UNIVERSITY OF CALGARY

AN EXPLORATION OF THE DETERMINANTS OF HEALTH FOR INUIT WOMEN IN NUNAVUT

by

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A THESIS

SUBMITTED TO THE FACULTY OF GRADUATE STUDIES

IN PARTIAL FULFILMENT OF THE REQUIREMENTS FOR THE

DEGREE OF MASTER OF SCIENCE

DEPARTMENT OF COMMUNITY HEALTH SCIENCES

CALGARY, ALBERTA

JUNE, 2006

UNIVERSITY OF CALGARY

FACULTY OF GRADUATE STUDIES

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Abstract

Published research that explores the relationship between social determinants of health and disease conditions in First Nations women is sparse. For Inuit women it is virtually non-existent. The objective of this qualitative study was to explore the determinants of health for Inuit women in Nunavut Territory from the perspective of women living in a Nunavut community.

Inuit women in this study discussed their health in terms of mental, emotional, spiritual and physical health, illustrating both positive and negative influences on health. In all interviews, women discussed the importance of roles of Tradition and Culture; Knowing; and Wellness in health, shedding light on the mechanisms through which the determinants of health impact women's everyday lives. Participants used stories that illustrated the experiences of themselves or others they knew to share their perspectives on the health and well-being of Nunavut women.

What has been made more explicit through this study is the considerable role that Inuit culture and knowledge plays in the lives of these women, including both the traditional and historical contexts of the Inuit commonalities and differences among Canada's indigenous peoples. The knowledge contributed by this study will make an important contribution to policy and programming initiatives in Nunavut, and contribute to the growing body of knowledge on Inuit health in Canada.

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Acknowledgements

Firstly, special thanks are extended to the women who participated in this study, without whom this research would not have been possible. Your willingness to share your stories, thoughts and experiences allowed me to achieve a greater understanding of the lives of women in our community.

Thank you to the territorial and community organizations in Nunavut and Iqaluit who supported and encouraged this research project.

Thank you to Eva Onalik and Canadian North Airlines for providing in-kind air travel assistance to and from Nunavut.

Thank you to my family, friends and loved ones who supported my efforts, provided encouragement, and never allowed me to lose sight of the end goal.

Thank you to Dr. Vollman for your stories, direction, and patience. Thank you to Dr. Mrkonjic for your time and constant support for this project.

Last but not least, many, many thanks to Dr. Meadows for your guidance, patience and mentorship, and especially your willingness to step out on a limb and take me (and my ideas) under your wing two years ago. It has meant so much to me!

Research Support

This research was generously financially supported by grants, scholarships and in-kind sponsorship from the following organizations:

Association of Canadian Universities for Northern Studies

Canadian North Airlines

Centre for Advancement of Health, University of Calgary

Faculty of Graduate Studies, University of Calgary

Northern Scientific Training Program, Indian and Northern Affairs Canada

Letters of support for this research were kindly sent by the following organizations in Nunavut:

Qikiqtani Inuit Association

Qulliit Nunavut Status of Women Council

Nunavut Department of Health and Social Services

This research was part of a larger project investigating Inuit women's health in Nunavut that is supported by the Canadian Institutes for Health Research.

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CHAPTER 1 – INTRODUCTION AND LITERATURE

I. Introduction

Good health is critical to our sense of well being, as well as our capacity to work and care for future generations. Many Arctic residents face challenges in achieving and maintaining good health (Arctic Council, 2004). In the Arctic, economic circumstances, lifestyle, exposure to severe cold and contaminants, dietary changes and geographic and political isolation pose many challenges to achieving good health (Arctic Council, 2004). Indigenous peoples in this region, with their continuing ties to the land and traditional foods, and their often marginalized status, are consequently the most affected by challenging circumstances (Arctic Council, 2004).

As demonstrated in the literature review that follows, in spite of the value of talking with people in their own environments about their health and well-being and influences on them, little research has focused on Inuit women's health. The aim of this study is to explore the determinants of Inuit women's health in Nunavut Territory, Canada.

