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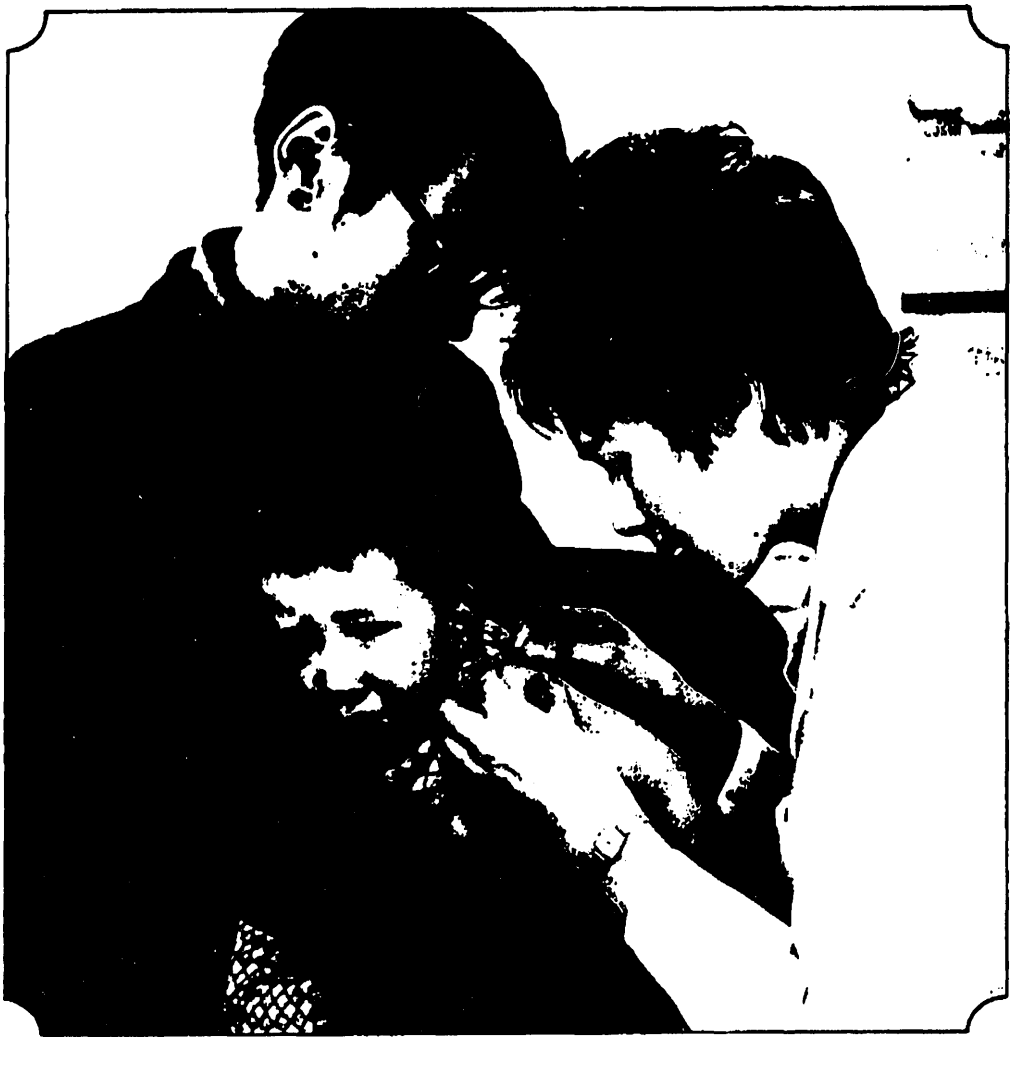
CENTRAL and EASTERN ARCTIC HEALTH SERVICES STUDY



CENTRAL and EASTERN ARCTIC

HEALTH SERVICES STUDY

HEALTH CARE PLAN

DEPARTMENT OF SOCIAL DEVELOPMENT

GOVERNMENT OF THE NORTHWEST TERRITORIES

April 1977

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1. INTRODUCTION

This study endeavours to provide a report on the present health programs, services, manpower and facilities in the Central and Eastern Arctic area. Recommendations to be considered in planning for the future are presented.

The members of the N.W.T. Legislative Assembly have encouraged the Government of the Northwest Territories to become more involved in health care planning. In 1974 the Government of the Northwest Territories' Department of Social Development commissioned Gordon A. Friesen (Canada) Ltd., Health Care consultants, to study health programs and facility requirements in the Mackenzie River area. The Mackenzie River Area Health Services Study was tabled in the N.W.T. Legislative Assembly in 1975. That study, combined with this report, provides an overview of the present health care system in the Northwest Territories.

The goal of the Government of the Northwest Territories is to develop a comprehensive, integrated and coordinated health care system. To attain this goal, continuous planning, both long term and short term, must be undertaken in order to ensure the most profitable use of our limited resources.

This report re-emphasizes the need to resolve the dichotomy which exists between the Federal and Territorial Governments with respect to the responsibility for providing health services. A firm date should be set for the transfer of total responsibility for the administration and delivery of health programs and services from the Federal to the Territorial Government. This will help to eliminate the difficulties and uncertainties which presently exist in terms of planning future programs and services.

The Government of the Northwest Territories should take the lead in establishing programs and services for Northern residents which promote opportunities to enjoy good health. Concerted efforts must be made to eradicate those factors which prevent people from gaining the opportunity to be exposed to possibilities which promote good health. The Chief Medical Officer for the Northwest Territories stated in his 1975 Report on Health Conditions in the N.W.T.:

> "The prime factors leading to positive health and the absence of much disease in the more highly developed parts of the world are fourfold. Good housing, adequate pure water, sufficient and nutritionally adequate food and efficient waste disposal methods spell the difference between the physically and medically well-to-do and the have-nots".

Many times it has been said that Canadians have the right to enjoy the highest attainable standard of health and the right of access to basic health services. At the same time each individual has the responsibility to choose a life style which is conducive to developing and maintaining good health. The Government has a responsibility to develop programs and provide the means of access to services.

It is necessary to ensure that all persons have an adequate basic income which allows them the choice to purchase nutritious food, sufficient clothing and adequate accommodation. A sufficient supply of good water must be available to each community and an efficient waste disposal system must be available to each building.

A comprehensive public health program is required along with treatment services.

It must be borne in mind that a study of this nature can only present a review of the situations as they are perceived by the person gathering and collating the data. The report and recommendations must be subject to constant revision through an updating of facts. A dialogue with community groups to verify the validity of the observations and to establish priorities for the future is necessary and must be part of the short term and long term planning process.

II. SUMMARY OF RECOMMENDATIONS

(*It should be noted that these recommendations are listed in the order which they appear in the Report, not in order of priority).

1. It is recommended that a definite date be established with respect to the transferring of the responsibility for the total administration of health services in the N.W.T. to the Government of the N.W.T.

2. It is recommended that a glossary of terms and concepts related to health care services be developed and published.

3. It is recommended that a package of educational material be developed for the use of individuals and community groups designed to develop a knowledge base of health services, programs, and facilities.

4. It is recommended that interpreter services be readily available at all major health centres and hospitals.

5. It is recommended that Health Committees be actively encouraged in each community to provide guidance in the development of programs at the community level.

6. It is recommended that the purpose and functions of auxiliary health care personnel be evaluated.

7. It is recommended that there be an evaluation of all education and training programs utilized by health care personnel from the N.W.T. to determine:

   (i) does the program have realistic goals and objectives?

   (ii) do the graduates utilize skills received from the program?

(iii) are a sufficient number of personnel being trained?

8. It is recommended that an Ear, Nose and Throat team be established to visit each community in the N.W.T. to assess those residents who are in need of services and to arrange treatment where required. This team should also attempt to determine causes and make recommendations to correct factors leading to problems.

9. It is recommended that an Ophthalmological team be established to visit each community in the N.W.T. to assess those residents who are in need of services and to arrange treatment where required. This team should also attempt to determine causes of visual problems and recommend methods of correcting the problems.

10. It is recommended that a training program be established as soon as possible for Audiological and Ophthalmic Technicians in the N.W.T.

11. It is recommended that the School of Dental Therapy in Fort Smith expand its program so that more Northerners are recruited and trained as Dental Therapists and thus be available to provide services in the communities in the study area.

12. It is recommended that efforts be continued to ensure that the orientation programs for Health and Welfare personnel, and Social Development personnel, be maintained; that they are current; and that they are as comprehensive as possible.

13. It is recommended that the document "A Comprehensive Nutrition Program for the Northwest Territories" be translated into Inuktitut and Syllabics and receive a wide distribution throughout the study area and that steps be taken immediately to implement the recommendations contained within "A Comprehensive Nutrition Program for the Northwest Territories".

14. It is recommended that planning be initiated with respect to programs and services for Senior Citizens in the Central and Eastern Arctic.

15. It is recommended that a system of inspection of facilities and equipment, including diagnostic equipment such as x-ray machines, be undertaken on an annual basis and that a system be developed so that a record is left at each Nursing Station indicating:

    i) the equipment and procedures checked
    ii) the date of the inspection
    iii) the name of the inspector
    iv) the results of the inspection and any recommendations
    v) an outline of any in-service training undertaken and the names of the individuals participating in the training

16. It is recommended that an inventory of pharmaceutical supplies in all communities be conducted and outdated drugs and supplies be returned to the wholesaler or manufacturer for credit, or disposed of immediately.

17. It is recommended that a radio communication network be set up between the Nursing Stations and their referral hospital.

18. It is recommended that increased financial resources and manpower be allocated to deal with environmental health services in the N.W.T.

19. It is recommended that the Government of the N.W.T. develop standards for occupational health, along with mechanisms which provide for enforcement of such standards.

20. It is recommended that resources to provide adequate housing of a design acceptable to Northern residents be increased.

21. It is recommended that the feasibility of establishing a Community Health Centre in Cambridge Bay be examined.

22. It is recommended that a new Health Centre, including facilities for acute and chronic care, be built in the Keewatin.

23. It is recommended that the use of Ste. Therese de l'enfant Jesus Hospital in Chesterfield Inlet as a chronic care facility be phased out in the next four years.

III. TERMS OF REFERENCE

1. Study Title

Central and Eastern Arctic Health Services Study

2. Study Area

The Mackenzie River Area Health Services Study covered the area West of a line drawn from Fort Smith, Pine Point, Fort Resolution, Yellowknife and Cambridge Bay.

It is proposed that this study include the area of the Northwest Territories East of the previous study and that the study be considered in two sections - Keewatin Zone and the Baffin Zone.

3. Objectives

(a) To conduct a review of the health delivery system in the Central and Eastern Arctic:

- programs
- services
- manpower
- facilities

(b) To identify gaps in the present health care delivery system;

(c) To provide recommendations to ensure adequate health care programs, services, manpower and facilities for the area.

4. Method

(a) A review will be made of previous documents and reports which relate to this study;

(b) Field work, including on-site visits to selected communities in the area will be carried out;

(c) The present health care programs, services, manpower and facilities will be reviewed;

(d) Present and future programs and service requirements will be considered;

(e) Alternative delivery systems will be considered;

(f) A report will be produced outlining the findings and recommendations.

5. Importance of the Study

At the present time there is not an overall plan for the future delivery of health services in the Central and Eastern Arctic. Rather than dealing with each community in isolation, it is important to consider the total area, and certain specific areas within the total.

This proposal advances an approach to provide background data, and recommendations, which will assist in making decisions in relation to the provision of health services.

IV. STUDY AREA

In this report the area under study is referred to as the Central and Eastern Arctic. For the purposes of this report, three areas have been distinguished which include the following communities:

AREA	COMMUNITY
Central Arctic	Coppermine
	*Holman Island
	Bathurst Inlet
	Cambridge Bay
	*Gjoa Haven
	*Spence Bay
	*Pelly Bay
	Resolute Bay
Keewatin Region	*Eskimo Point
	Whale Cove
	*Rankin Inlet
	*Baker Lake
	*Chesterfield Inlet
	*Coral Harbour
	*Repulse Bay
Baffin Region	Sanikiluaq (Belcher Islands)
	Lake Harbour
	Port Burwell
	*Cape Dorset
	*Frobisher Bay
	*Pangnirtung
	*Broughton Island/Cape Dyer
	Clyde River
	*Pond Inlet
	*Nanisivik
	Hall Beach
	Igloolik
	*Arctic Bay
	Grise Fiord

(*Denotes communities visited during data gathering process)
(Sanikiluaq is considered part of the Baffin Region by Government N.W.T. and part of Keewatin Region by Health and Welfare).

It should be noted that Coppermine, Holman Island and Cambridge Bay were included in the Mackenzie River Area Health Services Study. Due to the present pattern of medical services they have been included in this study as well.

V. POPULATION

Population statistics and projections is an area which appears to involve much confusion. There has been difficulty in obtaining accurate baseline data from years past. Previous projections of population increases appear to be somewhat inaccurate in terms of the data from the Statistics Canada 1976 Census Population figures which were released while this study was being prepared.

The 1976 Census figures were analyzed by the Government of the N.W.T.'s Department of Planning and Program Evaluation staff. This group made some revisions according to information available to them about populations in specific communities. The populations for the communities covered in the study for 1971, 1976 and projected annually to 1983 are presented in Appendix I. These projected figures do not take into account extraordinary events such as a decision for a major industrial undertaking or a government decision to encourage relocation.

Rather than engaging in a lengthy analysis of the hazards of population projections it is recommended that the following points be borne in mind when considering the N.W.T.:

1. The birth rate in the N.W.T. is higher than the national average for all ethnic groups (Appendix II).
2. Based upon recent census data analysis the population of the N.W.T. will show a small natural increase (Appendix I).
3. The population distribution by age indicates a very young population in the N.W.T. at the present time (Appendix III).

4. Although the actual percentage of senior citizens (age 65+) is not great, the rate of increase in terms of numbers of people in this category will be substantial during the next few years.

5. Major industrial development may produce changes in population patterns:

   a. during any construction phase there will likely be a substantial number of transient persons moving to communities seeking employment and bringing with them their personal health care requirements. This will create a strain on the services available in a given community unless planning has allowed for such changes.

   b. After the construction phase has ended the net population increase will probably be small.

   c. If preference is given to hiring northerners, and transportation is provided, several small communities on the periphery of the development corridor area will undergo population changes as workers rotate back and forth from the construction site.

VI. ORGANIZATION

The responsibility for the provision of health care services in the N.W.T. is divided between the Federal Government (Health and Welfare Canada - Medical Services Branch, Northwest Territories Region) and the Territorial Government (Department of Social Development - Health Care Plan).

It was not until 1954 that the Federal Government set up an administrative structure specifically for the provision of medical services to the residents of the N.W.T. In 1960 arrangements were made for the Territorial Hospital Insurance Services to begin operation and in 1971 the N.W.T. Medical Care Insurance Program came into existence. The Government of the N.W.T. has total responsibility for administering the insurance program aspects of health services in the Northwest Territories and the costs of these programs are met through the Territorial Government's budget.

For the purposes of this study four levels of health services are identified:

1. Primary - This is the "First Line" health service level which is provided in most communities through Lay Dispensers, nursing stations, health stations, health centres, community hospitals and physician offices. The services include emergency medical care and public health programs.

2. Secondary - Regional Referral Centres - At this level In-patient care is provided in hospital facilities which provide acute care: medical, obstetrics, surgery, pediatrics, ambulatory

and emergency care; chronic/extended care; physiotherapy; and home care. Facilities providing this level of care in the study area are located or being developed at: Frobisher Bay. Within the N.W.T. such facilities are being developed or located at: Inuvik and Hay River.

3. Teritiary - Territorial Referral Centre - At this level, the hospital facilities are capable of providing a wider range of specialist services, such as more complex laboratory and radiology services, and are capable of dealing with a wider range of surgical procedures. The specialists associated with this level of care are capable of providing consultative services to facilities and personnel at the primary and secondary level. The Stanton Yellowknife Hospital is being developed as a Territorial Referral Centre.

4. Quarternary - Major Medical Centre - At this level of care, hospital facilities offer highly specialized forms of services such as cardiac surgery and neurosurgery. These services are provided through arrangements with hospitals in Montreal, Toronto, Winnipeg, and Edmonton.

The Government of the N.W.T. is not presently involved in the direct provision of services at any of the above levels in the Central and Eastern Arctic Study area.

These services are arranged by Health and Welfare Canada, Medical Services Branch, which has its regional headquarters in Edmonton, Alberta. The Federal Government owns and operates the Nursing Stations in the study areas as well as the 32 bed hospital located in Frobisher Bay. The size and staffing of the community Nursing Stations are usually determined by the population these stations serve as well as by any particular medical needs of a specific community.

Health and Welfare Canada has divided the N.W.T. into four zones in their administrative structure. These "zones" correspond with the Territorial Government's "regions" with the only difference being the Federal Government's designation of the Mackenzie Zone being the equivalent to the Territorial Government's Fort Smith Region. The Central and Eastern Arctic Health Services Study area encompasses the communities in the Baffin and Keewatin Zones as well as the Central Arctic communities of Coppermine, Holman Island, Cambridge Bay, Gjoa Haven, Spence Bay and Pelly Bay in the Mackenzie Zone.

VII. MANPOWER

There is an extensive network of persons associated with or directly employed in the administration and delivery of health services in the N.W.T. The following Appendices provide an overview of the number of man years in specific areas:

Appendix IV	Health and Welfare Canada's 1977/78 man year allocation, N.W.T. Region
Appendix V	G.N.W.T.'s Health Care division, 1977/78 man year allocation
Appendix VI	N.W.T. Budget Review Hospitals, 1977/78 man year allocation
Appendix VII	Man year total for physicians in private practice in N.W.T.
Appendix VIII	Man year totals for dentists in private practice in N.W.T.

In addition to the personnel employed through the above programs, one must bear in mind that there are persons employed through contracts to provide specific services and there are a number of persons performing research activities related to the health field in the N.W.T. There are also many hours of service provided by volunteers in communities and in the facilities which must be taken into account when considering the total manpower associated with Health Care in the N.W.T.

