 ETC à Quaqtaq.

Au besoin, et selon les ressources disponibles, l'ajout d'une ressource en soins infirmiers de façon temporaire peut être considérée. Lors des vacances ou autre absence d'une infirmière du soutien à domicile, **au CSI**, une infirmière inscrite sur une liste de rappel (TPO) assure le remplacement, alors qu'**au CSTU**, la relève est assurée par les infirmières des CLSC, selon les besoins prioritaires.

4.1.5 Service d'assistance à la personne

Les services d'assistance à la personne sont assurés par les « *Family Social Aids* » (FSA) au CSI et les « *Family Helpers* » au CSTU. Ces employés assurent l'aide aux activités de la vie quotidienne ou domestique dont pourrait avoir besoin le client. Les interventions doivent toujours se faire en collaboration avec l'équipe interdisciplinaire et selon le plan d'intervention, et autant que possible en collaboration avec le client et ses proches. Plus spécifiquement, les FSA et les « *Family Helpers* » peuvent :

- Assurer les soins d'hygiène personnelle, incluant le bain complet, partiel ou éponge ; les soins des ongles (ongles sains seulement) ; l'hygiène bucco-dentaire ; le rasage ; les soins de l'oreille ; les soins capillaires ; le changement de pansements secs ; etc. ;
- Assister à la mobilisation et aux transferts;
- Surveiller les indicateurs anormaux et aviser l'infirmière des problématiques particulières ;
- Participer au ménage léger et aux tâches ménagères que le client est incapable d'effectuer ;
- Aider le client pour la préparation des repas ;
- Assurer la sécurité physique du client et des lieux ;
- Fournir la relève à domicile ;
- Assurer la traduction entre les professionnels et les clients, au besoin.

Au CSI, il y a un minimum de 2 ETC FSA à Puvirnituq, 1 ETC à Salluit et 1 ETC à Inukjuak. Du personnel temps partiel occasionnel (TPO) est recruté si nécessaire, selon les besoins identifiés dans chacune des communautés.

Au CSTU, il y a un total de 7 ETC « *Family Helpers* », dont 2,5 ETC à Kangiqsualujjuaq, 2 ETC à Kangirsuk et 0,5 ETC chacun à Kuujjuaq, Kangiqsujuaq, Quaqtaq, Aupaluk et Tasiujaq.

4.1.6 Relève à domicile

Les services de relève à domicile sont un ensemble de mesures planifiées et identifiées au plan d'intervention qui permettent aux proches d'assumer certaines fonctions ou de se reposer. Ces services peuvent être fournis selon la disponibilité des ressources, habituellement, par les AFS ou « *Family Helpers* », mais il est possible qu'une infirmière puisse assurer le service, selon les circonstances.

4.1.7 Fournitures médicales, équipements médicaux et produits pharmaceutiques

La majorité des fournitures médicales, équipements médicaux et produits pharmaceutiques nécessaires à la prestation de soins sont fournis, gérés et entretenus par le centre de santé.

Suite à l'évaluation du client, l'identification des fournitures médicales, équipements médicaux et produits pharmaceutiques nécessaires pour maintenir ou promouvoir l'autonomie du client est notée au plan d'intervention.

L'équipement prêté à court ou moyen terme demeure la propriété du centre de santé. À cet effet, il est de la responsabilité de l'équipe multidisciplinaire d'assurer l'enseignement sur l'utilisation et l'entretien des équipements auprès du client et de sa famille. Certains équipements médicaux nécessaires à long terme ou de façon permanente peuvent nécessiter des démarches auprès des services de santé non-assurés (SSNA).

L'entretien préventif des équipements doit être connu de tout le personnel pour qu'ils soient utilisés de façon efficiente et sécuritaire.

Des considérations particulières quant aux fournitures médicales, équipements médicaux et produits pharmaceutiques, aux méthodes d'entretien des équipements, de même que les modalités de prêt, font partie du Manuel de politiques et procédures du soutien à domicile de chacun des centres de santé.

4.1.8 Cueillette d'information et de données

La cueillette d'information et de données fait partie intégrante du PSDMCPNI. Cet aspect est d'autant plus important car il permet d'être à l'affût des besoins fluctuants de la clientèle du soutien à domicile et d'adapter les services en conséquence.