The Arctic Human Development Report (Arctic Council, 2004) asserts that the best predictor of an individual's health is one's own perception of one's own health. If you feel healthy, then you are healthy; if you believe you are healthy for your age, then you are. Northerners' perceptions of their health are influenced by their personal assessment of social, societal and cultural factors. These include personal involvement in

the community, family support structure and the availability of, and access to, health services that are culturally based (Tester & McNicoll, 2004).

A distinction is often made in the population health and health promotion literature between factors that influence health at a societal level and those individual behaviour factors over which one has some personal control and about which one can make healthy choices (Bolaria & Bolaria, 2002). Bolaria and Bolaria (2002) remind us that we make our life choices in the context of the environmental and material conditions in which we are living; therefore our social contexts play an important role in determining our health. Examining health in the Arctic by talking to northerners about health and examining the social contexts of their lives will contribute to a better understanding of their health and well-being.

In this chapter, an introduction to the geographical and historical context of Inuit living in the Canadian Arctic is provided with a particular focus on the eastern Arctic. It includes a detailed description of the research location and way of life for those living in Iqaluit, Nunavut, Canada. This chapter also contains a review of the literature pertinent to this study. The review includes an examination of literature determinants of health and Inuit health research, particularly what is known about the health of Canadian Inuit women. Building on the information set forth in this literature review, the chapter concludes with the justification for this study, the research question and the significance of the study.

II. The Circumpolar region

The Circumpolar region is an expansive area around the North Pole and comprises all or part of the eight Circumpolar countries: United States (Alaska); Canada; Denmark (Greenland); Iceland; Norway; Finland; Sweden; and Russia (See map, Appendix A). The people of the Circumpolar region are diverse and include many groups of indigenous peoples who share commonalities, such as living in geographically isolated communities, coping with the challenges of obtaining adequate health care and education, and relying on hunting, trapping and natural resources as a significant part of the economy. Given the similarities among the 'norths' of the Circumpolar region, several Arctic organizations representing educational institutions, health networks and the interests of northern indigenous peoples have joined together to build upon and improve existing infrastructures to improve the welfare of the world's northern peoples. These organizations include the University of the Arctic, Inuit Circumpolar Conference (that has consultative Status II with the United Nations), the International Network for Circumpolar Health Research, the Canadian Society for Circumpolar Health, and others.

III. Inuit regions of Canada

There are 4 regions within Canada that are traditionally inhabited by Inuit. Those regions are the Inuvialuit region of the Northwest Territories, Nunavut Territory, the Nunavik region of northern Quebec, and the northern regions of Labrador (See map, Appendix B).

IV. Inuit

The Inuit are the indigenous inhabitants of the North American Arctic, from the Bering Strait to east Greenland, a distance of over 6000 kilometres. Inuit live in Alaska, Greenland and the Canadian Arctic, and share a common cultural heritage, language and genetic ancestry. Of the approximately 150,000 Inuit living in the Circumpolar region, 45,000 live in Canada's North (Morrison, 2005).

Historical context

Nearly three centuries ago, the arrival of European whalers and explorers to the Arctic marked a significant turning point in the health of Inuit. Interaction with European visitors through trade and gift exchange resulted in the introduction of alcohol, infectious diseases, and unhealthy lifestyles to Inuit communities (Morrison, 2005; Inuit Tapiriit Kanatami (ITK), 2005). Since then, Canadian Inuit have undergone a tremendous cultural shift from a nomadic, subsistence lifestyle to working and living in communities year-round. Although the process of relocation to communities began as a response by indigenous peoples to the presence of fur traders, explorers, and missionaries, it took new form with the systematic efforts of the government in the 1950s to 'resettle' Canada's North. At that time, the Canadian government implemented resettlement programs in the eastern Canadian Arctic in an effort to: 1) protect Canada's sovereignty post-World War II; 2) facilitate the opening of trading posts by the Hudson's Bay company; and 3) police, educate, and provide health care for remote populations (Kirmayer, Brass & Tait, 2000; Indian and Northern Affairs Canada (INAC), 1996). During the federal government's

Inuit Resettlement Program in the eastern Arctic, several Inuit residents of Nunavik[1] were also re-located to remote Nunavut communities.