The information contained in the Appendices provides an overview for the N.W.T. It is possible to identify those

The Baffin region is served by five physicians who are Health and Welfare Canada employees. Four of the physicians are located at Frobisher Bay and a fifth physician will be located at Nanisivik and will provide services to surrounding communities.

Specialists services to residents of communities in all regions are provided through contracts with University hospitals in Edmonton, Winnipeg, Toronto, and Montreal. In some instances the specialists visit each community, in other instances patients are sent to the hospitals at Yellowknife, Churchill and Frobisher Bay to see the specialists. The type of arrangement utilized will depend on the number of patients to be seen, the available specialist time and the philosophy of the Zone Director and Zone Nursing Officer in each region.

Some residents and members of community councils expressed a desire to have physicians live in their community. This is not a practical consideration given the role assigned to nurse practitioners and given the workload a resident physician would have in a small community. It will be necessary to provide the public with more information about the roles of health care personnel and how services are most efficiently arranged and utilized.

Most physicians and nurses interviewed during the course of this study indicated that a two to three day visit every month to settlements with more than 700 persons, and a visit every six weeks to the smaller settlements, would be adequate. The major problem is the transportation interruptions which occur because of bad flying weather. Despite the unpredictable delays, most communities received physician visits as scheduled during the past year.

There is a scarcity of indigenous staff trained in health care functions. It is recommended that a greater effort be made to recruit and train indigenous staff members for a variety of health care positions. At the present time the only area in which indigenous personnel are hired at the primary level of health care is in the position of the Community Health Representative or Dental Therapist. To our knowledge there are no Indian or Inuit Registered Nurses in the N.W.T. who are available for employment. The role of the Certified Nursing Assistant throughout the Health Care system should be examined. It is recommended that steps be taken to evaluate the functions of Housekeeper, Janitor, Interpreter, Community Health Representative and Certified Nursing Assistant to determine whether or not there could be increased opportunities for employment at the community level. An ongoing review of salaries should be made to ensure that these positions offer financial reimbursement at a rate competitive with other jobs available in the community. A greater number of indigenous staff could lead to a greater employment stability at the community level.

It is recommended that an analysis be made of the various training and education programs attended by health personnel from the N.W.T. to determine their usefulness in preparing people to cope with the demands of their jobs. Included in this analysis should be an examination of the optimum number of personnel required to ensure that a sufficient number of persons can receive training each year.

VIII. FACILITIES

All facilities related to the delivery of health services in the Central and Eastern Arctic are owned and operated by the Federal Government with the exception of the St. Therese de L'Enfant Jesus Hospital in Chesterfield Inlet. This hospital is operated by the Churchill-Hudson Bay Diocese of the Roman Catholic Church with its headquarters in Churchill, Manitoba.

1. Nursing Stations

The Nursing Stations located in the Central and Eastern Arctic study area appear to be adequate in terms of their size for their functions. In those communities where the station is older and inadequate Health and Welfare Canada has a scheduled replacement program.

The general design of Nursing Stations provides for:

a. treatment area

b. in-patient acute care beds for adults, children and infants for the treatment of minor or uncomplicated illness

c. public health

d. basic laboratory facilities, including x-ray

e. office space

f. living quarters for nurses

Appendix X lists the Nursing Stations in the study area along with their in-patient bed capacity. One should bear in mind that the in-patient use of the Nursing Station is limited to persons in one or more of the following conditions:

i. patients awaiting evacuation

ii. patients requiring a short period of observation or assistance prior to decision re treatment or evacuation

iii. women in labour

The admission of a patient creates a strain on the nurses as they have to provide in-patient nursing care as well as carry out their regular program services. Appendix XI shows the utilization of the Nursing Stations as in-patient facilities during the past three years by Zones. Appendix X provides a breakdown by individual Nursing Stations. According to the nurses these statistics do not accurately reveal the extent to which the beds are utilized. For example, some stations do not record as an admission a person who is observed for a few hours. All such admissions should be recorded in the future.

However, it would appear that most Nursing Stations have an adequate number of beds to handle problems in their communities requiring in-patient services. A problem arises only if the beds are utilized on a regular basis. The exception would be the single nurse stations. These stations have sufficient beds considering the difficulties involved in have a single nurse providing in-patient care and carrying out her regular routine. In the single nurse station there is another difficulty due to the design of the facility in that utilizing the beds is difficult for certain cases - one cannot get a stretcher into the room where the adult bed is located. Due to inadequate storage area the pediatric room often serves as a storage area and has to be cleared out before it can be used.

Another problem can arise in a multi-nurse Nursing Station when one of the nurses has to escort a patient who is being evacuated. This places a heavier demand on the remaining nurse(s) until the escort arrives back.

The new Nursing Stations are bright and modern. The patient rooms are large and provide space for relatives to visit and to assist in caring for the patient. Most nurses encourage parents to assist in looking after their children. There is a great deal of value in this approach as often parents are able to learn techniques which are useful in their own home. A peripheral benefit is that persons who spend time in the Nursing Station become more aware of the demands made on the nurses' time.

The Nursing Station is also home for the nurses. Some are quite happy with this arrangement; others believe it would be better if detached living quarters were provided as they believe it is important to live apart from one's work. This is a difficult problem to resolve. The nurses are the first-line providers of medical services in a community and as such are required to be readily available 24 hours per day. Perhaps the alternative is to provide alternate accommodation facilities near the Nursing Station which will allow those nurses who feel happier being separate from their working quarters with an alternative to living in the Nursing Station and yet be an arrangement which allows a sufficiently quick response to emergencies.

However, the newly designed Nursing Stations provide very attractive and comfortable living accommodation. The nurses are immediately available for emergencies and to provide in-patient care.

The maintenance of buildings in the North is always a problem. Health and Welfare Canada employ maintenance personnel who travel to the various Nursing Stations. Unfortunately it seems that the equipment is not standardized due to the various ages and designs of the buildings and parts are not always readily available for repairs on the spot. The janitor and nurse are expected to perform minor maintenance functions and repairs. The major problem occurs when the maintenance person is unable to visit the community because of other work or because of weather. There is usually assistance available through the Government of the N.W.T. personnel, Department of Transport, Department of Communication personnel, Dew Line employees or, in some cases, tradesmen available in the community. Health and Welfare Canada have worked closely with the Department of Education to develop a program which assists the janitors to perform their duties. These efforts should be supported and expanded where practical.

2. Hospitals

There are two hospitals in the study area - Frobisher Bay General Hospital and the Ste. Therese de l'Enfant Jesus Hospital in Chesterfield Inlet. The Frobisher Bay General Hospital is owned by the Federal Government and rated as having a 32 bed capacity. For several years Health and Welfare Canada have held discussions regarding the renovation or replacement of this facility because as it presently stands it is neither adequate nor efficient considering the needs of the population it serves. The proposed Phase I renovations are currently being evaluated and it is hoped that construction will commence in 1977.

The hospital in Chesterfield Inlet was constructed in 1931. It is owned and operated by the Churchill-Hudson's Bay Diocese of the Roman Catholic Church. The acute care operation has been phased out. Until the fall of 1976 the Nursing Station was contained in the hospital building but with construction of a new building the Nursing Station was moved to its own location. The only service presently offered through the hospital facility is the care of four adults and five children in a chronic care program.

The building itself is old and is in need of extensive renovation to bring it up to a standard acceptable to the N.W.T. Fire Marshall. Bishop Robidoux, Bishop of the Diocese and the Administrator of this facility, has indicated that the Diocese is not prepared to provde funds to do the major renovation. Therefore, immediate planning must be engaged in with respect to arranging alternate care for the present residents of this facility.

The extent to which chronic care facilities may be required in the Keewatin and the Baffin will be better known upon the completion of a handicapped survey presently in its final stages. Once the numbers of handicapped persons requiring institutional facilities, and the numbers requiring assistance to remain in their homes or subsidized foster homes is known, planning by Department of Social Development personnel can commence in consultation with community councils, Health and Welfare Canada and Department of Education personnel to establish appropriate resources. The emphasis should be on locating as many services and resources as possible in local communities. In order to accomplish this a great deal of

discussion with, and the support of, community groups will be required. In all likelihood it will be necessary to provide long term institutional care for some people and this should be located in or near an acute care facility to offer the maximum service and to share services.

At the present time there is no hospital facility located in the Northwest Territories' Keewatin Region. Persons requiring in-patient treatment and medical care are evacuated to Churchill, Manitoba where the Churchill Health Centre is located. This 42 bed facility was opened in October 1975 to serve the residents of northern Manitoba and the Keewatin Region of the N.W.T. The facility is operated by a local Board of Directors and funded by the Manitoba Health Commission. The Board of Directors has physicians in Churchill through a contract with the Northern Medical Unit of the University of Manitoba.

As previously mentioned physician services to residents of the Keewatin are provided by the physicians in Churchill. Health and Welfare Canada arrange a contract with the Northern Medical Unit to provide for a physician's visit to Eskimo Point, Rankin Inlet, Baker Lake every month for two to three days and to the remaining communities in the Keewatin once every six weeks. Patients in the Keewatin requiring hospitalization are evacuated to the Churchill Health Centre. The Government of the N.W.T. pays a per diem rate on behalf of those patients for whom it has financial responsibility. The Government of the N.W.T. also arranges for Keewatin residents to be repatriated at their home community upon discharge from the Churchill Health Centre.

The Government of the N.W.T.'s Department of Social Development operates a Transient Centre in Churchill (actually Akudlik, which is located half-way between Churchill and the airport, a distance of approximately five miles from the Churchill Health Centre) for those Keewatin residents discharged and awaiting transportation back to their home community and for those patients receiving outpatient services. This facility provides hostel-type accommodation and is not a treatment-oriented facility.

It should be noted in this section that an increasing emphasis should be placed upon developing programs which keep people in their own communities as much as is possible. Public Health programs of a preventive nature should be expanded in order to combat the illnesses which lead to hospitalization. However, there will always be a need for a hospital to look after those who require this type and level of service. During the date gathering portion of this study many comments were received suggesting hospital care should be available in the Keewatin to Territorial residents. In all other regions basic hospital care is available in the N.W.T. Therefore, it is recommended that a hospital facility providing acute and extended care services be built in a suitably located community in the Keewatin. Consultation with community councils and community groups should take place regarding the location of such a facility. Again, greater employment of indigenous persons is desirable and plans should begin immediately with respect to ensuring that as many indigenous persons as possible will be trained for positions in this recommended new facility.

It is also recommended that sufficient hostel-type beds be made available in the same community as the proposed facility in order to accommodate discharged patients awaiting transportation home, patients receiving outpatient services and relatives of patients when the doctor or social worker recommends family members be available.

The proposed hospital services for the Keewatin should be part of a Health Centre facility which would provide the following services:

- outpatient and emergency services
- home care services
- acute care in-patient beds for adults and children
- chronic care/extended care beds
- offices for physicians and visiting clinics
- dental office
- offices for public health personnel
- offices for social service personnel
- hostel beds for those awaiting transportation.

IX. PROGRAMS AND SERVICES

1. General Comments

The development of programs and services in the study area has been rapid during the past few years. For many years religious groups had established and provided medical services in communities such as Chesterfield Inlet, Pond Inlet, and Pangnirtung. As Health and Welfare Canada have assumed the responsibility for providing medical services the facilities and services provided by the religious groups have gradually ceased to function or been phased out.

Health and Welfare Canada brought to the task an emphasis on developing programs and facilities in as many communities as possible. Thus, a network of Nursing Stations has developed in most communities with a population in excess of 100 people. With the construction and staffing of these facilities came an emphasis on direct treatment services through nurses, physician care and a basic public health program for all communities.

The Chief Medical Health Officer in the N.W.T. has noted that continued expansion and development of facilities at the primary care level will not necessarily lead to a corresponding reduction in the cost of dealing with illness. Renewed efforts must be made to eradicate those sources of illnesses which are identifiable (for example, contaminated water supplies, inadequate sewage disposal, poorly built and/or insulated homes, etc.). It would be beneficial to develop methods of evaluating the effectiveness of preventive public health programs in reducing illnesses and the sources of illnesses in such a way that residents of a community would be able to recognize the value of participating and contributing to these programs.

It would also be desirable to obtain greater lay involvement at the community level to identify local concerns and to participate in developing programs to cope with the concerns they have outlined. The process of involving lay persons in the development of programs and the evaluation of services will be slow. During the past five years many communities have faced the pressures of developing a local government system to assume more municipal responsibilities. Now many communities face decisions with respect to industrial development and changes which will inevitably occur in the day to day life of the community residents. This, combined with what appears to be a change in the role of the extended family, suggests some pressures which are currently facing individuals and community groups. Thus a great deal of sensitivity and patience will be required to encourage lay involvement. Also required will be a willingness on the part of medical and administrative personnel to work through the dilemmas of listening to other viewpoints and incorporating them into new programs and services. Mistakes will have to be analyzed, not to confirm failures, but to identify points of strength and to build upon these strengths.

Medical Services, Health and Welfare Canada has worked towards, and is continuing its efforts, to obtain local involvement through Health Committees and also by special community meetings to review and discuss problems and programs.

There must be constant vigilance maintained on industries which are operative in communities to ensure that their production methods do not contribute to a decline in the health of individuals or to a decline in the environment around the work area.

2. Alcohol

The abuse of alcohol and other drugs is a topic which never fails to spark a response from residents of any community. This abuse is a problem throughout the N.W.T. but the nature of the problem varies from community to community.

The N.W.T. Alcohol and Drug Coordinating Council has a membership of persons representing a variety of organizations and groups within the N.W.T. The Council meets four times per year, usually in a different location each time, to consider the problems presented by the abuse of alcohol and other drugs and to approve funding for programs prepared by community groups which attempt to alleviate problems in their community. The Council also endeavours to provide information and educational resources to interested parties. Several community groups have received funding for programs designed to provide information to people and to combat particular problems.

In addition it is possible for communities to hold a plebiscite to determine if a majority of residents want the supply of alcohol to their community controlled or banned outright.

It is desirable to maintain the flow of information and educational materials to communities in order to keep residents aware of potential problems and to provide stimulating ideas about the ways in which efforts can be made to combat specific problems.

3. Mental Health

Mental Health, like alcohol, is a topic which will often spark an animated discussion in communities. Although it is difficult to agree upon a definition of mental health, one can usually obtain agreement within a group for examples of persons who are no longer coping with day to day functions and demonstrate what is considered by most other residents to be inappropriate behaviour. Often these persons are referred to as being mentally ill and in need of treatment outside of the community.

Mental health services in the study area have basically consisted of an annual visit to most communities by a psychiatrist often accompanied by a psychologist. The Baffin and Keewatin Zones have been visited by the same personnel for a number of years which has led to a good level of awareness on the part of the consultants about life in the communities. Between visits, the nurse, Social Development personnel, teachers and physicians try to cope with persons demonstrating inappropriate behaviour until the psychiatrist's visit or until the person's behaviour becomes so threatening to others that evacuation is necessary. Both nursing and Social Development personnel indicated a decline in the need to have the psychiatrist visit communities for the purpose of treating persons. Rather there is now an increased emphasis upon this resource as a consultant with respect to ongoing treatment advice and with respect to developing community resources.

In order to assist the development of local community resources every effort should be made to ensure that more public health and Social Development personnel have a working knowledge of positive mental health approaches. It is desirable that an increased number of health and social service personnel employed in the Northwest Territories should have education or experience in community mental health. Attendance at workshops and seminars on topics of mental health should be a priority in order to upgrade the knowledge base of personnel presently employed in the N.W.T.

People in small northern communities have experienced rapid social and economic changes in the past few years. Many of the communities may be faced with the prospect of future industrial development. Efforts should be continued to increase the interest and involvement of local residents in their own health, and in health services and programs. It is also important that employment opportunities in the health field for indigenous persons continue to be developed. This is a critical area about which health and social services personnel should be concerned. There must be an increased emphasis upon encouraging and utilizing the inherent resources of people to cope with their problems at the community level. There must also be increased cooperation and coordiantion amongst resource persons available in each community.

4. Nutrition

Nutrition plays a very important role in the health of residents in the N.W.T. Several studies have been conducted in this field and more are planned. The Department of Social Development's Health Care Plan has prepared a comprehensive nutritional program for the N.W.T. It is recommended that the document "A Comprehensive Nutrition Program for the N.W.T.", be translated into Inuktitut, Syllabics and the Indian dialects in order to receive a wider distribution throughout the study are. and the remainder of the N.W.T.

It is further recommended that steps be taken immediately to implement the Comprehensive Nutrition Program for the N.W.T.

One of the unique problems in the N.W.T. is the high cost associated with transporting nutritious foods to each community. The problem is especially acute when dealing with fresh fruits and vegetables in both winter and summer periods. There is a very high rate of spoilage associated with these items with the result that store managers are reluctant to order large shipments and/or the prices in the local store are very high. Consideration should be given to designing lightweight modular units for transporting milk, fresh fruits and vegetables which will allow a proper temperature range to be maintained. When these goods have to be transferred from one carrier to another proper storage facilities should be provided to ensure that the goods arrive at their destination in good condition. Consideration should be given to a way of equalizing the cost of fresh foods for all residents in the N.W.T.

5. Dental Care

There appears to have been difficulties in attracting and retaining dental personnel in the study area. In several communities dissatisfaction was expressed about the difficulties involved in obtaining dental services and the short period of time the dentist spent in the community once he arrived.

During the past two years graduates of the School of Dental Therapy at Fort Smith have begun working in some communities in the study area. These Dental Therapists are supervised by dentists on the faculty of the School of Dental Therapy. Favourable comments were made about the work the Dental Therapists are performing.

The major problem in having Dental Therapists located in all communities in the study area is the lack of suitable Northern applicants. Medical Services are prepared to expand this service when qualified Dental Therapists are available.

Therefore, it is recommended that every effort be made to encourage Northerners to consider Dental Therapy as a career and that consideration be given to increasing the number of students attending the program in order to ensure an adequate number of Dental Therapists in the future.

6. Senior Citizens

At the present time in the study area there are no formal programs operating specifically for the elderly. Thus far a demand has not been perceived.