La cueillette d'information et de données pour le soutien à domicile se fait principalement au moyen de deux (2) outils, soit le dossier unique du client (système I-CLSC), qui comprend minimalement les données nominatives, l'OEMC, le plan d'intervention, le PTI, l'allocation des services et les réévaluations (outil *profil évolutif de l'autonomie*), et les systèmes de données statistiques de Santé Canada (e-SRDT et e-HRTT).

Il est donc crucial pour tous les membres de l'équipe multidisciplinaire offrant du soutien à domicile de compléter les outils de façon adéquate.

4.2 Services complémentaires

Les services complémentaires comprennent tous les autres services pouvant être offerts à la clientèle du Programme, mais qui ne sont pas obligatoires dans le cadre du PSDMCPNI.

4.2.1 Services psychosociaux

Les **services psychosociaux** visent à offrir un soutien et un accompagnement au client ou à ses proches. Les intervenants psychosociaux comprennent les travailleurs sociaux (TS) et les « *community workers* ». Le rôle des intervenants psychosociaux consiste essentiellement à **:**

- Évaluer les besoins psychosociaux ;
- Informer le client sur les diverses ressources disponibles, les démarches à entreprendre, et le référer ou l'assister au besoin ;
- Aider les clients avec leur gestion financière, au besoin ;
- Assurer les démarches pour l'hébergement temporaire ou à long terme, au besoin;
- Supporter la personne et les proches en situation de crise.

Au CSI, 1 ETC TS est disponible pour la clientèle du Programme de la communauté d'Inukjuak. Pour les autres communautés, les TS des services généraux sont interpellées, au besoin. Des « *community workers* », soit des intervenants sociaux inuit, sont également disponibles pour intervenir, au besoin. Ces intervenants peuvent aussi assurer la traduction entre les professionnels et les clients et leurs familles. À Puvirnituq, 1 ETC « *community worker* » est assigné spécifiquement à la clientèle du Programme.

Au CSTU, 2 ETC TS sont dédiées à la clientèle du Programme. Les travailleuses sociales reçoivent les demandes de services à domicile et effectuent la majorité des évaluations à l'aide de l'OEMC. Une d'entre elles offre le suivi des clients dans la communauté de Kuujjuaq, alors que l'autre assure les services dans les autres communautés. Une des travailleuses sociales assure aussi la formation des intervenants à l'utilisation de l'OEMC et la supervision clinique à cet effet, et offre son support et son expertise dans les cas complexes.

4.2.2 Réadaptation

Les services de **réadaptation**, offerts par des ergothérapeutes, des physiothérapeutes ou des thérapeutes en réadaptation physique (TRP), visent à favoriser le confort et la sécurité du client à domicile, particulièrement en ce qui a trait à l'autonomie fonctionnelle, la gestion de la douleur et la prévention des chutes et des plaies de pression, en intervenant principalement sur les aspects suivants :

- Aménager le domicile de façon sécuritaire, incluant la prévention des chutes ;
- Assurer l'octroi d'équipements adaptés et spécialisés pour la mobilité, le positionnement au lit, le positionnement assis, la prévention et le traitement de plaies de pression (matelas et coussins spécialisés) ;
- Assurer les traitements en lien avec les problématiques causant ou aggravant une perte d'autonomie ;
- Apporter de l'aide dans le contrôle de la douleur : application de glace, positionnements, stimulation électrique transcutanée (sur recommandation médicale), etc. ;
- Enseigner les techniques de transfert, les programmes de mobilisation passive, d'exercices de renforcement et des techniques de massage sur recommandation médicale ;
- Enseigner les techniques de déplacements sécuritaires et les techniques de mobilisation (PDSB).

Au CSI, 1 ETC TRP, basé à Puvirnituq, est dédié à la clientèle du Programme et assure les services dans les autres communautés selon les besoins. Il y a aussi 1 ETC ergothérapeute et 1 ETC physiothérapeute, basés aussi à Puvirnituq, qui assurent les services à l'ensemble de la population mais peuvent être sollicités, au besoin.