The resettlement program involved three types of resettlement: to move Inuit to southern Canada to cut relief costs; to resettle Inuit into remote High Arctic regions to maintain sovereignty and support the economic initiatives of the Hudson's Bay Company; and to move Inuit off the land and into communities to facilitate the provision of supplies, education and medical care. The Report of the Royal Commission on Aboriginal Peoples (1996) notes that in these years government administrators were concerned with the reports of health and welfare concerns coming out of the North; in fact, they came to see the North as being in a state of crisis (INAC, 1996). Increasingly, there were reports of Inuit starvation as the number of caribou across the North declined and/or migration patterns changed, particularly in the Kivalliq region of central Nunavut[2]. Inuit were ravaged by epidemics and illnesses, especially tuberculosis. In the Baffin region, many hunters lost their dogs to an outbreak of encephalitis, leaving them without a means of transportation and impacting hunting and food provision (INAC, 1996). While the motives and rationale behind the processes implemented by the Canadian government have been argued in the Arctic, the experiences of the resettled Inuit continue to have an impact on many Nunavut residents to this day.

In the lives of Inuit living in the North, many traditional activities have been set aside for more modern alternatives, for example, camping on the land, hunting, and fishing are reserved, for the most part, to the spring and summer months (ITK, 2005).

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[1] The Inuit occupied regions of Northern Quebec

Additionally, one outcome of community-living and greater contact with southern Canadians has been medical acculturation and the transition from traditional to contemporary or modern medicine. This has significantly changed traditional approaches to disease and infirmity. For example, maternity care and childbirth have typically been a family supported process rooted in the home. Today, not only is maternity care directed by health care providers, but births often occur away from the community in regional centres or in cities in southern Canada (e.g. Winnipeg, Ottawa and Yellowknife) where families rarely have the opportunity to be involved in the event (Midwives Association of the Northwest Territories, 2002).

In summary, the Inuit of northern Canada, as with other indigenous groups in Canada, have experienced, and are continuing to experience, a shift in their way-of-living and their traditional practices over the last several decades. What makes the experience unique to Inuit is that this transition has been extremely rapid, compared to the centuries-long process among other Canadian indigenous peoples, taking place in the last five to seven decades.

Research setting – Iqaluit, Nunavut, Canada

Canada has ten provinces and three territories. Nunavut, Canada's newest territory, came into being on April 1, 1999 when the Northwest Territories was partitioned into two separate territories. Nunavut means *'our land'* in Inuktitut, the most common local indigenous language, and its boundaries were created based on knowledge of traditional Inuit hunting grounds (see map Appendix C). In 2003, Statistics Canada

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[2] Also known as the Garry Lake famine (Indian and Northern Affairs Canada (INAC), 1996)

estimated Nunavut's population to be 29,357 (Statistics Canada, 2003) of whom approximately 22,000 are Inuit.

Nunavut's 26 communities are divided into three regions, the western-most is the Kitikmeot region containing five communities; the central Kivalliq region with seven communities; and the Qikiqtaaluk (formerly Baffin) region with 14 communities. Iqaluit's Baffin Regional Hospital (BRH) is the only hospital operating in the territory and services the entire Qikiqtaaluk Region. Every community in Nunavut has a health centre that provides basic medical services and is staffed by community health nurses and community health representatives (CHR). CHRs are typically Inuit women who are bilingual in English and Inuktitut and conduct public health education in communities.

Doctors visit community health centres periodically to run clinics and refer patients to either the BRH or a hospital in Yellowknife, NT, Winnipeg, MB or Ottawa, ON for treatments that are not available in the communities. Childbirth is a medically supervised practice, and requires that women leave their community four weeks in advance of their delivery date and live either in Iqaluit, NU, Yellowknife, NT, Rankin Inlet, NU (low-risk delivery birthing centre), or Winnipeg, MB for the delivery. Technological advancements are being made in the field of telehealth, and health services provision is slowly improving with the advent of two new health centres being built in the regional centres of the Kitikmeot and Kivalliq regions.