The basic need in many communities appears to be one of developing recreational facilities and programs for all age groups, including the senior citizens.

The majority of the elderly in the study area are still active and self-sufficient due to the availability of nurses to visit homes and help arrange for services as required. There has been a minimal demand for institutional care. Services to be developed in this area should stress the importance of assisting people to remain in their own homes for as long as possible. Support, in terms of services and programs, must be provided in each community to allow senior citizens to live as independently as possible and to recognize and alleviate strains on families when they attempt to assist their elderly members.

The concept of supporting individuals and community groups in their efforts to provide services to their residents should continue.

7. Public Health

Public health services, for the most part, are provided by the nurses in the Nursing Stations and by the Environmental Health Officers in each zone. In addition, personnel from the Territorial Government's Departments of Social Development, Education and Local Government are involved in providing educational services in such public health areas as nutrition, home management, water supply and waste disposal. During the past year the Canadian Public Health Association has established a N.W.T. Branch and it is anticipated that this voluntary organization will consider public health issues and encourage the development of programs and services to meet needs in this area.

Many of the observations and recommendations in this report outline the need for an increased activity in the public health sector. There is a need for a comprehensive public information/education program designed to inform people about services available, current issues, and the ways in which members of the public can contribute to the development of programs.

The treatment services of health care have been emphasized in the past with the desirable result of establishing Nursing Stations in most communities. Combined with the treatment services offered through the Nursing Stations has been an effort to provide public education on health matters. It seems appropriate at this point in time to increase efforts in this area and to combine this thrust with an increased interest in environmental health issues in order to eradicate the causes of certain preventable illnesses in the N.W.T. It would be desirable to obtain a greater degree of coordination in this area at the community level.

In order for communities to become more involved, it would be desirable to develop an inventory scale which will allow each community to assess its own level of service, plan programs to improve services and then evaluate their efforts at the end of a set time period. Resource personnel must be available to assist them in this task.

It was noted in some Nursing Stations that the nurses felt residents should come to the Nursing Stations for all services because these services were available from 9 a.m. to 5 p.m. daily except holidays and weekends. They felt that having nurses spend time in the community was not accomplishing a great deal as far as public health was concerned. In other stations nurses expressed concern about public health programs which involve increased home visiting as constituting an infringement on peoples' right to privacy.

Rapid classroom inspections are conducted twice a year to detect infections or infestations. Visual and auditory screening programs are conducted at the beginning of each school year.

Changes in services may result in a more efficient use of the nurses' time in the treatment and administrative areas but one has to be concerned about the long term effect on health of the population. It would be desirable to hold discussions in each community about the programs and the delivery of services in order to arrive at mutually agreed upon programs and services of which members of the community are fully aware, in which they can participate and wholeheartedly support.

A broad interpretation of the Public Health service role is desirable if progress is to be made towards eradicting causes of certain illnesses. Services to meet community requirements should be expanded and developed. A great deal of community involvement must be developed. A high priority should be assigned to this program area.

8. Nursing Station Programs

The Nurse-in-Charge at each Nursing Station is responsible for the supervision of several programs and arranging for the provision of services those programs entail. The programs and services can be summarized as follows:

PROGRAM	SERIVICES
1. Emergency and Ambulatory Care	a. Assessment, diagnosis and treatment for community residents. b. In-patient nursing care for those awaiting evacuation. c. Nursing services during evacuation. d. Physician clinics.
2. Maternal Health	a. Pre-natal clinics. b. Child birth. c. Post-natal clinics. d. Home visiting.
3. Infant and Pre-school Health	a. Mother and Well Baby Clinics. b. High Risk Infant Clinics. c. Immunization Program. d. Infant Mortality Study. e. Home Visiting. f. Pediatrician visits.
4. School Health	a. Pre-school or school readiness exams to all beginners. b. Rapid classroom inspection. c. Visual and auditory screening. d. Immunizations. e. Health education resource persons. f. Emergency dental care where there is no Dental Therapist.
5. Family Planning	a. Educational materials. b. Birth control measures. c. Counselling.

6. Chronic Diseases	a. TB follow-up by clinical examination, x-rays, sputum samples. b. Regular checks for persons on chronic disease lists. c. Specialists visits and clinics.
7. Public Health	a. Adult and children immunization clinics. b. Monitoring water supply and sewage disposal. c. Communicable disease treatment and follow-up. d. Home visiting. e. Educational programs. f. Liaison with community councils, health committee and other agency personnel. g. Counselling.

In addition to these programs and services the nurses are involved in performing administrative tasks, keeping up-to-date on developments in the medical and nursing fields, and encouraging residents in the community to adopt habits conducive to good health.

It is very difficult to identify all the services a nurse offers to a community. The above listing is very basic. Each nurse has to assess the needs of a particular community and apply personal skills to her job which result in the development of programs for that particular community.

Nurses come to their jobs from a variety of backgrounds, training and experiences. Some are recent graduates of schools of nursing, some have training and experience as public health nurses. Some nurses have completed post graduate studies, especially in the fields of midwifery and outpost nursing. Several nurses employed in

the study area are graduates of the clinical training course which is offered twice a year at the Universities of Western Ontario, Manitoba and Alberta. It would be valuable to contact those nurses who have graduated from the Clinical Training programs, and who have returned to practise in the N.W.T., and develop an assessment of the strengths and weaknesses of the course in relation to the demands of their job.

Most nurses indicated that their time was equally split between treatment services and public health measures. Most nurses expressed a feeling that an increasing amount of their time is being spent on administrative tasks. Most nurses felt the future should see an increase in preventive public health services.

One area in which anxiety was expressed by consumers of the services concerns referrals to the doctors and specialists. In many instances it seems residents do not have direct access to these services unless they are referred by the nurse or are prepared to pay their own travel fares to a major medical referral centre in one of the provinces. In those communites where direct access is offered a complaint often heard is that insufficent notice of the visits is given. The difficulties of scheduling visits and having the weather cooperate is a constant battle.

The nurse must be recognized as the primary provider of medical services at the community level. A general practitioner or specialist visiting the community comes as a consultant to the nurse. The nurse prepares referrals for those persons she would like the visiting doctor to examine. Provision should be made to allow the doctor a

block of time to see those persons who would like to have a consultation but have not been referred by the nurse. However, appointments would have to be arranged through the nurse in order to ensure that sufficient time is available to perform all the tasks required by a specialist during a specialist clinic and to ensure continuity of service.

It is important to discuss these issues at the local level and to seek ways of resolving them in each community. This type of problem will possibly be even greater if an increased use of para-medical personnel occurs and residents are not aware of how each person fits into a health system and how their services should be utilized.

9. Institutional Care

This section deals with the need to develop services for those persons who are handicapped to the extent that they require ongoing assistance to perform daily tasks. At the present time there are no facilities in the study area apart from the chronic care unit at Chesterfield Inlet which must be replaced. (The present renovations proposed for the Frobisher Bay General Hospital do not provide for the inclusion of any extended/chronic care beds).

The future will likely see the need to develop programs for senior citizens and handicapped persons. The challenge will be to develop programs which will eliminate the need for institutional care for all except the most severely handicapped. Programs designed to assist people in their own homes should be given priority. There is a need to develop training programs so that sufficient persons are available to assist handicapped persons in their home communities. The key point is to assist handicapped persons to be as responsible for themselves as is possible and to assist families to care for handicapped members. Programs such as Meals on Wheels, Home Care Nursing, Adopt a Grandparent, should be explored and modified to meet the needs of a particular community.

Where institutional care is an inevitable program then facilities should have services which again allow the individual to do as much as possible for himself and to provide sufficient assistance. The provision of personal care units within Senior Citizen complexes is a good program - however

efforts must be made to encourage self-sufficiency. Persons in chronic care facilities should be encouraged to do as much as is possible for themselves. Institutional programs should be flexible enough to allow residents to leave for varying periods of time, depending upon the individual's capacity and the capacity of the family to maintain that person. The institution should arrange supportive services to allow the visit to last as long as is possible.

Should a facility for extended/chronic care be required then it should be built as part of an acute care centre to minimize construction, maintenance and operating costs. Locating the facility within or adjacent to the acute care unit will facilitate the visits of specialists and the provision of such services as physiotherapy and occupational therapy.

X GAPS IN SYSTEM

The following is a summary of the perceived gaps in the health care system, some of which are expanded upon in the following section of background material for the recommendations.

First, and foremost, was the difficulty in nearly all communities of beginning a discussion of the "health care system". Basic questions seem to revolve around "what is it all about?" Most people were able to discuss quite comfortably issues related to hospitals, doctors' visits or medical evacuations. However, once one tried to direct consideration to less concrete subjects people were less aware of the importance of these issues for their community.

Part of the above problem, related to the lack of knowledge, stems from the almost total lack of involvement of indigenous people in the planning of health services. This situation still exists although Medical Services continue their efforts to promote community involvement. Most community health committees are an appendage of the Nursing Station and discuss those issues that the nurses bring to their attention. If there are difficult relationships with the nurses in the communities, then on occasion the health committee degenerates. Medical Services personnel have commented upon various efforts which have been made to involve indigenous persons in the health care system. It is recognized that considerable effort has been made in the past and efforts must continue in the future. It would be beneficial to identify again those areas where local input is possible and to seek new avenues for input which perhaps have not yet been identified. Apathy at the community level must be overcome through consistent and sincere approaches to work together.

In addition to the lack of involvement of indigenous persons in planning, there is also a lack of employment opportunities in service delivery areas. Most local employment is at the janitorial/housemaid level combined with some responsibilities for interpreting. In some communities nurses have unofficially upgraded the duties and responsibilities through their own initiative by providing on the job training and supervision.

Another observation made involves the area of interdepartmental communication and cooperation. There appears to be an overall lack of coordination between the services - neither party appears to understand nor appreciate the role the other plays in the community. This appeared to be most apparent between the social workers and the nurses. Perhaps this is due to an inadequate orientation program for both nurses and social workers. Although both Health and Welfare Canada and the Department of Social Development endeavour to provide an orientation program many personnel arrive to work in a community without a complete understanding on the job to be done, of the traditions operative in that community and also of their own Department's philosophy and role. It is always difficult to design and operate systems without communication problems, however, every effort must be made to improve communications without inflicting any unnecessary formality into the system.

There should be better access to information about services available and policies affecting services. In addition, people should have better access to information about themselves and their dependants when they are receiving treatment. People also have the right to know about the health risks to which they are exposed.

A better communication network is required. The Minister of Indian Affairs and Northern Development recently announced that during the next five years reliable telephone services will become available to all, even the remotest, northern communities. However, consideration should be given to establishing a radio network similar to the one utilized by the R.C.M.P. and by the Fish and Wildlife Division of the Department of Natural and Cultural Affairs. Such a network could allow quick communication between Nursing Stations and their referral hospital. Scheduled times could be established to obtain information about patients from a particular community and to pass on messages to patients. The suggested study by Health and Welfare Canada involving satellite tele-communication in the Baffin Region should be expanded to include other departments. Such a system shared between Departments might prove to be more economically feasible and the necessity of sharing facilities might improve inter-departmental communication. The use of such a facility for conferencing might reduce the overall travel budgets of the various departments. Also, when resource persons arrive in communities, both parties might be better prepared to deal with specific issues.

Improvements must be made to the interpreting services available at the major medical referral centres. Many persons have complained about the lack of service available to them at the major referral hospitals. The possibilities of providing accommodation for interpreters in these major centres and having a two, four or six month rotation of interpreters should be considered.

A training program for interpreters and health personnel should be implemented to develop knowledge of appropriate terminology. This recommendation complements the public information recommendation made in this report.

Salaries and status of health care personnel should be continually reviewed and compared with other employment opportunities available through the Territorial and Municipal Governments. Consideration should be given to programs offering more on the job training which will result in an upgrading of health care positions and allow for advancement.

A special effort should be made to establish an Ear, Nose and Throat team and an Ophthalmological team to visit all communities in the Central and Eastern Arctic in an effort to satisfy an apparent need for a complete assessment and evaluation of problems in these areas. This work would have to be coordinated with those specialists who have been endeavouring to provide the service in the past. Associated with the Ophthalmological team should be a representative of an optical firm which would supply adequate follow-up service of fitting prescribed glasses and would offer prompt repairs.

Nursing Stations, for the most part, appear to be well equipped. An effort has been made to standardize equipment and supplies. A quarterly ordering procedure is in effect which seems to be working quite well. Each Nursing Station is equipped with an x-ray machine. All personnel working in the Nursing Station are monitored closely to ensure that they are not exposed to dangerous levels of radiation. The equipment and procedures are checked when

the radiological technician visits each community. At that time the in-service training session is held for personnel operating the x-ray equipment.

In relation to inspections of facilities and equipment, and especially x-ray equipment and laboratory equipment, a system should be developed so that a record is left at the Nursing Station indicating that the equipment and procedures have been checked. A short description should also be left of the in-service training undertaken with the names of the individuals who participated. Every effort should be made to conduct such inspections and reviews on an annual basis.

During the past few years there has been a great deal of discussion related to the transfer of all responsibilities in the health care field from the Federal Government to the Government of the Northwest Territories. The Mackenzie River Area Health Services Study refers to several documents outlining the background for these discussions (Report of the Advisory Committee on the Development of the Government of the N.W.T. 1966; Government of Canada's National Objectives for Northern Canada, approved in December 1970; the Federal Government's policy for Northern Development 1971-1981 approved July 1971; statements made by members of the N.W.T. Council such as that recorded in the Official Report of Debates for the 48th session of the N.W.T. Council January 25, 1973). These discussions continue, but thus far a definite date for the transfer of responsibilities has not yet been set. It is recommended that a definite date be established as soon as possible in order that more effective integration and coordination of planning will occur.

The Government of the Northwest Territories is committed to a policy of developing the necessary framework and skills to allow greater community control of programs and delivery of services. There was a fair amount of feedback during the data gathering trips to the effect that the Territorial Government was and is prepared to listen. This is not to suggest that the process has always been utilized or that it always works smoothly, but it does suggest the effort has been recognized.

It is time to develop a public information program designed to facilitate discussion about the important components of a health care system. The concept, "health care", is very vague and needs careful definition. This vagueness was one of the greatest difficulties encountered while attempting to discuss the possible changes for the future with community councils and health committees.

This report, combined with the Mackenzie River Area Health Services Study provides the groundwork for the development of a Territorial plan for future delivery of health services in the Northwest Territories. By preparing such a plan, and by sitting down with local groups to establish needs and priorities, the development and delivery of health services can be coordinated.

XI RECOMMENDATIONS

The following recommendations are presented as a result of the information obtained during the course of this study. They are listed in the order in which they are mentioned in the Report, not in a recommended order of priority for implementation. A brief statement of supporting data has been provided as a background for the recommendations.

1. Transfer of Responsibilities

It is recommended that a definite date be established with respect to the transferring of the responsibility for the total administration of health services in the N.W.T. to the Government of the Northwest Territories.

The Government of the N.W.T. has developed a policy of decentralization and devolution. It is presently in the process of identifying those programs and services which can be delegated to a community level of management. As has been mentioned in other sections in this report greater community involvement in the planning and delivery of health services and programs should be encouraged.

The development of a coordinated and integrated system is hampered by the present duplication of manpower and financial resources by Health and Welfare Canada and the Territorial Government at the administrative level and by the confusion this creates at the community level.

It is recognized that there are many complex facets to this question which have to be thoroughly resolved in order to prevent future complications. It is also recognized that a great deal of work must go into the planning of an orderly transfer of responsibility. Therefore, a planning group should be established as soon as possible to expedite the administrative

tasks associated with a transfer. This planning group should solicit ideas from individuals and community groups with respect to the specifics of the services and programs to be developed and implemented.

2. Terminology

It is recommended that a glossary of terms and concepts related to health care services be developed and published.

"Health Care" is a very vague concept to most people. Many are unaware of the scope of the health care field and how it is inter-related with so many other disciplines. Defining concepts and having them translated into Inuktitut would be a first step in the process of beginning discussions in many communities in the study area.

The problems of translating for patients and medical personnel was mentioned many times. Valuable time can be lost trying to find the right words to phrase a question or give a precise answer in reply. A glossary of terms would be of assistance in ensuring that correct and complete information is translated.

Such a glossary would also be valuable to community groups, such as the community council and community health committee, to assist them in understanding issues in the health care field.

3. Public Information/Education Package

It is recommended that a package of educational material be developed for the use of individuals and community groups designed to develop a knowledge base of health services, programs and facilities.

At present if an individual or community group wants to find out about programs and services they often have to go to several sources to obtain a complete picture. The development of a comprehensive package, including audio-visual resources, would assist in providing individuals and groups with a knowledge base.

Short audiovisual cassettes could be prepared outlining the goals and objectives of various health services and programs. These could be set up for viewing in waiting rooms in hospitals, nursing stations, government offices and airport waiting rooms.

A document should be prepared outlining the Canadian and N.W.T. Health Care system and the present goals and objectives of the N.W.T. organization. A timetable should be developed concerning the achievement of the goals and objectives. This would assist community health committees in the establishment of their own priorities. This document should be given as wide a distribution as possible in order to ensure community councils and community health committees give a high priority to defining their particular needs and required resources.

4. Interpreting Services

It is recommended that interpreter services be readily available at all major health centres and hospitals.

The problems of interpreting becomes very great when Inuit residents travel to centres such as Montreal, Winnipeg, and Edmonton for treatment and they are unable to converse easily in English.

Health and Welfare Canada endeavours to provide patients and medical personnel with interpreter services. However, problems do exist, for example: in Montreal the most common complaint received was that the interpreters are from northern Quebec and speak a different dialect than the people from the Northwest Territories.

The lack of adequate interpreting services can lead to a very lonely and frustrating experience for the patient.

The arrangement at the hospital in Moose Factory where Health and Welfare Canada hires interpreters on a rotating basis should be reviewed.

It is recommended that discussions be initiated with the Director of Information Services, Government of the Northwest Territories to determine the possibility of a more comprehensive interpreter service being undertaken under the auspices of the Interpreter Corps.