Au CSTU, 2 ETC TRP, 1 ETC ergothérapeute et 1 ETC physiothérapeute offrent les services de réadaptation à l'ensemble de la population. Bien que ceux-ci soient basés à Kuujjuaq, ils assurent les services dans les autres communautés, selon les besoins.

4.2.3 Consultation en nutrition

Les services en **nutrition** sont interpellés lors de problématiques particulières d'alimentation, tel que la dysphagie, les troubles digestifs, la dénutrition, les diètes particulières, les gavages, etc. Les interventions consistent principalement à :

- Procéder à l'évaluation nutritionnelle ;
- Individualiser les recommandations alimentaires selon les problèmes rencontrés ;
- Supporter le client et ses proches dans les modifications à apporter à l'alimentation.

Au CSI, il n'y a actuellement aucune ressource en nutrition.

Au CSTU, 1 ETC nutritionniste pour l'ensemble de la population est interpellé au besoin pour la clientèle en soutien à domicile.

4.2.4 Soins des pieds

Les soins de pieds sont offerts par les infirmières qui sont formées pour ce faire. **Au CSI**, il n'y a présentement aucune ressource pouvant assurer le soin – certaines infirmières devraient être formées sous peu. **Au CSTU**, 2 infirmières assurent les soins de pieds (à Kuujjuaq et Tasiujaq) et peuvent se déplacer dans les autres communautés selon les besoins.

4.2.5 Milieux de vie substituts (« *Elders' Homes* »)

Sur la **côte de l'Hudson**, on retrouve à Puvirnituq une résidence pour aînés et personnes à mobilité réduite de huit (8) unités, nommée *Sailivik*. Cette résidence est un organisme communautaire qui offre l'hébergement, les repas, l'entretien ménager et certains soins de base (aide à l'hygiène) à ses occupants. Le personnel du soutien à domicile de Puvirnituq y assure les soins infirmiers et certains soins de base plus complexes, selon les besoins.

Du côté de la **côte de l'Ungava**, le CSTU assure la gestion et la prestation des soins dans une résidence pour aînés et personnes en perte d'autonomie à Kuujjuaq de 12 unités, nommée *Tusaajiapik*. Le centre M-19 ou *Akilasakalak*, à Kangiqsualujjuaq, est une résidence supervisée multi-clientèle qui offre 14 unités de logements pour personnes en perte d'autonomie, trois (3) unités adaptées pour les personnes avec déficience physique et deux (2) unités de transit pour les clients à court terme. À Kangiqsujuaq, on retrouve une résidence de dix (10) unités pour personnes âgées ou à mobilité réduite, *Qilangnguanaaq*, qui est un organisme communautaire qui offre l'hébergement, les repas, l'entretien ménager et certains soins de base (aide à l'hygiène) à ses occupants.

4.2.6 Service de relève en établissement

Le service de relève en établissement, aussi connu sous les termes « répit » ou « hébergement temporaire », est un ensemble de mesures planifiées et identifiées au plan d'intervention qui permet de fournir l'hébergement et les soins au client sur une certaine période afin de permettre aux proches d'assumer certaines fonctions ou de se reposer.

Au CSI : la clientèle du soutien à domicile peut avoir accès gratuitement à un service d'hébergement temporaire à l'hôpital de Puvirnituq ou à la résidence *Sailivik*, pour une période d'au plus 2 semaines par 3 mois. Il est possible pour les clients ou leur famille de se prévaloir d'une période plus longue, moyennant certains frais.

Au CSTU : la clientèle du soutien à domicile peut avoir accès gratuitement à un service d'hébergement temporaire à l'hôpital de Kuujjuaq ou à la résidence *Tusaajiapik*, pour une période d'au plus 2 semaines par 3 mois. Il est possible pour les clients ou leur famille de se prévaloir d'une période plus longue, moyennant certains frais.

4.2.7 Soins de jour pour adulte

Des travaux sont en cours afin de procéder à la réouverture du Centre de jour de Kuujjuaq, un organisme communautaire qui bénéficie du soutien du CSTU et de la RRSSSN. De plus amples de détails sur la structure et les activités du Centre de jour seront disponibles sous peu.