Life expectancy in Nunavut in 1999 was 68.6 years compared to life expectancy in Canada as a whole at 78.8 years (Nunavut Bureau of Statistics, 2003). Compared to other Canadian provinces and territories, Nunavut has the highest rates of teenage pregnancy, youth smokers, tuberculosis, genital chlamydia, and death due to suicide

(especially among young males) than any other province or territory in Canada (Nunavut Bureau of Statistics, 2003). In addition, lung cancer mortality in Nunavut is significantly higher than the national average.

Iqaluit (formerly known as Frobisher Bay) is Nunavut's capital city and is located on Baffin Island in the eastern Arctic. Iqaluit's estimated population in 2001, according to the Census, was 5,236. Iqaluit, however, has experienced a tremendous population explosion since being named the territorial capital, and some estimates from local agencies put the population closer to 7,500. Iqaluit was selected to be the research setting given the relationship the researcher has with the community and her established trust and acceptance with community members.

'Iqaluit' is an Inuktitut word meaning 'many fish'. The community is located beside Sylvia Grinnell River that empties into Frobisher Bay. Iqaluit is the centre for government in Nunavut, and is home to the Nunavut Legislative Assembly. One of the goals of the Nunavut government is to 'de-centralize' government departments to various Nunavut communities in order to promote employment and community participation in government. However, Iqaluit houses a large proportion of the government offices and government is the largest source of employment in the community.

The first recorded visit by Europeans to this area was by Sir Martin Frobisher who 'founded' the community of Iqaluit in 1576, although the area is known to have been inhabited by Inuit for over 4000 years (Explore North, 1996). The area remained virtually unsettled by Europeans until a trading post was established in the early 20th century. Iqaluit's most significant growth and infrastructure development has occurred in the last 50 years. In 1942, an American airbase and airstrip was built in the area and that gave

Iqaluit (then Frobisher Bay) official settlement status. The airstrip is now part of the small international airport located in the community, offering flights to many Nunavut communities, as well as Yellowknife, NT, Ottawa, ON and Montreal, PQ, and Nuuk, Greenland (charter flights).

The population of Frobisher Bay increased rapidly during the construction of the Distant Early Warning Line (also known as the DEW line, a system of radar stations, coordinated by NORAD[3]) in the mid-1950s. Hundreds of construction workers, military personnel and administrative non-Inuit staff moved into the community. After 1959, the Canadian government established permanent services at Frobisher Bay, including full-time doctors, a school and social services. The Inuit population grew rapidly in the community as the government persuaded Inuit to resettle permanently in communities with government services.

The founding of the Gordon Robertson Educational Centre (now Inuksuk High School) in the early 1970s in Iqaluit confirmed the community's status as an administrative centre. At the time of its founding, it was the sole high school (grades 7-12) operating in the Baffin Region, which encompasses 14 communities. Today, every community in Nunavut has a high school and Inuksuk High School serves only Iqaluit residents. Iqaluit now has three elementary schools (grades K-5), a 'middle' school (grades 6-7), and a French immersion school (grades K-7) in addition to Inuksuk High School (grades 8-12).

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[3] North American Aerospace Defense

It is not possible to purchase liquor in any community in Nunavut, however, Iqaluit and Rankin Inlet have bars and restaurants at which patrons can consume alcohol. In addition, Rankin Inlet and Iqaluit residents may purchase a permit through the liquor control board and place a liquor order for personal consumption; the liquor must be sent from Rankin Inlet for Iqaluit residents, and vice versa for Rankin Inlet residents.

Iqaluit is a very young community compared to other Canadian towns and cities, and the way of life for Iqaluit residents involves a combination of contemporary and traditional activities. Balancing wage employment with traditional land activities such as camping, hunting, and preparing skins has become the new way of life in this community. Examining the changing way of life raises questions about health determinants and the roles of culture, income, lifestyle and health services, among others, for Nunavut residents. In the following section, population health and health determinants are introduced, followed by a review of the literature on the determinants of health in Nunavut, the health of Inuit, and the health issues facing Inuit women.