5. Community Health Committees

It is recommended that Health Committees be actively encouraged in each community to provide guidance in the development of programs at the community level.

Communities have been encouraged by Medical Services, Health and Welfare Canada to set up health committees, usually as a committee of the Community Council.

Recently, Medical Services have established a special assignment to encourage community activity in this respect.

The relationship of the community nurse to those committees varies in terms of the commitment of the nurse to local development and the interest the committee members bring to their task. In all too many cases it appears that the committees have ended up with three main functions:

1. Community clean-up work
2. Local complaint group
3. Token support to nurse

In some communities the committees are very active and spend much of their time attempting to learn about programs and disseminating this information to the community. These committees usually meet on their own and request the nurse to attend as a resource person. These committees are also able to bring to the attention of the nurse situations which they feel the nurse should be involved in resolving. They are also able to offer criticisms which community members and groups have voiced about the health care system in a constructive manner.

It is recommended that material be prepared for presentation to community councils which outline the purpose and functions of health committees. Comprehensive Terms of Reference should be drawn up as guidelines for committees to consider. Each committee should set its own goals and objectives. A method of monitoring the achievement of the objectives should be developed. Workshops should be organized to allow members of various health committees to meet together to exchange ideas and further develop their knowledge and expertise.

The Community Health Committee is an excellent vehicle to obtain local input into program development and service delivery. At the present time there is limited local input and there is no formal mechanism to ensure that attention is paid to individual community requirements.

6. Auxiliary Health Care Personnel

It is recommended that the purpose and functions of Auxiliary Health Care personnel be evaluated.

In 1961 the Department of Indian Affairs and the Department of National Health and Welfare began planning for a Community Health Auxiliary course to be held in northern Manitoba. In 1972 a task force was established to examine the Community Health Auxiliary situation. In 1973 Health and Welfare Canada's Northern Region set up its first two training programs in this area.

However, in the N.W.T. the turn-over rate has been high and at the community level the program does not seem to be well understood.

The purpose of this recommendation is not to initiate another task force for study. It is to provide a vehicle for greater community involvement in the service process, in order to allow the development of a program geared to those needs and priorities established within the communities. This is also very possibly an area where employment opportunities in local communities can be further developed. It is necessary that career development be carefully considered so that personnel trained in these areas are not stuck in dead-end jobs. A high turn-over rate in the beginning should not necessarily be looked upon in a negative manner, as the knowledge gained through training will undoubtedly be put to work in the individual's personal life. However, should a person wich to pursue a career in the health care field there must be a range of opportunities available.

It would be wise to coordinate such a review with the various departments that are now involved in training and education programs.

7. Evaluation of Education/Training Programs

It is recommended that there be an evaluation of all education and training programs utilized by health care personnel from the N.W.T. to determine:

(i) does the program have realistic goals and objectives?
(ii) do the graduates utilize skills from the program?
(iii) are a sufficient number of personnel being trained?

Health and Welfare Canada have developed, or assisted in developing, several education and training programs such as the Community Health Representatives and Clinical Nurse Training Programs. In addition there are persons employed in the Health Care field in the N.W.T. who have completed post-graduate work in other countries. Graduates of all programs should be approached to determine the relevancy of these programs to their daily job. Those aspects of the program which are identified as being useful should be incorporated in future programs. Changes should be made to those aspects which are not identified as serving any useful function.

An analysis should also be made of personnel requirements to ensure that a sufficient number of persons are able to receive appropriate training and post-graduate studies.

8. Ear, Nose and Throat Team

It is recommended that an Ear, Nose and Throat Team be established to visit each community in the N.W.T. to assess those residents who are in need of services and to arrange treatment where required. This Team could also attempt to determine causes and make recommendations to correct factors leading to problems.

Such a service presently exists through arrangements made between Health and Welfare Canada and university medical personnel in Montreal, Winnipeg and Edmonton, however, the comprehensiveness of such services have been limited by budgetary constraints and the necessity to provide other required specialty services at the same time. Estimates of the extensiveness of the E.N.T. problems vary but most medical personnel indicate that there are a significant number of chronic problems in each community in the N.W.T. The increased usage of skidoos and the central location of electrical generating plants in some communities, has undoubtedly led to an increasing number of auditory problems. A team of specialists should be given the mandate to examine these problems in depth. The identification of causes should occur along with recommendations as to how these causes could be eliminated or reduced.

A program to assess and arrange for treatment of all E.N.T. problems will be costly if it is to be comprehensive. Discussions should be held with those specialists who have been providing the service in order to coordinate the workload and not duplicate what has already been accomplished.

An important component of the task for this team will be an educational program. Some audiological problems which exist are not improved by medical treatment. This has to be explained to people and suggestions made as to how the handicap can be minimized. Also ways of preventing problems for residents in the future should be recommended to each community.

In addition, the team should consider, in each community it visits, any environmental factors which could be causes of the problems (e.g. noise levels, housing). The team should make recommendations specific to the community regarding ways of minimizing these causative factors.

9. Ophthalmological Team

It is recommended that an Ophthalmological team be established to visit each community in the N.W.T. to assess those residents who are in need of services and to arrange treatment where required. This team should also attempt to determine causes of visual problems and recommend methods ~~of correcting~~ the problems.

The situation with eyes is much the same as for the E.N.T. problems mentioned in the previous recommendation. This program should also be coordinated through the specialists presently providing the service. The team should examine the causes of visual problems and provide recommendations as to how these causes can be minimized.

In nearly every community visited during the data gathering portion of this study, comments were made by community council members, residents and nurses about difficulties in this field. Services were sporadic, some communities had not been visited, in this specialty area, during the past two years. When the specialists did come, sometimes there was insufficient notice given to those people out hunting and/or trapping so they could arrange to travel into twon to see the specialist. There were many complaints about the length of time required to receive glasses and the adjustments required to obtain a reasonable fitting. Complaints about the quality of frames were common. Repairs for broken glasses and frames are stated to be very difficult to arrange and there are also lengthy service delays.

A way must be found to correct the deficiencies in this service area. However, such factors as weather conditions, transportation, and the availability of specialty services must be recognized.

10. Training Program for Audiological and Ophthalmic Technicians

It is recommended that a training program be established as soon as possible for Audiological and Ophthalmic Technicians in the N.W.T.

It should be noted that programs in ophthalmology, ear, nose and throat, and speech and hearing are being developed through the Stanton Yellowknife Hospital. As soon as possible this program should extend services to all residents of the N.W.T.

Until a territorial program can be established, arrangements should be made to utilize the services from southern Canada. An investment in audiometers and trained technicians would allow an initial examination, especially for school children, which would help to determine developing problems. The development of the program will also ease the workload of the nurses in the Nursing Stations and be a very welcome asset to most teachers.

11. Dental Therapists

It is recommended that the School of Dental Therapy in Fort Smith expand its program so that more Northerners are recruited and trained as Dental Therapists, and thus be available to provide services in the communities in the study area.

Some of the communities in the study area have received the services of Dental Therapists during the past two years. Their work has been appreciated and other communities have expressed interest in receiving the same services. Continued efforts must be made to attract Northern residents to enter this program for training and future employment.

12. Orientation Program

It is recommended that efforts be continued to ensure that the orientation program for Health and Welfare personnel, and Social Development personnel, are maintained; that they are current; and that they are as comprehensive as possible.

Despite the best intentions of both Health and Welfare Canada and the Government of the N.W.T. many persons arrive at their place of employment with little or no pre-employment orientation. This often leads to difficult situations during the first few weeks for both the employer and the residents of the community. If it is not possible to provide a formal orientation program before beginning a job, perhaps consideration could be given to developing an audiovisual program for all employees to utilize before starting a new job. Specific programs will have to be developed to deal with the unique features of each community and region.

An important part of an orientation program should be the identification of resource persons and organizations and training in the utilization of these resources. Too often people work in isolation or ignorance of each other and many benefits are lost.

15. X-Ray

It is recommended that a system of inspection of facilities and equipment, including diagnostic equipment such as X-ray machines, be undertaken on an annual basis and that a system be developed so that a record is left at each Nursing Station indicating:

a) the equipment and procedures checked
b) the date of the inspection
c) the name and position of the inspector
d) the results of the inspection and any recommendations
e) an outline of any in-service training undertaken and the names of the individuals participating in the training

The majority of Nursing Stations personnel visited were unable to provide information as to when the X-ray machine in their station was last checked and serviced, although Medical Services have a program under which the equipment is to be checked on an annual basis by one of their radiological technicians.

The X-ray machines are well utilized in most Nursing Stations and form an integral part in the preventive public health program as well as being utilized in the direct treatment area. Standards for the use of X-rays, and specifications and directions for those operating X-ray machines should be established and form part of the orientation program for health personnel. The on-going orientation and training program under Medical Services should be continued to ensure that individuals are familiar with the operation of X-ray equipment.

16. Pharmaceutical Supplies

It is recommended that an inventory of pharmaceutical supplies in all communities be conducted and outdated drugs and supplies be returned to the wholesaler or manufacturer for credit, or be disposed of immediately.

Most Nursing Stations have a well stocked pharmaceutical area. However, it was noted by some personnel that many of the supplies are outdated or never used. Some of the doctors indicated that they would never use some of the materials stocked because of improvements and/or alternatives which have been developed and are superior. Health and Welfare Canada personnel have indicated that a program to standardize and control drug stocks is underway and this should assist in eliminating future problems.

Discussions should be held with doctors at the major medical centres to ensure the drugs they are utilizing in an on-going treatment program for discharged patients are available in the patient's home community in the N.W.T. If not available the drugs should accompany the patient back to the community.

17. Communication Network

It is recommended that a radio communication network be set up between the Nursing Station and their referral hospital.

Many problems were cited by nurses who have had to rely upon the commercial communications network to obtain medical advice, especially in emergency situations. In many communities the problem is not as acute as it was in the past now that more reliable telephone service has been introduced. A recent announcement (January 1977) by the Minister of Indian and Northern Affairs would indicate that during the next five years all communities in the N.W.T. will have excellent telephone service available.

In the meantime, and until such time as all problems are worked out in the new telephone service, it is recommended that all Nursing Stations be equipped with radio transmitters which will allow them to have a communication grid as reliable as can be obtained at this time. Such a system would allow instant communication with other Nursing Stations and a hospital and would facilitate the flow of information about patients and their families. It might also provide some social and professional contact with other nurses and doctors. With the emergency power capability at most Nursing Stations the radio might also be a valuable link to obtain assistance during emergencies.

Prior to action being initiated on this recommendation careful analysis of the proposed telecommunication study by Health and Welfare Canada in the Baffin Zone should be made as well as an examination of previous efforts made to update communications, for example at Sioux Lookout and in Alaska.

18. Environmental Health

It is recommended that increased financial resources and manpower be allocated to deal with environmental health issues in the N.W.T.

There is a point at which increased investment in treatment programs does not bring about an equivalent decline in illness. The argument has been put forth that perhaps the N.W.T. is rapidly reaching this point (Report of Chief Medical Officer, 1975).

The Environmental Health Officers are charged with the responsibility of monitoring the housing, water supply, waste disposal, and food supplies in the N.W.T. The problems of obtaining an adequate water supply have plagued several communities for many years. Although all levels of Government agree that adequate levels of water supply are required there is confusion when it comes to accepting responsibility for locating the necessary financial resources to ensure such a supply.

The same problems exist with sewage disposal, compounded by the fact that many residents in a community do not concern themselves with this problem to the same extent that they do with their water supply. A great deal of effort has to be expended in educating people about the importance of proper sewage disposal and the necessity to deal firmly with those who violate the basic rules. The problem is not so much the actual disposal as it is the attitude of the people about disposal.

As industrial development increases, the personnel available to monitor the effects of this development of the environment must be expanded. The N.W.T.'s environment has undergone numerous studies during the past few years related to industrial development and more are promised. The information from such studies should provide excellent base line data for monitoring changes. It is important that sufficient personnel are available to do this task.

19. Occupational Health

It is recommended that the Government of the N.W.T. develop standards for Occupational Health along with mechanisms which provide for enforcement of such standards.

The area of occupational health and safety has come to the forefront during the past few months. It is recommended that the Government of the N.W.T. become a leader in this field by establishing standards and ensuring that such standards that are set, are enforced. At the present time there is a minimum of industrial development in the Central and Eastern Arctic area, however, valuable non-renewable resources are located in these areas and safeguards should be established now for protection of the residents of the area. Regardless of the cost of production, the health of workers and the environmental effects on the community must be of paramount importance.

Occupational Health should be considered an integral part of community and public health services. In some jurisdictions a fragmentation of services has been permitted to develop and as a result there is duplication of services and required resources. Therefore, in the N.W.T., Occupational Health should be planned as an important aspect of the total health service.

20. Housing

It is recommended that resources to provide adequate housing of a design acceptable to Northern residents be increased.

Many reports on health and social issues in the N.W.T. comment upon the lack of adequate housing and the abundance of substandard units. The difficulties of determining what kind of structures are appropriate for the Arctic climate and Northern residents have been well documented and discussed. However, until sufficient adequate units are available the opportunity to enjoy the maximum level of good health will be thwarted. A substantially increased amount of money and manpower must be invested immediately to alleviate overcrowding and the continued use of substandard units.

21. Central Arctic Community Health Centre

It is recommended that the feasibility of establishing a Community Health Centre in Cambridge Bay be examined.

The Central Arctic communities have a combined population of 3,108 persons and population projections to 1983 show a total of 4,232 persons being in this geographic area. There is one doctor resident in Cambridge Bay who serves these communities but the present facility in Cambridge Bay is an expanded Nursing Station and is not designed to provide any services other than the regular Nursing Station functions. It is possible that with a small community health centre available, the number of persons having to travel to Yellowknife from this area for medical services could be reduced. This would, of course, require an analysis of the past patterns of services to determine the feasibility of the recommendation. Any facility proposed for this area should include both acute and extended care services.

22. Keewatin Health Centre

It is recommended that a new Health Centre, including facilities for acute and chronic care, be built in the Keewatin Region.

During the data gathering portion of this study many comments were received from former patients, members of health committees, and members of community councils in the Keewatin Region indicating a desire to see a hospital facility built in the Keewatin. Many people are unhappy about travelling to Churchill for outpatient and inpatient hospital care. They would prefer to receive such care closer to home as do residents in the Western and Eastern Arctic regions.

The Government of the N.W.T. has located their administration and service centre in Rankin Inlet. Native groups, such as the Inuit Tapirisat of Canada, have indicated their desire to locate their headquarters in the N.W.T., possibly in a community in the Keewatin Region. There is a possibility of significant industrial development in the future which should be borne in mind. The population projections for the Keewatin Region show a steady growth in the number of residents and there are a sufficient number to support a small health centre. An analysis of the number of patient days spent by N.W.T. residents at the Churchill Health Centre indicates the viability of operating a facility in the Keewatin. The funds spent by the Government of the N.W.T. in transportation costs, per diem costs and the operation and maintenance of an antiquated and poorly located Transient Centre in Churchill might be better invested in facilities and jobs within the N.W.T.

Consultation with community councils and groups should take place regarding the location of this proposed facility. Scheduled and chartered air transportation services will have to be taken into account as well as the community's ability to provide services to a major undertaking such as this recommended facility.

22. Keewatin Health Centre - Continued

The Keewatin Regional Health Centre should contain sufficient space to provide the following services:

1. Ambulatory services for outpatients and emergencies
2. Home Care
3. Acute care inpatient beds for adult and children
4. Chronic/Extended care beds
5. Physicians' offices and facilities for visiting clinics
6. Dental offices
7. Offices for Public Health personnel
8. Offices for Social Service personnel
9. Hostel beds for those awaiting transportation

Based upon nationally recommended standards of beds per thousand population ratios, the proposed facility in the Keewatin should contain 25 beds. It should be served by physicians who could provide services at the health facility as well as providing physician services to the communities in the Keewatin Region.

23. Chesterfield Inlet - Chronic Care

It is recommended that the use of Ste. Therese de l'enfant Jesus Hospital in Chesterfield Inlet as a chronic care facility be phased out during the next four years.

As mentioned previously the necessary renovations to the building to bring it up to minimum acceptable standard in relation to fire regulations are too costly for the Diocese to consider. The facility is not suitably designed for chronic care and the staff are hard pressed to overcome all the built-in deficiencies.

An effort should be made to provide care for some of the patients in their home communities. This will require a great deal of planning, coordination and support. Planning for the home care of individual patients has been attempted in the past but there should be personnel trained in the home community prior to any person being moved, in an effort to provide the home and community support necessary to make the plans and program succeed.

Those patients for whom home care cannot be considered could become residents of the proposed new chronic care facility in the Keewatin health unit as soon as it is available.