4.2.8 Soins palliatifs

Les soins palliatifs sont offerts au besoin par le personnel du Programme ou les infirmières des CLSC, selon les communautés, avec le soutien des médecins et d'autres professionnels. Tel que mentionné précédemment, plusieurs travaux en lien avec les soins palliatifs ont été entamés dans les dernières années suite à l'entrée en vigueur de la Loi concernant les soins palliatifs et de fin de vie, en décembre 2015. Entre autres exigences, les centres de santé doivent adopter une politique et un programme clinique en soins palliatifs et de fin de vie. Ces travaux devraient être finalisés au cours de l'hiver 2017-2018. Plusieurs efforts ont été déployés afin de promouvoir la formation et le soutien des professionnels du Nunavik en matière de soins palliatifs et de fin de vie, incluant l'élaboration d'un répertoire de formation en ligne, et la mise en place de service de consultance.

4.2.9 Transport

Chacune des communautés peut assurer le transport des personnes âgées ou à mobilité réduite grâce à des autobus financés par les municipalités.

4.2.10 Programme de repas

Il existe quelques groupes de cuisines collectives qui offrent le service de repas, dont à Inukjuak et Kuujjuaq. Chaque communauté offre aussi un service de « frigo communautaire », particulièrement pour le « country food » (nourriture traditionnelle). Ces services sont offerts par d'autres programmes des centres de santé, des organismes communautaires, ou la municipalité.

5. Prévisions budgétaires

Le Programme de soins à domicile du Nunavik bénéficie de financement de différentes sources, dont le PSDMCPNI. Une grande partie des services et soins offerts à la clientèle sont assurés par les budget d'opération des centres de santé. Le financement du PSDMCPNI est utilisé principalement pour couvrir les dépenses liées directement à la gestion du programme et au salaire des infirmières dédiées.

Des ajustements aux prévisions budgétaires des sommes allouées par le PSDMCPNI ont été effectués pour l'année 2017-2018 et suivante, suite à l'octroi d'une indexation de 3% du budget de 2016-2017.

Le budget alloué par le PSDMCPNI pour les années futures est nécessaire afin d'assurer le maintien des services tels que rendus actuellement. Un exercice de réflexion est en cours afin de revoir les allocations budgétaires, particulièrement dans un contexte d'octroi possible de nouveaux fonds. Les prévisions budgétaires seront donc ajustées en conséquence, au moment opportun.

Vous trouverez donc aux pages suivantes les prévisions budgétaires selon les montants connus. Le premier tableau présente l'entente flexible actuelle, pour les années 2016 à 2019. Le deuxième tableau présente les prévisions selon la prochaine entente à négocier, de type global, pour les années 2019 à 2024.

Tableau 4 : Prévisions budgétaires selon l'entente flexible actuelle, années 2016 à 2019

			2016-2017	2017-2018*	2018-2019*
1 - RESSOURCES HUMAINES ADDITIONELLES					
RRSSSN	1	Agent de planification et programmation	$173 398.00	$173 398.00	$173 398.00
		Formation du personnel	$60 000.00	$19 421.00	$19 421.00
		Logement	$29 000.00	$29 000.00	$29 000.00
		Sous-total :	**$262 398.00**	**$221 819.00**	**$221 819.00**
CSI	1	Chef de programme (infirmier)	$175 110.00	$175 110.00	$175 110.00
	5	Infirmières en communautés	$736 444.00	$818 271.00	$818 271.00
		Sous-total :	**$911 554.00**	**$993 381.00**	**$993 381.00**
CSTU	1	Chef de programme (infirmier)	$175 110.00	$175 110.00	$175 110.00
	4.5	Infirmières en communautés	$736 444.00	$736 444.00	$736 444.00
	1	Thérapeute en réadaptation physique	$0.00	$140 000.00	$140 000.00
		Sous-total :	**$911 554.00**	**$1 051 554.00**	**$1 051 554.00**
TOTAL (ressources humaines):			**$2 085 506.00**	**$2 266 754.00**	**$2 266 754.00**
2 - BUDGET D'OPÉRATION					
2.1 Entretien et remplacement de l'équipement et des fournitures médicales spécialisées pour la clientèle					
CSI	1	Entrepôt	$3 050.00	$3 050.00	$3 050.00
CSTU	1	Entrepôt	$3 050.00	$3 050.00	$3 050.00
		Sous-total :	**$6 100.00**	**$6 100.00**	**$6 100.00**
2.2 Équipement médical spécialisé					
CSI	1		$100 000.00	$45 000.00	$45 000.00
CSTU	1		$100 000.00	$45 000.00	$45 000.00
		Sous-total :	$200 000.00	$90 000.00	$90 000.00
2.3 Frais d'administration					
RRSSSN	1		$23 340.00	$23 340.00	$23 340.00
CSI	1		$30 000.00	$30 000.00	$30 000.00
CSTU	1		$30 000.00	$30 000.00	$30 000.00
		Sous-total :	$83 340.00	$83 340.00	$83 340.00
TOTAL (budget d'opération):			**$289 440.00**	**$179 440.00**	**$179 440.00**
GRAND TOTAL:			**$2 374 946.00**	**$2 446 194.00**	**$2 446 194.00**

***Sujet à modifications par Santé Canada**

Tableau 5 : Prévisions budgétaires selon l'entente à négocier, années 2019 à 2024

			2019-2020	2020-2021	2021-2022	2022-2023	2023-2024
		Budget annuel du PSDMCPNI*	$ 2,446,194.00	$ 2,446,194.00	$ 2,446,194.00	$ 2,446,194.00	$ 2,446,194.00
1 - RESSOURCES HUMAINES ADDITIONELLES							
RRSSSN	1	Agent de planification et programmation	$ 173,398.00	$ 173,398.00	$ 173,398.00	$ 173,398.00	$ 173,398.00
		Formation du personnel	$ 20,000.00	$ 20,000.00	$ 20,000.00	$ 20,000.00	$ 20,000.00
		Logement	$ 29,000.00	$ 29,000.00	$ 29,000.00	$ 29,000.00	$ 29,000.00
		Sous-total	$ 222,398.00	$ 222,398.00	$ 222,398.00	$ 222,398.00	$ 222,398.00
CSI	1	Chef de programme (infirmier)	$ 175,110.00	$ 175,110.00	$ 175,110.00	$ 175,110.00	$ 175,110.00
	5	Infirmières en communautés	$ 818,271.00	$ 818,271.00	$ 818,271.00	$ 818,271.00	$ 818,271.00
	1 annuel	Ressource professionnelle additionnelle	$ 163,654.00	$ 327,308.00	$ 490,962.00	$ 654,616.00	$ 818,270.00
		Sous-total	$ 1,157,035.00	$ 1,320,689.00	$ 1,484,343.00	$ 1,647,997.00	$ 1,811,651.00
CSTU	1	Chef de programme (infirmier)	$ 175,110.00	$ 175,110.00	$ 175,110.00	$ 175,110.00	$ 175,110.00
	4.5	Infirmières en communautés	$ 736,444.00	$ 736,444.00	$ 736,444.00	$ 736,444.00	$ 736,444.00
	1	Thérapeute en réadaptation physique	$ 140,000.00	$ 140,000.00	$ 140,000.00	$ 140,000.00	$ 140,000.00
	1 annuel	Ressource professionnelle additionnelle	$ 163,654.00	$ 327,308.00	$ 490,962.00	$ 654,616.00	$ 818,270.00
		Sous-total :	$ 1,215,208.00	$ 1,378,862.00	$ 1,542,516.00	$ 1,706,170.00	$ 1,869,824.00
TOTAL (ressources humaines):			$ 2,594,641.00	$ 2,921,949.00	$ 3,249,257.00	$ 3,576,565.00	$ 3,903,873.00
2 - BUDGET D'OPÉRATION							
2.1 Entretien et remplacement de l'équipement et des fournitures médicales spécialisées pour la clientèle							
CSI	1	Entrepôt	$ 3,050.00	$ 3,050.00	$ 3,050.00	$ 3,050.00	$ 3,050.00
CSTU	1	Entrepôt	$ 3,050.00	$ 3,050.00	$ 3,050.00	$ 3,050.00	$ 3,050.00
		Sous total	$ 6,100.00	$ 6,100.00	$ 6,100.00	$ 6,100.00	$ 6,100.00
2.2 Équipement médical spécialisé							
CSI	1		$ 45,000.00	$ 45,000.00	$ 45,000.00	$ 45,000.00	$ 45,000.00
CSTU	1		$ 45,000.00	$ 45,000.00	$ 45,000.00	$ 45,000.00	$ 45,000.00
		Sous total	$ 90,000.00	$ 90,000.00	$ 90,000.00	$ 90,000.00	$ 90,000.00
2.3 Frais d'administration							
RRSSSN	1		$ 6,671.94	$ 6,671.94	$ 6,671.94	$ 6,671.94	$ 6,671.94
CSI	1		$ 36,152.55	$ 41,062.17	$ 45,971.79	$ 50,881.41	$ 55,791.03
CSTU	1		$ 37,897.74	$ 42,807.36	$ 47,716.98	$ 52,626.60	$ 57,536.22
		Sous-total	$ 80,722.23	$ 90,541.47	$ 100,360.71	$ 110,179.95	$ 119,999.19
TOTAL (budget d'opération):			$ 176,822.23	$ 186,641.47	$ 196,460.71	$ 206,279.95	$ 216,099.19
GRAND TOTAL**			$ 2,771,463.23	$ 3,108,590.47	$ 3,445,717.71	$ 3,782,844.95	$ 4,119,972.19
			$ (325,269.23)	$ (662,396.47)	$ (999,523.71)	$ (1,336,650.95)	$ (1,673,778.19)