APPENDICES

APPENDIX I

POPULATION OF STUDY AREA 1971, 1976 PROJECTION TO 1983

a) CENTRAL ARCTIC REGION

COMMUNITY	1971	1976	1977	1978	1979	1980	1981	1982	1983
COPPERMINE	637	754	801	833	866	900	932	964	994
HOLMAN ISLAND	241	262	278	290	301	313	324	335	346
CAMBRIDGE BAY	716	746	898	935	972	1,010	1,045	1,080	1,116
GJOA HAVEN	276	418	444	462	481	500	517	535	551
SPENCE BAY	209	437	464	483	502	521	539	558	576
PELLY BAY	215	242	257	268	278	289	299	308	320
RESOLUTE BAY	134	249	264	275	286	297	308	318	329
TOTAL	2,428	3,108	3,406	3,546	3,686	3,830	3,964	4,098	4,232

Source: Government of the N.W.T.
Department of Planning and Program Evaluation
(Based upon Statistics Canada Census data)

APPENDIX I

POPULATION OF STUDY AREA 1971, 1976 PROJECTION TO 1983

b) KEEWATIN REGION

COMMUNITY	1971	1976	1977	1978	1979	1980	1981	1982	1983
ESKIMO POINT	875	837	892	932	971	1,013	1,051	1,091	1,130
WHALE COVE	213	177	177	177	177	177	177	177	177
RANKIN INLET	566	842	905	955	1,005	1,057	1,108	1,161	1,215
BAKER LAKE	756	853	893	916	937	958	974	990	1,006
CHESTERFIELD INLET	258	241	241	241	241	241	241	241	241
CORAL HARBOUR	242	266	283	294	306	318	329	341	530
TOTAL	3,265	3,626	3,825	3,966	4,104	4,247	4,378	4,515	4,650

Source: Government of the N.W.T.
Department of Planning and Program Evaluation
(Based upon Statistics Canada Census data)

APPENDIX I

POPULATION OF STUDY AREA 1971, 1976
PROJECTION TO 1983

c) BAFFIN REGION

COMMUNITY	1971	1976	1977	1978	1979	1980	1981	1982	1983
SANIKILUAQ	-	298	316	329	342	356	368	381	393
PORT BURWELL	107	97	94	94	94	94	94	94	94
LAKE HARBOUR	189	233	246	255	264	273	281	289	296
CAPE DORSET	597	617	657	686	714	744	772	801	830
FROBISHER BAY	2,014	2,291	2,428	2,524	2,617	2,715	2,803	2,893	2,982
PANGNIRTUNG	690	946	1,004	1,046	1,087	1,130	1,169	1,209	1,247
BROUGHTON ISLAND	334	351	373	388	403	419	434	449	464
CLYDE RIVER	274	348	370	386	401	418	433	448	464
POND INLET	416	500	531	554	576	599	620	642	662
NANISIVIK	-	265	307	347	389	435	482	533	587
HALL BEACH	-	662	303	315	327	340	351	363	375
IGLOOLIK	563	235	668	722	738	757	770	814	862
ARCTIC BAY	269	388	411	427	442	458	473	488	500
GRISE FIORD	109	120	126	129	132	135	137	140	141
TOTAL	5,562	7,351	7,834	8,202	8,526	8,873	9,187	9,544	9,897

Source: Government of the N.W.T.
Department of Planning and Program Evaluation
(Based upon Statistics Canada Census data)

APPENDIX II

II.

NORTHWEST TERRITORIES

Vital Statistics - 1975

	INDIANS 1975 Pop. - 7,678 (7,605)				ESKIMOS 1975 Pop. - 14,303 (14,117)				OTHERS 1975 Pop. - 16,867 (16,626)				ALL GROUPS 1975 Pop. - 38,848 (38,348)				ALL CANADA
	1975		1974	1973	1975		1974	1973	1975		1974	1973	1975		1974	1973	1973
	No.	Rate	Rate	Rate	No.	Rate	Rate	Rate	No.	Rate	Rate	Rate	No.	Rate	Rate	Rate	Rate
Livebirths (a)	198	26.0	23.6	26.0	458	32.4	28.4	32.8	540	32.4	29.3	34.2	1196	31.2	27.8	32.0	15.5
Illegitimate Live Births (b)	107	54.0	49.4	45.6	168	36.6	29.0	30.2	114	21.1	20.3	16.2	389	32.5	28.4	25.3	-
Livebirths born in Hosps. and N/S (c)	196	98.9	97.8	96.9	446	97.8	98.9	97.3	535	99.0	99.0	99.6	1179	98.5	98.0	98.5	98.8
Low Birth Weight Infants (d)	26	13.1	8.9	12.4	25	5.4	8.6	10.9	21	3.8	5.0	4.3	72	6.0	7.0	8.1	-
Stillbirths (e)	5	25.2	0	5.1	4	8.7	20.2	15.6	7	12.9	12.4	7.2	16	13.3	13.2	10.1	10.6
Perinatal Deaths (f)	13	64.0	16.8	25.9	9	19.4	49.5	26.8	10	18.2	24.6	12.7	32	26.4	33.2	20.2	17.6
Neonatal Deaths (0-28 days) (g)	8	40.4	16.8	20.7	8	17.4	40.4	13.4	5	9.2	12.4	5.4	21	17.5	23.7	10.9	10.8
Post Neonatal Deaths (29-365 days) (h)	5	25.2	38.1	10.3	14	30.5	30.3	31.3	2	3.7	6.2	7.2	21	17.5	18.9	16.8	4.8
Infant Deaths (under 1 year) (i)	13	65.6	44.9	31.0	22	48.0	70.7	44.7	7	12.9	18.7	12.7	42	35.1	42.6	27.7	15.5
Total Deaths (Crude Death Rate) (j)	53	6.9	6.2	5.9	87	6.1	6.7	6.1	57	3.4	4.5	5.8	197	5.1	5.7	5.9	7.4
Deaths in Hosps. and N/S (k)	33	62.2	65.9	71.4	46	52.8	48.9	57.1	26	45.6	58.6	47.3	105	53.2	56.0	55.7	-
Natural Increase (l)	145	19.0	17.4	20.1	371	26.2	21.6	26.6	483	29.0	24.7	23.4	999	26.0	22.3	26.1	8.1
Maternal Deaths (m)	0	0	0	0	1	21.8	25.5	0	0	0	0	0	1	8.3	9.5	0	1.2

Source: Report on Medical Conditions in the N.W.T., 1975

(a) rate per 1,000 population
(b) rate per 100 live births
(c) rate per 100 live births
(d) rate per 1,000 live births
(e) stillbirths plus deaths 0-7 days per 1,000 total births (live births & stillbirths)
(f) deaths 0-28 days per 1,000 live births
(g) deaths 29-365 days per 1,000 live births
(h) deaths under 1 year per 1,000 live births
(i) crude death rate - deaths per 1,000 population
(j) rate per 100 deaths
(k) rate per 1,000 population
(l) rate per 10,000 live births

( ) Figures in brackets are "mid-year" pop.

N.B. To bring statistics into line with national compilations, rates (a) (j) and (l) have been calculated this year on the mid year calculated populations. In previous reports the end of year population has been used as a basis for calculation. Result is to elevate (slightly) calculated rates!

APPENDIX III

III. NORTHWEST TERRITORIES

POPULATION BY FIVE YEAR AGE GROUPS AND SEX 1971

	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	90-94	+95
TOTAL	34305	5475	5390	4080	2995	3435	3115	2405	2005	1540	1300	990	740	580	320	210	125	70	15	5	5
MALES	18280	2815	2770	2110	1500	1755	1605	1230	1100	845	725	550	415	355	180	95	70	40	5	-	5
FEMALES	16525	2660	2615	1965	1490	1680	1455	1130	905	695	575	440	320	230	145	115	55	25	5	5	-

Source: Statistics Canada, 1971 Census

IV

HEALTH AND WELFARE CANADA
1977/78 MAN-YEAR ALLOCATION, N.W.T. REGION

a) REGIONAL HEADQUARTERS

Division	Classification	Man-Years
Regional Director	MD-MOF	1
	ST-SCY	1
Property Management	EG-ESS	1
	GL-CO1	1
	GL-	1
Assistant Regional	AS	1
	ST-SCY	1
Office Management	AS	1
	CR	1
	CR	1
	CR	1
	CR	1
	ST-SCY	1
	STN	1
	CR	1
Personnel	PE	1
	PE	1
	PE	1
	PE	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	ST-SCY	1
	CR	1
Program Planning	AS	1
	CR	1
Regional Alcohol Consultant	WP	1

....2

a) REGIONAL HEADQUARTERS (cont'd)

Division	Classification	Man-Years
Fort Smith School of Dental Therapy	CR	1
	CR	1
	CR	1
	EG-HOT	1
	GL-INM	1
Chronic Disease Control	MD-MOF	1
	MOF	1
	PM	1
	EG-HOT	1
	CR	1
	CR	1
	CR	1
	CR	1
	ST-TYP	1
	ST-TYP	1
	EG-HOT	1
	CR	1
Northern Medical Research	MD-MSP	1
	MOF	1
	ST-SCY	1
Finance	FI	1
	FI	1
	FI	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	AS	1
	CR	1
Director Program Development	MD-MOF	1
	ST-SCY	1
	DE	1
	EG-ESS	1
Regional Psychiatrist	MD-MSP	1
Health Educator	ED-EDS	1
	EDS	1

.....3

a) REGIONAL HEADQUARTERS (Cont'd)

Division	Classification	Man-Years
Infectious Diseases	PM	1
	CR	1
Registered Nurses	NU-CHN	1
	CHN	1
	CHN	1
Regional Engineer	EN-ENG	1
Reg. Nutritionist	HE-ADV	1
		78

1977/78 MAN-YEAR ALLOCATION

b) MACKENZIE ZONE

Division	Classification	Man-Years
Mackenzie Zone H.Q.	PM	1
	NU-CHN	1
	CHN	1
	ST-SCY	1
	TYP	1
	TYP	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	AS	1
Fort Resolution	NU-CHN	1
	NU-CHN	1
	HS-HDO	1
	HDO	1
Fort Smith Clinic	MD-MOF	1
	MOF	1
	MOF	1
	CHN	1
	CHN	1
	CHN	1
	CR	1
	CR	1
Fort Providence	NU-CHN	1
	NU-CHN	1
	HS-PHS	1
	HS-HDO	1/2
	HDO	1
Hay River	NU-CHN	1
	CHN	1
	NU-CHN	1
	HS-PHS	1
	CR	1
Fort Wrigley	NU-CHN	1
	HS-HDO	1/2
	HDO	1/2

....2

b) MACKENZIE ZONE (cont'd)

Division	Classification	Man-Years
Fort Liard	NU-CHN	1
	HS-HDO	1/2
	HDO	1/2
Fort Rae Clinic	MD-MOF	1
Yellowknife Health Centre	NU-CHN	1
	CHN	1
	CHN	1
	CHN	1
	CHN	1
	CHN	1
	CR	1
Snowdrift	NU-CHN	1
	HS-HDO	1/2
	HDO	1/2
Health Services	EG-ESS	1
	ESS	1
	ESS	1
	MD-MSP	1
	PSY	1
	GL-PIP	1
	MAM	1
	MD-MOF	1
Edzo Health Centre	NU-CHN	1
	CHN	1
	HS-PHS	1
Fort Simpson Clinic	MD-MOF	1
	NU-CHN	1
	HOS	1
	EG-HOT	1
	HOT	1
	NU-CHN	1
	HS-PHS	1
Pine Point	NU-CHN	1
		69½

1977/78 MAN-YEAR ALLOCATION

b) RAE-EDZO HOSPITAL

Division	Classification	Man-Years
Edzo-Hospital Nursing Administration	NU-CHN	1
Edzo-Hospital Nursing Care	NU-HOS	
	HOS	
	HOS	
	HOS	
	HOS	5
	HS-PHS	1
Edzo-Hospital General Administration	CR	1
Edzo-Hospital Dietary	HS-HDO	
	HDO	2
Edzo-Hospital Housekeeping	HS-HDO	1
		11

Total Mackenzie Zone Man Years: 99½

1977/78 MAN-YEAR ALLOCATION

b) FORT SIMPSON HOSPITAL

Division	Classification	Man-Years
Fort Simpson Hospital	NU-HOS	1
F.S.H. Nursing Care	NU-HOS	
	HOS	
	HOS	
	HOS	
	HOS	5
	HS-PHS	
	PHS	
	PHS	3
F.S.H. Gen. Admin.	CR	
	CR	
	CR	3
F.S.H. Dietary	HS-HDO	
	HDO	
	HDO	3
F.S.H. Housekeeping	HS-HDO	
	HDO	
	HDO	3
F.S.H. Plant Maintenance	GL-MAM	1
		19

1977/78 MAN-YEAR ALLOCATION

c) KEEWATIN ZONE

Division	Classification	Man-Years
Keewatin Zone H.Q.	PM	1
	NU-CHN	1
	CR	1
	CR	1
	CR	1
	CR	1
	ST-SCY	1
Zone Health Service	EG-ESS	1
	GL-PIP	1
	MDO	1
Baker Lake	NU-CHN	1
	EG-HOT	1
	NU-CHN	1
	CHN	1
	HS-HDO	1
	HDO	1
	CR	1
Coral Harbour	NU-CHN	1
	NU-CHN	1
	HS-HDO	1
	HDO	1
	CR	1
Chesterfield Inlet	NU-CHN	1
	HS-HDO	1
	HDO	1
Rankin Inlet	NU-CHN	1
	CHN	1
	EG-HOT	1
	NU-CHN	1
	CHN	1
	CHN	1
	HS-PHS	1
	CR	1
	HS-HDO	1
	HDO	1
Eskimo Point	NU-CHN	1
	CHN	1
	EG-HOT	1
	NU-CHN	1
	HS-PHS	1
	PHS	1
	CR	1
	HS-HDO	1
	HDO	1

....2

c) KEEWATIN ZONE (cont'd)

Division	Classification	Man-Years
Whale Cove	NU-CHN	1
	HS-HDO	1
Repulse Bay	NU-CHN	1
	HS-HDO	1
Belcher Island	NU-CHN	1
	HS-HDO	1
Dental Clinic	DE	1
	HS-PHS	1
Total Keewatin Zone Man Years		52

1977/78 MAN-YEAR ALLOCATION

d) BAFFIN ZONE

Division	Classification	Man-Years
Baffin Zone H.Q.	MD-MOF	1
	ST-SCY	1
	NU-CHN	1
	CHN	1
Frobisher Bay Clinic	MD-MOF	1
	MOF	1
	MOF	1
	MOF	1
Cape Dorset	NU-CHN	1
	EG-HOT	1
	NU-CHN	1
	HS-HDO	1
	HDO	1
Lake Harbour	NU-CHN	1
	HS-HDO	1
Pangnirtung	NU-CHN	1
	EG-HOT	1
	NU-CHN	1
	HS-HDO	1
	HDO	1
Foxe	NU-CHN	1
	NU-CHN	1
	HS-HDO	1
	HDO	1/2
Pond Inlet	NU-CHN	1
	CHN	1
	EG-HOT	1
	NU-CHN	1
	HS-HDO	1
	HDO	1/2
Igloolik	NU-CHN	1
	CHN	1
	HS-PHS	1
	HDO	1
	HDO	1
	EG-HOT	1

....2

1977/78 MAN-YEAR ALLOCATION

d) BAFFIN ZONE (cont'd)

Division	Classification	Man-Years
Clyde River	NU-CHN	1
	CHN	1
	HS-PHS	1
	HDO	1
	HDO-3	1
Zone Health Services	EG-ESS	1
Frobisher Bay Health Centre	NU-CHN	1
	CHN	1
	CHN	1
	CHN	1
	CHN	1
	CHN	1
	CR	1
	CR	1
Broughton Island	NU-CHN	1
	CHN	1
	HS-HDO	1
	HDO	1
Arctic Bay	NU-CHN	1
	HS-PHS	1
	HDO	1
Resolute Bay	NU-CHN	1
	CHN	1
	HS-HDO	1
	HDO	1/2
Dental Clinic	DE	1
	DE	1
	DE	1
	HS-PHS	1
	PHS	1
	PHS	1
Nanasivik	MD-MOF	1
	NU-CHN	1
		70

1977/78 MAN-YEARS ALLOCATION

d) FROBISHER BAY HOSPITAL

Division	Classification	Man-Years
FGH Nursing Admin.	NU-HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HS-PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	CR-CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
FGH Operating Room	NU-HOS	1
FGH Central Supply	HS-PHS	1
FGH Laboratory Clinical	EG-HOT	1
FGH Pharmacy	PH-DIS	1
FGH Radiology	EG-HOT	1
FGH General Admin.	AS-AS	1
	AS-AS	1
	CR-CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR-CR	1
	CR	1
	CR	1

...2

1977/78 MAN-YEAR ALLOCATION

d) FROBISHER BAY HOSPITAL (cont'd)

Division	Classification	Man-Years
FGH Gen. Admin.(cont'd)	ST-STN	1
	GL-MDO	1
	MDO	1
	MDO	1
	MDO	1
	MDO	1
	HS-HDO	1
FGH Medical Records	CR-CR	1
FGH Linen	HS-HDO	1
FGH Plant Operator	GL-MDO	1
FGH Plant Maintenance	GL-PIP	1
	GL-EIM	1
	GL-VHE	1
	GL-PIP	1
	GL-ELE	1
	GL-MAM	1
		67
Total Baffin Zone Man Years		137

1977/78 MAN-YEAR ALLOCATION

e) INUVIK ZONE

Division	Classification	Man-Years
Inuvik Zone H.Q.	MD-MOF	1
	ST-SCY	1
	NU-CHN	1
Fort Norman	NU-CHN	1
	HS-HDO	1
Fort Franklin	NU-CHN	1
	NU-CHN	1
	HS-PHS	1
	HS-HDO	1
	HS-HDO	1
Inuvik Clinic	MD-MOF	1
	MOF	1
	MOF	1
	MOF	1
	MOF	1
	MOF	1
	ST-SCY	1
Fort McPherson	NU-CHN	1
	CHN	1
	EG-HOT	1
	NU-CHN	1
	HS-HDO	1
	HDO	1
	PHS	1
Fort Good Hope	NU-CHN	1
	NU-CHN	1
	HS-PHS	1
	HS-HDO	1
	HDO	1
Aklavik	NU-CHN	1
	CHN	1
	NU-CHN	1
	HS-HDO	1
Tuktoyaktuk	NU-CHN	1
	CHN	1
	EG-HOT	1
	NU-CHN	1
	HS-HDO	1
	HDO	1/2

....2

1977/78 MAN-YEAR ALLOCATION

e) INUVIK ZONE (cont'd)

Division	Classification	Man-Years
Inuvik Zone Health Services	EG-ESS	1
	ESS	1
Sachs Harbour	NU-CHN	1
Inuvik Health Centre	NU-CHN	1
	CHN	1
	CHN	1
	CHN	1
	CHN	1
	CR	1
Norman Wells	NU-CHN	1
	CHN	1
	HS-HDO	1
Dental Clinic	DE	1
	DE	1
	DE	1
	CR	1
	HS-PHS	1
	PHS	1
		56

1977/78 MAN-YEAR ALLOCATION

e) INUVIK GENERAL HOSPITAL

Division	Classification	Man-Years
IGH Nursing Admin.	NU-HOS	1
IGH Nursing Care	NU-HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HOS	1
	HS-PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1
	PHS	1