* selon la base budgétaire 2017-2018
** indexation d'environ 3% à ajouter

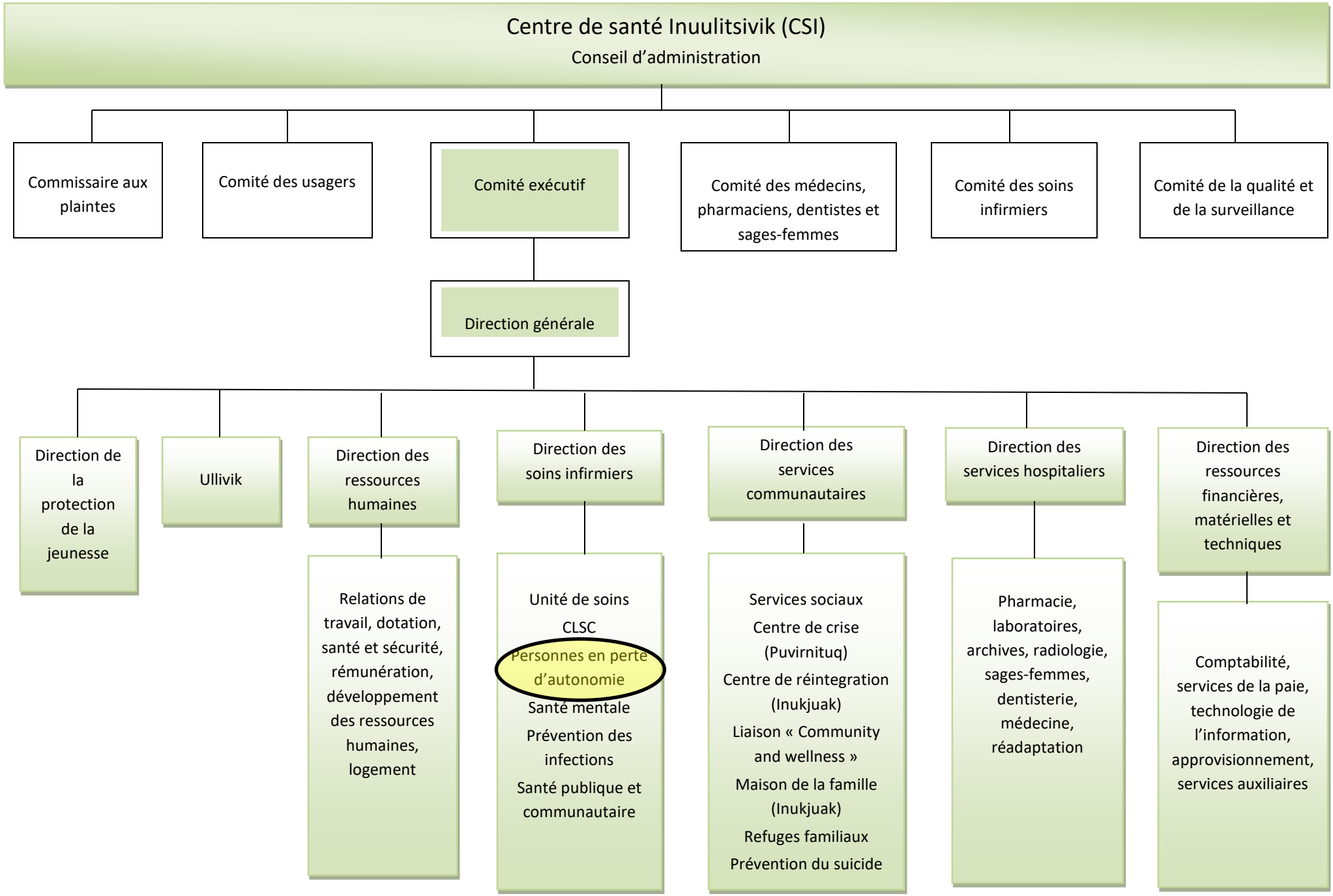
Conclusion

Les acteurs impliqués dans la gouverne du Programme ont le souci de l'amélioration continue de la qualité et de l'efficience dans l'organisation et la prestation des soins aux personnes en perte d'autonomie. À cet effet, les travaux en lien avec le présent plan de prestation des services ont permis d'identifier certaines pistes afin de consolider l'offre de services au Nunavik.

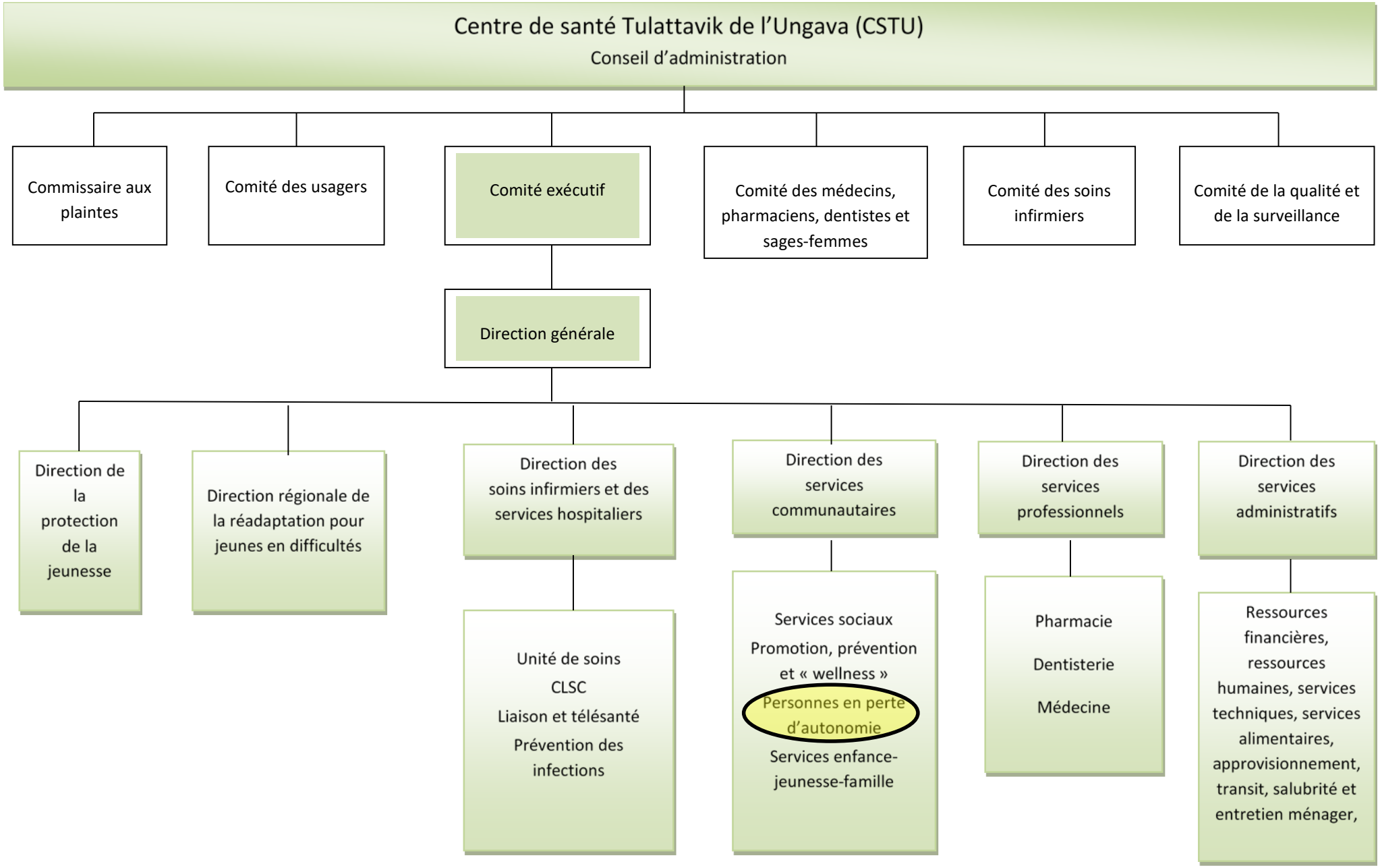
Différentes actions seront donc mises en place dans les prochains mois afin d'évaluer les opportunités et mettre en place des moyens dans le but d'améliorer les soins et services. De plus, l'octroi des nouveaux fonds amèneront assurément des changements dans les ressources allouées.