...2

1977/78 MAN-YEAR ALLOCATION

e) INUVIK GENERAL HOSPITAL (Cont'd)

Division	Classification	Man-Years
IGH Nursery	NU-HUS	1
	HS-PHS	1
IGH Operating Room	HS-PHS	1
IGH Central Supply	HS-PHS	1
IGH Lab-Clinical	EG-HOT	1
	HOT	1
	HOT	1
IGH Pharmacy	PH-DIS	1
IGH Radiology	EG-HOT	1
	HOT	1
IGH Occup. Therapist	OP-OP	1
IGH General Admin.	AS-AS	1
	AS	1
	CR-CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	CR	1
	ST-STN	1
	HS-HDO	1
	HDO	1
	HDO	1
	HDO	1
IGH Medical Records	CR-CR	1
	CR	1
IGH Dietary	HS-HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1

...3

1977/78 MAN-YEAR ALLOCATION

e) INUVIK GENERAL HOSPITAL (Cont'd)

Division	Classification	Man-Years
IGH Housekeeping	HS-HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HDO	1
	HS-PHS	1
IGH Plant Operator	GL-MAM	1
	ELE	1
	HS-HDO	1
	HDO	1
	HDO	1
IGH Plant Maintenance	GL-EIM	1
	EIM	1
	PIP	1
	WOW	1
	HS-HDO	1
	HDO	1
		112
Total Inuvik Zone Man Years		168

APPENDIX V

GOVERNMENT OF THE N.W.T. 1977/78 MAN-YEARS ALLOCATION
DEPARTMENT OF SOCIAL DEVELOPMENT, HEALTH CARE PLAN

POSITION	MAN-YEARS
Chief	1
Senior Programs Officer	1
Programs Officer	1
Programs Officer	1
Programs Officer	1
Programs Officer	1
Supervisor, Health Care Plan	1
Senior Administration Clerk	1
Secretary	1
Secretary	1
Clerk Typist	1
Clerk Typist	1
Clerk Typist	1
Senior Registration Clerk	1
Registration Clerk	1
Registration Clerk	1
Registration Clerk	1
Registration Clerk/Hospital* shared	½
Registration Clerk	1
Senior Control Clerk	1
Financial Control Clerk	1
Financial Control Clerk	1
Audit Control Clerk	1
Financial/Physician Reg. Clerk	1
Senior Hospital Claims Clerk	1
Hospital/Registration Clerk* shared	½
Senior Medical Claims Clerk	1
Assessment Clerk	1
Assessment Clerk	1
Total Man Years	28

APPENDIX VI(a)

N.W.T. BUDGET REVIEW HOSPITAL
YELLOWKNIFE - STANTON YELLOWKNIFE HOSPITAL

Medical - Ophthalmological Program	Ophthalmic Surgeon	1
	Ophthalmic Surgeon (To be recruited)	1
	Ophthalmic Technician	1
	Ophthalmic Technician	1
	Ophthalmic Technician	1
	Ophthalmic Technician	1
	Registered Nurse	1
	Secretarial	1
Medical - Ear, Nose, Throat Program	Otorhinolaryngologist	1
	Registered Nurse	1
	Secretarial	1
Medical Specialists	Gynecologist	1
	Orthopedic Surgeon	1
	Registered Nurse	1
Medical - Speech Therapy	Speech Therapist	1
Nursing - Administration	Director of Nursing	1
	Supervisor, RN	1
	Supervisor, RN	1
	Supervisor, RN	1
	Supervisor, RN	½
	Supervisor, RN	½
Nursing - Nursery	RN	1
	CNA	1
	CNA	1
Nursing - Operating Room	Charge Nurse, RN	1
	RN	1
	RN	1
	RN	1
	Technician	1
Nursing - Obstetrics	Charge Nurse, RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1

APPENDIX VI(a) continued

Nursing - Medicine	Charge Nurse, R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
Nursing - Pediatrics	Charge Nurse, R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
Nursing - Surgery	Charge Nurse, R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
	C.N.A.	1
Nursing - Emergency	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1
	R.N.	1/2
	R.N.	1/2
Nursing - C.S.R.	Orderly	1
	C.N.A.	1
	Aide	1
Laboratory	Supervisor	1
	Technician	1
	Technician	1
	Technician	1
	Technician	1
	Technician	1
	Technician	1
	Assistant (Aide)	1
	Assistant (Aide)	1

APPENDIX VI(a) continued

Pharmacy	Pharmacist	1
Radiology	Technician	1
	Technician	1
Physiotherapy	Director	1
	Physiotherapist	1
	Physiotherapist	½
Coordinated Homecare	Director	½
Administration	Administrator	1
	Business Manager	1
	Secretary	1
	Purchasing Agent	1
	Payroll Clerk	1
	Acct. Rec. Clerk	1
	Acct. Pay. Clerk	1
	Admitting Supervisor	1
	Admitting Clerk	1
	Admitting Clerk	1
	Admitting Clerk	1
Medical Records	Librarian	1
	Accredited Record Tech.	1
	Accredited Record Tech.	1
	Accredited Record Tech.	1
Dietary	Director	1
	Food Services Dietician	1
	Therapeutic Dietician	1
	Diet Tech. Student	1
	Cook	1
	Cook	1
	Cook	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
Housekeeping	Supervisor	1
	Custodian	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1

APPENDIX VI(a) continued

Laundry	Aide	1
	Aide	1
	Aide	1
Linen	Seamstress	1
Plant Operation	Director	½
	Engineer	1
Plant Maintenance	Director	½
	Utility Room	1
	Utility Room	1
TOTAL MAN YEARS APPROVED BY T.H.I.S. FOR 1977		141

APPENDIX VI (b)

N.W.T. BUDGET REVIEW HOSPITAL
HAY RIVER - H.H. WILLIAMS HOSPITAL

Nursing Administration	Director of Nursing	1
	Clinical Supervisor	1
	Activity Control Centre	
	Administrative Communication Centre Clerk	1
	Clerk	1
	RN	1
	RN	1
Nursing Care - Acute and Chronic Care	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	RNA/CNA	1
	Orderly	1
	ORRN	1
	ORRN	½
Nursing Care - Home Care SPD	RN	1
	Aide	1
	Aide	1
	Supply Technician	1
Administration	Administrator	1
	Accountant	1
	Accounting Clerk	1
	Secretary	1

Laboratory	Technician	1
	Asst. Technician	½
	Clerk	1
Radiology	Technician	1
	Asst. Technician	½
Admitting	Admitting Clerk	1
	Admitting Clerk	1
	Admitting Clerk	1
Medical Records	Technician	1
Housekeeping	Director	1
	Maid	1
	Maid	1
	Maid	1
	Janitor	1
Laundry and Linen	Maid	1
	Maid	1
Maintenance	Plant Engineer	1
	Helper	1
	Helper	1
Dietary	Dietary Technician	1
	Cook	1
	Cook	1
	Cook	1
	Maid	1
	Maid	1
	Maid	1
	Maid	1
Purchasing and Stores	Supervisor	1
TOTAL MAN-YEARS		68.5

Approved by T.H.I.S. for 1977

APPENDIX VI (c)

N.W.T. BUDGET REVIEW HOSPITAL
FORT SMITH - ST. ANN'S GENERAL HOSPITAL

Nursing Administration	Director of Nursing	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	RN	1
	CNA	1
	CNA	1
	CNA	1
	CNA	1
Nursing Care - Chronic	RN	1
	RN	1
	CNA	1
	CNA	1
	CNA	1
	CNA	1
	RNA	1
	RNA	1
	WA	1
	WA	1
	WA	1
	WA	1
	WA	1
	WA	1
Laboratory and Radiology	RT	1
	Laboratory Aide	1
	RT	1
Administration and Medical Records	Administrator	1
	Clerk	1
	Admitting Clerk	1
	ART	1
Dietary	Supervisor	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
Laundry Linen	Supervisor	1
	Aide	1
	Aide	1
	Aide	½

Housekeeping	Supervisor	1
	Aide	1
	Aide	1
	Aide	1
	Aide	1
Operation and Maintenance	Engineer, Supervisor	1
	Engineer	1
	Engineer	1
	General Labour	1
TOTAL MAN-YEARS APPROVED BY T.H.I.S. FOR 1977		54

APPENDIX VII

PHYSICIAN SERVICES AVAILABLE IN N.W.T. THROUGH PRIVATE PRACTITIONERS

LOCATION	SERVICES	MAN-YEARS
Fort Smith	GP	1
Hay River	GP	1
	GP	1
	GP	1
	Surgeon	1
Inuvik	GP	1
Yellowknife	Surgeon	1
	Surgeon	1
	GP	1
	GP	1
	GP	1
	GP	1

* See Stanton Yellowknife Hospital for additional Specialist services

DENTAL SERVICES AVAILABLE IN N.W.T. THROUGH PRIVATE PRACTITIONERS

LOCATION		MAN-YEARS
Hay River	Dentist	1
	Dentist	1
	Dentist	1
	Dental Assistant	1
	Dental Assistant	1
	Dental Assistant	1
	Receptionist	1
	Receptionist (Pine Point)	½
Yellowknife	Dentist	1
	Dentist	1
	Dentist	1
	Dental Assistant	1
	Dental Assistant	1
	Dental Assistant	1
	Dental Hygienist	1
	Receptionist	1
	Office Manager	

APPENDIX IX

CONSULTANT SERVICES AVAILABLE THROUGH STANTON YELLOWKNIFE HOSPITAL, 1977/78

SERVICE	MAN-YEARS*
Dietician and Nutritionist	
Otorhinolaryngology	
Speech and Hearing Therapy	
Ophthalmology	
Ophthalmic Technicians	
Ophthalmic Nurse	
Clerk	
Physiotherapy	
Occupational Therapy	

*Man-years listed under Stanton Yellowknife Hospital

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

A. Central Arctic

1. COPPERMINE

		Rated Capacity	Patient Days
1974	Adult	4	27
	Bassinets	1	10
1975		4	55
		1	7

2. HOLMAN ISLAND

1974		3	18
		2	6
1975		3	18
		2	10

3. CAMBRIDGE BAY

1974		5	179
		2	22
1975		9	158
		2	29

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

4. GJOA HAVEN

		Rated Capacity	Patient Days
1974	Adult	5	76
	Bassinets	2	17
1975		5	45
		2	11

5. SPENCE BAY

1974		4	35
		1	15
1975		4	30
		1	17

6. PELLY BAY

1974		3	31
		1	7
1975		4	39
		1	3

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

7. RESOLUTE BAY

		Rated Capacity	Patient Days
1974	Adult	4	36
	Bassinets	2	4
1975		4	29
		2	6

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

B. Keewatin

1. ESKIMO POINT

		Rated Capacity	Patient Days
	Adult	2	120
1974	Bassinets	2	41
		2	102
1975		2	31

2. WHALE COVE

1974		2	50
		1	15
1975		2	11
		1	4

3. RANKIN INLET

1974		3	72
		1	15
1975		3	102
		1	12

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

4. BAKER LAKE

		Rated Capacity	Patient Days
1974	Adult	5	25
	Bassinets	2	19
1975		5	45
		2	26

5. CORAL HARBOUR

1974		5	51
		2	4
1975		5	37
		2	3

6. REPULSE BAY

1974		2	10
		1	--
1975		2	13
		1	--

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES
AND PATIENT DAYS, 1974 & 1975

C. BAFFIN

1. SANIKILUAQ

		Rated Capacity	Patient Days
1974	Adult	2	56
	Bassinets	1	11
1975		2	40
		1	10

2. LAKE HARBOUR

1974		4	12
		1	4
1975		4	22
		1	2

3. PORT BURWELL

1974		--	--
		--	--
1975		2	--
		2	--

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

4. CAPE DORSET

		Rated Capacity	Patient Days
1974	Adult	4	135
	Bassinets	1	16
1975		4	152
		1	40

5. PANGNIRTUNG

1974		4	99
		1	18
1975		4	175
		1	26

6. BROUGHTON ISLAND

1974		5	57
		2	25
1975		5	40
		2	6

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

			Rated Capacity	Patient Days
7. CLYDE RIVER	1974	Adult	5	58
		Bassinets	2	10
	1975		5	122
			2	2
8. POND INLET	1974		2	36
			1	5
	1975		2	54
			1	8
9. HALL BEACH	1974		4	78
			1	13
	1975		4	93
			1	20

APPENDIX X

NURSING STATIONS: IN-PATIENT CAPACITIES AND PATIENT DAYS, 1974 & 1975

10. IGLOOLIK

		Rated Capacity	Patient Days
1974	Adult	2	59
	Bassinets	1	18
1975		2	70
		1	25

11. ARCTIC BAY

1974		3	33
		2	13
1975		3	54
		2	8

12. GRISE FIORD

1974		3	9
		2	3
1975		3	16
		2	4

APPENDIX XI

ADMISSIONS AND PATIENT DAYS IN ZONE NURSING STATIONS*

		ADMISSIONS	PATIENT DAYS
1975	Baffin	548	993
	Inuvik	238	353
	Keewatin	252	437
	Mackenzie	900	2,966
	Totals	1,938	4,749
1974	Baffin	402	741
	Inuvik	156	250
	Keewatin	312	540
	Mackenzie	392	741
	Totals	1,337	2,651
1973	Baffin	246	476
	Inuvik	164	300
	Keewatin	301	714
	Mackenzie	588	1,731
	Totals	1,299	3,221

*Source: Report on Health Conditions in the N.W.T. 1973, 1974 and 1975

APPENDIX XII

MEDICAL SERVICES - NORTHWEST TERRITORIES REGION

PROGRAMME NARRATIVE

1978-79

Northern Health Activity

OBJECTIVE: To provide, or arrange for the provision of health services for residents of the Northwest Territories, with the aim of achieving a standard of health comparable to that of Canadians resident in the provinces. Health Services should comprise both primary health care, consultative services and provisions for public health in all organized habitations within the Territories by:

1) Providing primary care and treatment services.
2) Providing public health services in the fields of
   a) Maternal and Infant Health including prenatal, postnatal and infant health care programs.
   b) Pre-school Health.
   c) School and Adolescent Health.
   d) Pre-Marital and marital (family) health.
   e) Geriatric Health.
   f) Communicable Disease Control.
   g) Chronic Disease Control.
   h) Nutrition.
   i) Environmental Health.
   j) Environmental Safety.
   k) Public Health Engineering.
   l) Health Education.

3) Providing basic dental care services to eligible residents and facilitating total dental care services through full time employed Dental Practitioners, Dental Therapists and by contractural arrangements with private Dental Practitioners in the Northwest Territories.

4) Operating a mental health program.

5) Operating an alcohol addiction program.

6) Providing for medical research.

7) Providing an immigration medicine service.

8) Arranging for civil aviation medicine services.

9) Making provisions for an emergency health services operational plan serving the Northwest Territories.

10) Providing a medical service to sick mariners.

Administrative Activity

PROGRAM DESCRIPTION:

Administratively to facilitate health care operations by:

1) Maintaining official liaison with the Territorial administration.

2) Developing a registry of handicapped to aid Northwest Territories Departments of Education and Social Development in their programme planning.

3) Promoting of standardization of methods and of inventory in all Nursing Stations.

4) Emphasizing quality of health services available to northern residents.

5) Offering assistance in selection and training of health auxiliaries in departmental programs.

6) Encouraging the formation of hospital advisory boards for government hospitals.

7) Developing hospital administration to work with hospital advisory boards.

8) Encouraging the development of Medical Careers Day in northern schools.

9) Developing of training for native people in health care programs.

10) Meeting with officials of the Territorial Health Plan with the objective of expanding the home care nursing program within the Northwest Territories and determine with H.D.I.S. financial responsibility for the same.

11) Promoting the formation of health committees and to observe and record the natural history of those now in existence.

12) Promote active community involvement in all matters of health care delivery emphasizing besides primary health care, matters pertaining to public health, environmental factors, and life styles and active participation in matters of health education.

APPENDIX XIII

GOVERNMENT OF THE NORTHWEST TERRITORIES
HEALTH CARE PLAN
DEPARTMENT OF SOCIAL DEVELOPMENT
1977/78 OBJECTIVES

OBJECTIVES

1. The promotion, improvement, and preservation of the health of residents of the Northwest Territories whose care is not the responsibility of the Government of Canada.
2. The development of an integrated and coordinated health care system in the Northwest Territories to provide services for citizens of the Northwest Territories.

SUB-OBJECTIVES

i. To provide hospital insurance services as provided for in the "Territorial Hospital Insurance Services Ordinance" and the "Hospital Insurance and Diagnostic Services Act of Canada".
Territorial Hosital Insurance Services Program.

ii. To provide medical care insurance services as provided for in the "Medical Care Ordinance" and the "Medical Care Act of Canada".
Medicare Care Insurance Program (Medicare).

iii. To provide a broad range of public health services under the "Public Health Ordinance".
Public Health Programs - a broad range of public health programs implemented by Health and Welfare Canada at the request of Territorial Government.

iv. To provide diagnostic and treatment services for specific illnesses, such as: Tuberculosis, cancer, mental illnesses, veneral diseases.
Health Control Programs.

v. To encourage the training of health care personnel.
Professional Training Program.

vi. To plan for the orderly transfer of patient services from Medical Services Branch, Health and Welfare Canada, to the Territorial Government and the establishment of a broadly-based Territorial Health Program.
Northwest Territories Health Services Coordinating Program.

ᖃᐅᔨᓴᓂᐊᕐᓂᖅ ᖃᐅᔨᒪᔭᕐᓂᖅ

ᐊᒻᒪᓗᒋᑦᓴᖅᑐᑦ ᑲᒪᒋᔭᖅ ᖃᓄᐃᓕᒋᑦᓴᖅ

Central : Eastern Arctic
Health Study

ᐊᓯᔾᔨᕐᓗᒍᓱᑦᓴᖅᑐᑦ ᐱᓕᕆᔨᒋᐊᕐᓂᖅ ᓴᓇᔨᓴᕐᓂᖅ

ᐊᒻᒪᓗᒋᑦᓴᖅᑐᑦ ᑲᒪᒋᔭᖅ

(ᓄᓇᕗᑦ ᑲᑎᒪᔨᖏᑦ)

1977

1. ᕐᑲᐅᔨᒃᑲᑦᑕᐅᓂᐊ

ᕐᑭᑎᕐᒥᐅᓂ ᕐᑭᑭᕐᑖᓗᓐᓄ ᒥᒃᓵᓂ ᕐᑲᐅᔨᓴᕐᑐᑦ ᐊᕐᔨᕈᑕᐅᕐᒪᑕ ᑎᑎᖅᑕᐅᓂᐊᕐᑐᓂᒃ ᐋᓐᓂᐊᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᕆᔭᓂᒃ, ᐋᓐᓂᐊᕐᑐᓕᕆᓂᕐᒧᓪᓗ, ᐅᓚᑕᐅᓂᕐᒥᓐᓄᓪᓗ, ᓱᓇᕈᑎᕐᒥᓐᓄᓪᓗ. ᓄᓇᑦᓯᐊᑉ ᑲᑎᒪᔨᕐᒥᑦ ᓄᓇᑦᓯᐊᑉ ᑲᕙᒪᑯᕐᒥᓐᓂᒃ ᐋᓐᓂᐊᕐᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐊᖅᑭᒃᓱᕐᑕᐅᕙᓪᓕᐊᔪᓂᒃ ᑲᒪᒋᔭᐅᒥᐊᒃᑲᓐᓂᑦᑯᓯᕙᑦ. 1974,ᒥ ᓄᓇᑦᓯᐊᑉ ᐊᕙᖅᓴᑦᑐᓕᕆᔾᑯᕐᒥᑦ ᑯᐊᑦᑕᓐ ᔫᓯᓐ ᑲᓇᑕᒥ ᐋᓐᓂᐊᕐᓂᕐᒧᑦ ᕐᑲᐅᔨᒪᔨᒥᒃ ᑎᓕᓯᑕᐅᑦᑐᑦ ᒥᑭᓐᓱᒥ ᐋᓐᓂᐊᕐᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐱᔭᐅᔭᕆᐊᓕᕐᓂᒃ ᕐᑲᐅᔨᓴᑦᑯᓐᓗ. 1975,ᒥ ᓄᓇᑦᓯᐊᑉ ᑲᑎᒪᔨᕐᒥᑦ ᑲᑎᒪᑎᓐᓗᒥᑦ ᒥᑭᓐᓱᐅᑉ ᒥᒃᓵᓂ ᐋᓐᓂᐊᕐᓂᐅᑉ ᒥᒃᓵᓄᑦ ᕐᑲᐅᔨᓴᐅᑎᐱᓐᓂᑦ ᓴᖅᑭᑕᐅᓚᐅᑦᑐᑦ. ᑖᒃᑯᐊ ᕐᑲᐅᔨᓴᐅᑎᐱᓐᓂᑦ ᐅᑯᓄᕐᓕ ᑎᑎᕐᕆᒪᔪᓄᑦ ᐃᓚᒋᓕᐅᑎᓯᒪᔪᑦ ᕐᑲᐅᔨᒋᐊᒃᑲᓐᓂᕈᑕᐅᔪᓐᓇᑦᑐᑦ ᒫᓐᓇᐅᔪᒃᑯᑦ ᓄᓇᑦᓯᐊᑦᒥ ᐋᓐᓂᐊᕐᓂᕐᒧᑦ ᐊᑐᑦᑕᐅᔪᓄᑦ.

ᓯᕗᓂᒃᓴᒧᑦ ᐊᑐᓕᑦᑕᐅᔪᒪᔪᑦ ᓴᖅᑭᑕᐅᓚᐅᑦᑐᑦ.

ᓄᓇᑦᓯᐊᑉ ᑲᕙᒪᑯᕐᒥᑦ ᐋᓐᓂᐊᕐᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐊᖅᑭᒃᓯᒥᐊᕈᒪᔪᑦ ᐊᑐᑦᑕᐅᒐᔭᖅᑐᓂᒃ, ᒪᓕᒋᐊᒃᓴᖅ ᐊᔪᑦᓇᑦᓴᕐᒥᑦᑐᓂᒃ ᑎᑎᑦᓯᒪᑦᓯᐊᑦᓗᑎᒃᓗ. ᐅᐃᒪᐃᒍᒪᑎᒃ, ᐱᓕᕆᐊᑦᑲᐃᓐᓇᕆᐊᑦᑲᐳᑦ ᓯᕗᓂᒃᓴᒧᑦ ᐊᑐᑦᓂᑦᑲᑦᓯ ᐊᑦᓭᖅᑐᓂᒃ ᐱᔭᕆᐊᑐᒐᓗᐊᑦᐸᑕ ᐱᔭᕆᐊᑐᕐᒥᒃᑲᓗᐊᑦᐸᑦᑑᓐᓂᑦ. ᑲᓇᑕᐅᑉ ᑲᕙᒪᑯᕐᒥᑕ ᑲᒪᒋᕙᑦᑕᕐᒥᑦ ᐋᓐᓂᐊᕐᓂᐅᑉ ᒃᒥᒃᓵ ᓄᑦᑎᑦᑕᐅᐱᓕᑦᑕᕐᓚ ᓄᓇᑦᓯᐊᑉ ᑲᕙᒪᑯᕐᒥᓐᓄᑦ ᐅᓪᓗᐊ ᐅᑦᑲᑕᐅᓖᑦᑐᖅ. ᐅᓖᒃ ᓄᑦᑎᑦᑕᐅᒃᐸᑕ ᓄᓇᑦᓯᐊᑉ ᑲᕙᒪᑯᕐᒥᓐᓄᑦ ᑲᒪᒋᔭᕐᑳᓕᑦᓗᑎᒃ ᐊᑦᓱᕈᓐᓇᕐᒥᓐᓂᑦᓴᐅᒐᔭᒪᑕ ᐊᖅᑭᒃᑕᐅᒐᓱᓕᑦᐸᑕ ᓯᕗᓂᒃᓴᒧᑦ.

ᓄᓇᑦᓯᐊᑉ ᑲᕙᒪᑯᕐᒥᑦ ᐋᓐᓂᐊᕐᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐱᓕᕆᐊᑦᑲᓇᐊᖅᑳᓇᐊᑦᑲᓴᓗᐊᑦᒪᑕ ᓄᓇᑦᓯᐊᕐᒥᐅᑦ ᐊᓐᓂᐊᓇᑦᑐᑦᑲᓂᐊᕐᒥᒪᒪᑕ. ᐸᑦᓇᒃᓯᒪᔪᑦᑲᐃᓐᓇᕆᐊᑦᑲᖅᐳᖅ ᑎᑭᑕᐅᑦᑕᐃᓕᑦᑯᓗᒥᑦ ᐃᓄᐃᑦ ᐋᓐᓂᐊᓇᖅᑐᒧᑦ. ᓄᑦᑎᐊᒥ ᐋᓐᓂᐊᑦᑲᓂ ᐃᓯᒪᑕᕆᔭᐅᔪᖅ ᑎᑎᕐᕐᑕᒥᓂ ᐅᑦᑲᓖᓚᐅᖅᑕᒥᓂ ᓄᑦᑎᐊᒥᐅᑦ ᐋᓐᓂᐊᑦᓇᒧᑦ ᐱᑦᔪᑎᒥᓐᓗ ᒥᑦ 1975ᓐ ᔪᑎᓐᓗᔪ ᑎᑎᕐᕐᑕᑭᓂᑦᒥᓂ ᐃᒪᓐᓇ ᐅᑦᑲᓗᖅᓯᒪᐳᖅ:

> " ᐋᓐᓂᐊᑦᓇᑦᑲᕈᓐᓃᖅᐸᓪᓕᐊᓂᖅ ᓯᓚᑦᔪᐊᒥ ᐱᕙᓪᓕᐊᑭᐅᔪᓂ ᓄᓇᓂ ᐱᐅᓂᖅᓴᐅᔫᒥᓕᖅᐳᖅ ᑎᓴᒪᐃᖅᑕᖅᑐᑦᔪ ᔫᖅᑐᒥᒃ. ᐃᒃᓗᑦᑲᑦᓯᐊᑦᓂᑦᓗ, ᐃᒪᖅᑕᑦᑲᑦᓯᐊᑦᓂᑦᓗ, ᓂᑦ ᑭᑦᑕᑦᑲᑦᓯᐊᑦᓂᑦᓗ ᐊᒻᒪᓗ ᐃᑎᕈᓐᓗ ᐊᒃᑕᑯᓐᓗ ᑯᐱᑦᑲᑦᑲᑦᓯᐊᑦᓂᖅ ᐊᑲᐅᔪᑕᐅᕙᓪᓕᐊᒍᑕᐅᔪᓇᖅᐳᖅ ᐋᓐᓂᐊᓇᖅᑐᑦ ᑎᑭᕙᐅᓇᕐᒥᓐᓂᖅ ᓴᐅᓂᑦᒧᑦ".

ᐊᒥᓱᐊᖅᑎᖅᓱᓂ ᐅᑦᑲᐅᓯᐅᓯᒪᐳᑦ ᑕᒪᒃᑯᐊ ᑲᓇᑕᒥᐅᑦ ᒥᐊᓂᕐᓴᐅᒥᐊᑦᑲᒻᒪᓇᕐᓂᕐᒥᓐᓄᑦ ᐋᓐᓂᐊᓇᑦᒧᑦ, ᐃᑲᔪᖅᑕᐅ ᒥᐊᑦᑲᒻᒪᓇᒃᐳᖅ ᐋᓐᓂᐊᓇᑦᒧᑦ ᑎᑭᑎᑕᐅᑦᑕᐃᓕᓂᑦᒧᑦ, ᑎᑭᑕᐅᑦᑕᐃᓕᓂᑦᒧᑦ. ᐊᒻᒪᓗ ᐊᑕᐅᑦᓯᒃᑯᑦ ᕿᓇᑐᐃᓐᓇᖅ ᑲᒪᔭᕆᐊᑦᑲᖅᐳᖅ ᐃᕐᕿᓂᒃ ᒥᐊᓂᕐᓴᑦᑲᕆᐊᑦᑲᖅᐳᖅ ᐃᓅᓯᑦᒥᓂᒃ ᐋᓐᓂᐊᓇᑦᑲᕐᒥᓐᓂᑦᒧᑦ ᐃᓕᓯᒪᐃᓐᓇᕐᓯᐊᑦᓗᓂ. ᐅᑯᓚ ᒃᑯᑦ ᐱᓕᕆᐊᑦᑲᕆᐊᑦᑲᐳᑦ ᐋᓐᓂᐊᕐᓂᕐᒥᓐᓂᑦᒧᑦ ᐃᑲᔪᕆᐊᑦᑲᐳᑦ ᑭᑯᓕᒫᓂᒃ.

ᑭᑯᓕᒫᑦ ᕿᓇᐅᔭᑦᑲᖅᑎᑕᐅᓯᐊᑦᑲᑦᑕᕆᐊᑦᑲᐳᑦ ᓂᐅᕕᑦᑲᑦᑕᕈᓐᓇᑦᑯᓐᓗᒥᑦ ᓂᑦ ᑭᑦᓯᐊᕙᓂᒃ, ᐊᓐᓄᕌᑦᑲᖅᓯᐊᕈᓐᓇᑦᑯᓐᓗᒥᓐᓗ, ᐃᒡᓗᑦᑲᑦᓯᐊᕈᓐᓇᑦᑯᓐᓗᒥᓐᓗ. ᐊᒻᒪᓗ ᓄᓇᓕᖕᓂ ᐃᒪᖅᑕᑦᑲᑦᓯᐊᕐᒥᓐᓇᑦᑲᑦᑕᕆᐊᑦᑲᖅ, ᐊᒻᒪᓗ ᐊᒃᑕᑯᕐᒥᑦ, ᑯᑦᐱᖅᒥᑦ ᑯᐱᒃᑕᑦᑲᑦᓯᐊᕆᐊᑦᑲᑦᑲᑦᑕᕆᐊᑦᑲᐳᑦ.

ᐋᖓᓂᐊᖅᓯᐅᖅᑎᑦᑕᕐᑲ ᕐᓯᐊᓇᐊᕐᑲᖅᐳᖅ ᐊᒻᒪ, ᐋᖓᓂᐊᕐᓇᖅᑐᒧᕐ ᑎᑭᑕᐅᕐᑕᐃᓕᓂᕐ ᒧᕐ ᐃᓕᓐᓂᐊᖅᑎᕐᑎᕙᕐᑲᐃᓐᓇᕐᑲᕐᑕ ᓇᐊᕐᑲᖅᐳᖅ.

ᕐᑲᐅᔨᒪᔪᕐᑲ ᓈᕐᑲᖅᐳᖅ, ᐅᑐᕿᔨᐅᒪᔪᕐᑲ ᖀᕐᑲ ᑰᐳᖅᑭᕐ ᑳᐅᔨᓴᖅᑐᕐᑲᓚᖅᐸᐃ, ᖁᓐᓇ ᕐᑲᐅᔨᓴᖅᑐᖅ ᑭᓯᐊᓂ ᕐᑲᐅᔨᔭᓚᐃᔭᕐᒥᓂᒃ ᐃᒃᐱᒋᔭᓚᐃᔭᕐᒥᓂᒃ ᑦᑎᖅᐸᓚᐊᓗᓂ ᕐᑲᐅᔨᔭᓚᐃᔭᕐᒥᓂᒃ ᐊᑲᐅᓂᖅᓴᐅᓇᖅᐳᖅ. ᑦᑎᖅᑕᐅᔭᓚᐃᔪᕐ ᐊᓯᒃ ᑐᖅᑕᐅᕐᑲᕐᑕᐃᓐᓇᓇᐊᕐᑲ ᖃᖅᓯᑎ ᓗ ᐊᑲᐅᓂᖅᓴᐅᔪᕐ ᑐᑭᓯᐅᔭᓚᐃᔮᖅᒪᑕ. ᑦᑎᖅᑕᐅᓂᑯᓗ ᕐᑲᐅᔨᓴᖅ ᑕᐅᕐᑲᕐᑕᓇᐊᕐᑲᖅᐳᕐ ᓈᒻᒪᖕᓂᖕᒋᕐ ᕐᑲᐅᔨᓴᖅᑕᐅᓗᑎᒃ ᕚᓚᖕᒥᐅᓄᕐ ᐱᔪᕐᑲᕐᑲᕐᑕᓇᐊᕐᑲᖅᐳᖅ ᐊᒻᒪᓗ ᐃᓯᒪᒃᓴᖅ ᓯᐅᕿᓐᓇᕐᑲᕐᑕᕐᑯᓐᓗᒋᕐ ᓯᐳᓂᒃᓴᒥᖕᓄᕐ ᐊᑐᖅᑕᐅᓇᓴᖅᑐᓂᒃ.

11. ᓇᐃᓪᓕᒥᐊᖅᓯᒪᔪᑦ ᐊᑐᓕᑦ ᑯᔭᐅᔪᓄᑦ ᑎᑎᕋᖅᑕᐅᓯᒪᔪᑦ

(*ᕿᒃ ᑯᐊ ᐊᑐᓕᑦ ᑯᔭᐅᔪᑦ ᑎᑎᕋᖅᑕᐅᓯᒪᐳᑦ ᑎᑎᕋᖅᑕᐅᓚᐅᖅᑐᓂᑦ ᐱᔭᐅᓯᒪᓪᓗᑎᒃ, ᓯᐳᓪᓕᐅᑎᑕᐅᒥᐊᑦᑲᖅᑐᑦ ᓯᐳᓪᓕᐅᑎᑕᐅᓯᒪᓕᒻᒥᑦᐳᑦ).

1. ᑦᑲᓪᓚᒃ ᑯᓪᓚᕆᒃ ᔫᒃᑎᖅᑎᑕᐅᓂᐊᑦᒪᓪ ᓚᓚ ᐅᑦᑲᖅᓯᒪᔪᑦᑲᕆᐊᑦᑲᑦᐳᖅ ᐱᓕᕆᐊᑦᑲᑦᑲᑦᑕᑦᓂᐊᓕᑦᓂᓪᒥᑦ ᔪᓇᑦᑎᐊᑉ ᒐᐗᒃ ᑯᓪᒥᑦ ᐋᓐᓂᐊᕿᓕᕆᓂᐅᑉ ᒥᒃᓵᓄᑦ ᔪᓇᑦᑎᐊᒥ.

2. ᐱᒥᐊᑦ ᑯᓯᔪᑦᑲᖅᐳᖅ ᑎᑎᕋᖅᓯᒪᔪᓂ ᓗ ᐃᓯᒪᒥᔭᐅᔪᓂ ᓗ ᐋᓐᓂᐊᑦ ᕿᓕᕆᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐊᑐᓕᖅᑕᐅᔪᒃᓴᓂᒃ ᐋᖅᑭᒃᓯᔪᑦᑲᕆᐊᑦᑲᖅᐳᖅ ᑎᑎᕋᖅᓯᒪᔪᓂᒃ; ᐅᑦᑲᓖᓚᒃᓴᐅᔪᓂᒃ ᐋᖅᑭᒃᓯᔪᑦᑲᑦᑐᓂ.

3. ᐃᓕᓐᓂᐊᕈᑎᐅᔪᒃᓴᓂ ᓗ ᐋᖅᑭᒃᓯᔪᑦᑲᕆᐊᑦᑲᖅᐳᖅ ᐊᑐᖅᑕᐅᔪᒃᓴᓂᒃ ᓄᓇᓕᓐᓄᑦ ᐃᓕᓴᕈᑎᐅᓗᑎᒃ ᑦᑲᐅᓯᑦᓪᓕᕈᓐᓇ ᑦᑯᓪᓗᒥᑦ ᐋᓐᓂᐊᑦᓇᐅᑉ ᒥᒃᓵᓄᑦ.