Le plan de prestation des services sera donc mis à jour selon l'évolution de la situation.

Annexe 1 : Organigramme du CSI



Annexe 2 : Organigramme du CSTU



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9.9 List of Home and Community Care policies and Procedures

ÉTAT D'AVANCEMENT DES TRAVAUX en lien avec les Politiques et procédures exigées pour le PSDMC en date du 2018-08-20	**CSI**			**CSTU**		
	En rédaction	En attente d'adoption	Finalisé	En rédaction	En attente d'adoption	Finalisé
Confidentialité des renseignements personnels			X			X
Évaluation de rendement du personnel	X			X		
Formation du personnel (plan de formation)			X		X	
Gestion des plaintes	X			X		
Organigramme et description de travail des employés			X	X		
Vérification du renouvellement du droit de pratique des professionnels et de l'assurance professionnelle	Fera partie de « Évaluation de rendement du personnel »					
Preuve de renouvellement annuel de l'assurance responsabilité civile et contre la faute professionnelle	Disponible auprès des centres de santé					
Gestion et conservation des dossiers médicaux	X			X		

ÉTAT D'AVANCEMENT DES TRAVAUX en lien avec les Politiques et procédures exigées pour le PSDMC en date du 2018-08-20	**CSI**			**CSTU**		
	En rédaction	En attente d'adoption	Finalisé	En rédaction	En attente d'adoption	Finalisé
Description des collaborations, des ententes de services et des procédures régissant les professionnels invités et les contractuels	Non applicable					
Droit de refus au traitement	X			X		
Gestion des déchets biomédicaux	X			X		
Gestion des rapports d'incidents et accidents	X			X		
Prêt d'équipement	X			X		
Procédure et outil pour fin de priorisation des cas	Pas nécessaire (aucune priorisation)					
Procédure lors d'absence du client	X			X		
Décès d'un client à domicile	X			X		
Procédure régissant les médicaments, la gestion des fournitures et équipement médicaux	X			X		
Santé au travail, sécurité et prévention			X			X
Supervision professionnelle (soins infirmiers, hygiène du milieu, hygiène dentaire)	Fera partie de « Évaluation de rendement du personnel »					

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

Health Plan
Block Funding Agreement
2019-2029

Photo by Julie Duquette