4. ᐊᒻᒪᓗ ᑐᓵᔪᑦᑦᑲᐃᓐᓇᕆᐊᑦᑲᖅᐳᖅ ᐋᓐᓂᐊᑦ ᕿᓐᓂᓗ ᐊᒻᒪᓗ ᐋᓐᓂᐊᑦ ᕿᓕᐊᑦᓇᐅᕙᒃᑐᓂ ᓄᓇᓕᓐᓂ.

5. ᐊᒻᒪᓗ ᑕᒪᒃ ᑯᐊ ᐋᓐᓂᐊᖅᑐᓕᕐᓂᑦ ᒧᑦ ᑲᑎᒪᔩᑦ ᑐᓴᕐᑎᑦᑎᑦᑲᑦᑕᑦ ᑯᔭᐅᐳᑦ ᑲᑎᒪᑎᑦᑎᑦᑲᑦᑕᑦ ᑯᔭᐅᐳᑦ ᓄᓇᓕᓐᓂ ᐃᓕᓴᖅᑎᐅᔪᒃᓴᐅᓗᑎᒃ ᒥᐊᓂᕆᐅᔪᒃᓴᐅ ᑎᒃ ᓄᓇᓕᓐᓂ.

6. ᐋᓐᓂᐊᑦᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐊᑐᑦᑕᐅᔪᑦ ᑦᑲᐅᔨᓴᑦᑕᐅᒃᑲᓐᓂᕆᐊᖑᑦ.

7. ᐋᓐᓂᐊᑦ ᑐᓕᕆᔾᔪᑦ ᒥᒃᓵᓄᑦ ᐃᓕᓐᓂᐊᑦᑕᐅᕙᒃᑐᑦ ᑦᑲᐅᔨᓴᑦᑕᐅᒃᑲᓐᓂᕆᐊᖑᑦ ᐃᒪᐃᒻᒪᑦ ᕿᑕ?

(1) ᑕᒪᒃ ᑯᐊ ᐃᓕᓐᓂᐊᑦᑕᐅᕙᒃᑐᑦ ᑕᒪᑦᒥᒃ ᐊᑐᑦ ᑐᒃᓴᒪᐅᑕᐅᖐᑦ?

(2) ᑕᒻᒪᒃ ᑯᐊ ᐃᓕᓐᓂᐊᑦᓂᒃ ᑯᑦᓇᐊᔾᔨᕐᓇᐃᑦᑎᐊᑦᑲᑦᑦᒪᓪ ᕿᑕ ᐃᓕᓐᓂᐊᑦ ᑕᕝᕕᓂᑦᒥᓂᒃ?

(3) ᐋᓐᓂᐊᕐ ᑐᓕᓂᕐ ᒧᕐ ᐃᕐᑲᓇᐃᔾᕐ ᑐᓕᕆᔾᒃᓴᐃᕐ ᐊᒥᒐᖅᒥᕐᑐᕐ ᐃᓕᓐᓂᐊᕐᑎᑕᐅᕐᑲᕐᑕᕐᒪᖅᑳᑕ?

8.

8. ᐊᒻᒪᓗ ᐃᓱᒪᒋᔭᐅᖅᒥᔪᖅ ᑕᒃᑯᐊ ᓘᕐᑳᕐ ᓯᐅᑎᓄᓪᓗ, ᕐᑭᖅᒐᕐᓄᓪᓗ ᐃᒡᒥᐋᓄᓪᓗ ᐃᓄᐃᕐ ᓄᓇᖅᒐᓂ ᓄᓇᓂᖅ
ᓄᕐ ᓄᕐ ᐅᐸᕐᑲᕐᑕᕐᐸᕐᑕ ᐃᑲᔪᕆᐊᕐ ᑐᓪᓗᑎᒃ ᕐᑲᐅᔨᓴᕆᐊᕐ ᑐᕐᓗᑎᒃᓗ ᐃᓱᐃᖅᒥᑑᑎᕐᑲᑐᓂᒃ ᐊᑲᐅᕐᑲᑕᕐᓴᕐᒪᕐ.
ᑳᒃᑯᐊ ᓘᕐᑳᕐ ᕐᑲᐅᔨᓴᕐᑲᕐᑕᕐᓗᑎᒡᓗ ᓱᒧᕐ ᑕᒃᑯᐊ ᑳᓐᓂᐊᕈᑎᒋᔭᖅᒥᕐ ᑕᐃᒪᐃᒻᒪᖅᑳᑕ, ᐊᒻᒪᓗ
ᑕᒃᑯᑕᒃᑯᐊ ᐋᓐᓂᐊᕈᑕᐅᔪᕐ ᐊᖏᒃᑕᐅᒥᐊᕐ ᐸᓪᓗᑎᒃᓗ

9. ᐃᓱᒪᒋᔭᐅᖅᒥᔪᖅ ᑳᒃᑯᐊ ᐃᓱᓂᐊᕐᐱᕐ ᓄᓇᕐᓯᐊᕐᒥ ᓄᓇᓕᓚᖕᓄᕐ ᐅᐸᕐᑲᕐᑕ ᑕᒃᑯᓂᖅᒐ ᕐᑲᐅᔨᓴᕐᓇᐊᕐᑐᕐᓗ
ᑎᒃ ᐃᓱᐃᒥᑑᑎᕐᑲᑐᓂᒃ ᐋᓐᓂᐊᕐᑲᑐᓂᒃ, ᐊᒻᒪᓗ ᐃᓱᐊᕐᓴᐃᓇᓱᐊᕐᓗᑎᒃ ᐃᓱᐃᖅᒥᑑᑕᐅᔪᓂᒃ.
ᐊᒻᒪᓗᒃ ᑕᐅᖅ ᑳᒃᑯᐊ ᐃᓱᐃᖅᒥᑑᑕᐅᔪᕐ ᐊᖏᒥᐊᕐᓗᓂ ᓚᔪᕐ ᐋᓐᓂᐊᕈᑕᐅᔪᓂ ᓗ ᕐᑲᐅᔨᓴᕐᓗᑎᒃ ᐊᑲᐅᓇᓴᕐ
ᑐᖅ ᑐᖅ.

10. ᐃᓱᒪᒋᔭᐅᓚᐅᕐᒥᔪᖅ ᑳᓚᒃᑯᐊᐃᐃᓱᓕᓈᓂᕐᒧᕐ ᓯᐅᑎᓕᕈᓂᕐᒧᓪᓗ ᐃᑲᔪᕐᑎᒃᓴᐃᕐ ᐃᓕᓴᕐᑕᐅᕐ ᑯᔭᐅᓴᓗᑎᒃ
ᕐᑭᓚᒥᐅᓇᓱᒃᑐᒥ.

11. ᐃᓱᒪᒋᔭᐅᓚᐅᕐᒥᔪᖅ ᑳᐃᓐᓇ ᔪᐊᕐᓴᒥᕐᒥ ᑭᒍᑎᓕᓈᕐ ᐃᓕᓐᓂᐊᕐᐱᖅᒐᕐ ᐊᖅᒥᓪᓕᒥᐊᕐ ᑕᐅᕐ ᑯᔭᐅᓴᓂ
ᓄᓇᕐᓯᐊᕐᒥᐅᕐ ᐃᓕᓐᓂᐊᕐᑐ ᐊᒥᓱᓂᕐᓴᐅᕐ ᑯᓪᓗᒥᕐ ᓄᓇᓂᖅᓂ ᐃᑲᔫᓴᔪᖅᑐᕐ.

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12. ᐃᓱᒪᒋᔭᐅᓚᐅᕐᒥᔪᖅ ᑲᓇᑕᐅᕐ ᐋᓐᓂᐊᕐ ᑐᓕᓂᕐᒧᕐ ᐃᕐᑲᓇᐃᔾᕐ ᑐᓕᕆᔾᒃ ᑯᖅᒥᕐ [illegible]
ᓂᕐᓗᑎᐃᕐᑲᓇᓚᔾᕐ ᑐᓕᕆᔾᒃ ᑯᖅᒥᕐ, ᐃᓕᓐᓂᐊᕐ ᑕᐅᕐᑲᕐᑕᕐᓗᑎᒃ ᕐᑲᓄᖅ ᐆᓚᓂᖅᒥᕐ ᐊᖏᒃᓯᒪᕐᑎᐊᕐᒪᖅᒐᑕ
ᕐᑲᐅᔨᒪᔭᐅᕐ ᑯᒧᕐ.

13. ᐃᓱᒪᒋᔭᐅᖕᒥᔪᖅ ᑖᒃᑯᐊ ᑎᑎᕋᖅᓯᒪᔪᑦ "ᓄᓇᑦᓯᐊᑦᒥᐅᓄᑦ ᑖᒃᑯᐊ ᐱᔮᕆᑦᓯᒪᑦᑎᐊᑦᑐᑦ ᓂᑦᑭᑦᑲᑦᑎᐊᑦᓯᐊ ᑦᓂᑦᒧᑦ ᐱᓕᕆᐊᕆᔭᐅᔪᑦ" ᐃᓄᒃᑎᒍᓕᑦᑎᑕᐅᔭᕆᐊᑦᑲᒪᑕ ᑕᒪᒃᑯᓄᖕᒪ ᑦᑲᐅᔨᓴᑦᐅᔪᓄᑦ ᑐᓂᐅᑦᖅᑕᐅᔪᒃᓴᐅ
ᓗᑎ ᓗᑎᒃᑦ ᑭᓪᓕᒥᐅᓇᓱᒃᑐᖅ ᐊᑐᑦᑕᐅᓕᑦ ᑯᓪᓗᒥᑦ ᐃᓄᐃᑦ ᓄᓈᖅ ᒪᓂ.

14. ᐃᓱᒪᒋᔭᐅᖕᒥᔪᖅ ᑦᑭᑎᑦᒥᐅᓂᓗ ᑦᑭᑭᑦᑖᓗᖓ ᒥᒃᓵᓂ ᑕᒪᒃᑯᐊ ᐃᓄᑐᑦᑲᐃᑦ ᐱᓕᕆᐊᕆᔭᒃᓴᖕᒥᑦ ᐊᕐᑭᒃᓱᑦᑕᐅᑦ ᑯᔭᐅᓪᓗᑎᒃ.

15. ᐃᓱᒪᒋᔭᐅᓚᐅᑦᒥᔪᖅ ᐅᑭᐅᑦ ᑖᑦ ᑕᒪᒃᑯᐊ ᐋᓐᓂᐊᕕᖕᓄᑦ ᓱᓇᑦᐱᑏᑦ ᐊᑐᑦᑕᐅᑲᒃᑐᑦ ᑦᑲᐅᔨᓴᐳᑕᐅᓪᓗᑎ
ᒃ ᑭᒃᑯᑐᐃᓐᓇᑦᓂᒃ ᐋᓐᓂᐊᑦᕕᖕᒥ ᑦᑲᐅᔨᓴᑦᑕᐅᑲᒃᑐᓂᒃ ᑦ ᑲᓄᐃᓐᓂᑦᑲᖕᒥᑦᑎᐊᑦᒪᖕᑳᑕ ᑦᑲᐅᔨᓴᕐᑕᐅᑦᑲ
ᑦᑕᑦ ᑯᔭᐅᓪᓗᑎᒃ, ᑎᑎᕋᖅᓯᒪᔪᔅ ᑐᓂᔭᐅᑦᑲᑦᑕᑦᓗᑎᒃ ᓄᓇᓕᖕᓂ ᐋᓐᓂᐊᑦᕕᖕᓄᑦ ᐃᒪᒃ ᐅᑦᑲᓯᒪᓗᑎᒃ:

1) ᓱᓇᓯᕚᕿᑎᖕ ᒍᓪᓗ ᒪᓕᒃᐸᑦᑕᖕᒥᓪᓗ ᑦᑲᐅᔨᓴᕐᓴᓗᑎᒃ ᑦᑲᐅᔨᓴᑦᑕᐅᓗᑎᒃ
2) ᑦᑲᐅᔨᓴᑦᑕᐅᐱᐊᑕ ᐅᓪᓗᐊ
3) ᑦᑲᐅᔨᓴᑦᑯᑦ ᐊᑎᐊ
4) ᑦᑲᐅᔨᓴᐅᑎᕖᑦ, ᐊᑐᓕᑦ ᑕᐅᔪᒪᔪᓪᓗ
5) ᑖᒃᑯᐊ ᐋᓐᓂᐊᑦ ᕕᐅᑉ ᐃᓗᐋᓂ ᐃᓕᓐᓂᐊᑦᑐᑦ ᐊᑎᖕᒥᑦ ᐃᓕᓐᓂᐊᑦᑕᖕᒥᓪᓗ ᑎᑎᕋᖅᑕᐅᓗᑎᒃ.

16. ᐃᓱᒪᒋᔭᐅᖕᒥᔪᖅ ᑕᒪᒃᑯᐊ ᓄᓇᓕᓕᖏᓂ ᐃᓅᓕᓴᐅᑏᑦ ᑭᓪᓕᓕᓴᒃᓴᐃᓪᓗ ᑲᒪᒋᔭᐅᑦᑎᐊᑦᐸᒃᓗᑎᒃ ᐆᓄᑦᓂᖕᒥᓪᓗᒍ
ᓪᓗ ᓇᐃᓴᑦᑕᐅᓗᑎᒃ, ᐊᒻᒪᓗ ᐅᓪᓗᖕᒥᑦ ᑎᑎᕋᖅᑕᐅᓗᑎᒃ, ᐊᒻᒪᓗ ᓄᑕᐅᒍᓇᐃᑦ ᐸᑕ ᐅᑎᑦᑎᑕᐅᓗᑎᒃ
ᓴᓇᕙᒃᑐᓄᑦ ᓂᐅᕕᑦᑎᑦᑎᕙᒃᑐᓄᓪᓘᓐᓂᑦ ᐃᓅᓕᓴᐅᑎᓂᒃ ᑦᑭᓪᓕᓴᒃᓴᓂ ᓘᓐᓂᑦ, ᐅᕙᖖᓘᓐᓂᑦ ᓄᑕᐅᒍᓇ
ᐃᖕ ᒪᑕ ᐃᒥᑕᐅᑐᐃᓐᓇᑦ ᐸᓪᓗᑎᒃ.

17. ᐃᓱᒪᒋᔭᐅᖕᒥᔪᖅ ᑕᒪᒃᑯᐊ ᓄᓇᓕᖕᓂ ᐋᓐᓂᐊᓯᐆᑦᑎᓕᓚᐅᑕᐅᕕᒃ ᑯᔭᐅᖅ ᒪᓯᓗᑐᓗᑦ ᐋᓐᓂᐊᑦᕕᖕᓂ ᑯᔭᐅᓪᓗᑎ
ᐅᑦᑲᕐᓇᑦᑲᑦᑕᑦᑯᓪᓗᒥᑦ.

18. ᐃᓱᒪᒋᓭᐅᖅᒥᔪᖅ ᓄᕿᓈᐅᓯᖅᑖᖅ ᑲᓈᓂᑦ ᑯᔭᐅᓪᓗᑎᒃ ᑐᐱᖃᓈᐃᓯᑦᑎᑖᖅᑲᓈᓂᔪᖅᑖᓯᐅᖅᑎᓪᓚᑦ ᓄᓈᓐᖅᓂ ᐋᓚᓂᐊᑦᓂ ᑦᑐᑦ ᐃᑦᑲᓇᐃᓯᑦ ᑐᒃᓴᓂᒃ ᓄᓇᓐᖅᓂ.

19. ᐃᓱᒪᒋᓭᐅᖅᒥᔪᖅ ᒪᕙᒪᑯᑦ ᐋᖅᑭᒃᓯᑦ ᑯᔭᐅᓪᓗᑎᒃ ᓈᒻᒪᒃᑐᓂᒃ ᐊᑐᑦ ᑕᐅᔪᒃᓴᓂᒃ ᐃᑦᑲᓇᐃᓯᑦ ᐸᒃᑐᓄᑦ.

20. ᐃᓱᒪᒋᓭᐅᖅᒥᔪᖅ ᒪᕙᒪᑯᑦ ᐃᓪᓗᑦᑲ ᑦᑎᐊᑦᑎᑦᑎᑦᑲ ᑕᑦ ᑯᔭᐅᓪᓗᑎᒃ ᓄᓇᑦᑎᐊᒥᐅᓂᒃ ᐊᒻᒪᓗ ᒫᓐᓇ ᓄᓇᑦᑎᐊᒥ ᐃᒡᓗᓂ ᐅᓄᑦᓯᑎᑦᑎᒋᐊᑦ ᑯᔭᐅᓪᓗᑎᒃ.

21. ᐃᓱᒪᒋᓭᐅᖅᒥᔪᖅ ᐃᑦᑲᓗᑦᑎᐊᒥ ᓄᓈᑦ ᐋᓐᓂᐊᑦ ᑐᓕᓐᓅᑖᑦ ᑯᔭᐅᓪᓗᑎᒃ.

22. ᐃᓱᒪᒋᓭᐅᖅᒥᔪᖅ ᑭᔭᐊᑕᒥ ᐋᓐᓂᐊᑦ ᐱᒃᑕᑦ ᑯᔭᐅᓪᓗᑎᒃ ᑕᒪᒃ ᑯᓄᖅᑲ ᐋᓐᓂᐊᑦᑲᓪᓚᓇᒃᑐᓄᑦ ᐅᐸᒃᓯᒪᔭᐅᑦᑲᑦ ᑕᕋᔭᑦ ᑐᒥᒃ.

23. ᐃᓱᒪᒋᓭᐅᖅᒥᔪᖅ ᐃᒡᓗᓕᑦᔪᒃ ᐋᓐᓂᐊᐱᒃᑖᑦ ᑯᔭᐅᓪᓗᓂ ᐋᓐᓂᐊᑦᑲᓪᓚᓇᒃᑐᓄᑦ ᐅᐸᒃ ᑕᐅᑦᑲᑕᕋᔭᑦ ᑐᒥᒃ, ᐅᑭᐅᑦ ᑎᓴᒪᑦ ᓈᐸᐸᑕ ᐱᒋᐊᑦ ᑕᐅᓛᑦ ᓗᓂ.