V. Population health

Important epidemiological works measure health status by quantifiable indicators such as mortality rates and causes, and incidence and prevalence of some conditions (morbidity). However, they do little to increase our understanding of underlying factors contributing to morbidity and mortality, such as social context or social determinants of health. For instance, epidemiological research documents that rates of smoking are much higher among indigenous populations compared to Canadians, but stops short of asking why this is so (Young, 2003a).

A population health approach to health and well-being focuses on the entire population and includes the examination of health inequalities in populations in order to improve the health status of population groups (Public Health Agency of Canada (PHAC), 2005b). Population health recognizes that health is affected by factors at individual, family, community and society levels of influence. This approach also recognizes the full range of health determinants, factors and influences that shape the health of individuals and communities. Determinants of health are personal, social, economic and/or environmental factors that determine the health status of individuals or populations (World Health Organization (WHO), 2006).

Health Canada has defined the determinants of health for Canadians to be 1) gender; 2) culture; 3) health services; 4) employment and working conditions; 5) personal health practices (i.e., lifestyle) and coping skills; 6) social environment and social support; 7) physical environment; 8) income and social status; 9) education; 10) biology; 11) genetic endowment; and 12) healthy child development (York University Determinants of Health as cited in Raphael, 2004; PHAC, 2005a). In investigating the determinants of health and well-being of Inuit women, we are investigating the influence of these determinants on their health.

The term ‘lifestyle’ is used to refer to certain individual behaviours such as smoking, drinking and drug abuse, which are considered causes of illness (Frohnich & Potvin, cited in Bolaria & Bolaria, 2002). In this context, health problems and health outcomes are linked to personal choices, lifestyles and behaviours that are presumably within individual discretion and control. The tendency to treat lifestyles and health behaviour as matters of individual choice has received some criticism (Bolaria & Bolaria,

2002) as the focus on self-imposed risks tends to downgrade the importance of social, economic, and environmental factors in the production of illness. Social-structural conditions in society can both enable and constrain individual life choices. In other words, lifestyles and life choices are influenced by life chances – the opportunities we may or may not have to acquire material goods, services and desirable living conditions (Bolaria & Bolaria, 2002).

Northern determinants of health

While Health Canada's determinants of health are relevant to many Canadians, it is recognized that the circumstances surrounding life in the Arctic create a different picture of health determinants for northerners.

In a workshop held in Nunavut in March 2005, representatives from a variety of fields related to health, well-being, policy and Inuit culture in Nunavut met to discuss the determinants of health for the Nunavut population. They identified the following health determinants as influencing health in Nunavut: acculturation/self-determination; education; quality of early life; productivity; income and its distribution; food security; health care services; social safety net; housing; and environment (Nunavut Department of Health and Social Services (NDH&SS), 2005). These determinants are discussed in further detail next.

Acculturation/self-determination

Culture is the integrated pattern of human behaviour that includes thought, speech, action, and artefacts, and is transmitted from generation to generation through

learning (Merriam-Webster Medical Dictionary, 2002). It includes the customary beliefs, social forms, and material traits of an ethnic, religious, or social group.

At present, discussions of Inuit culture become enveloped in discussions of the concept of acculturation. Acculturation has different meanings but in a Nunavut context refers to replacement of the traits of one culture with those of another, such as happened to many indigenous peoples around the globe during the process of colonization. Acculturation occurs when a community undergoes a transition from a 'traditional society' to a 'modern, industrialized society' (NDH&SS, 2005). Inuit in Nunavut have undergone an enormous transition over the past 50 years and many feel that this stress has had a negative impact on health. For example, Nunavut has four official languages: English, French, and two Inuit languages, Inuktitut, which is spoken in 24 eastern Nunavut communities, and Inuinnaqtun, which is spoken in Nunavut's two westernmost communities. There are many Inuit elders who are unilingual in Inuktitut or Inuinnaqtun, and many younger people who are unilingual in English, therefore, the three groups cannot communicate with each other. The Nunavut Department of Health and Social Services Social Determinants of Health Report (2005) argues that when acculturation leads to loss of language, unilingual Inuit are marginalized, causing low-self-esteem, frustration, and loss of traditional knowledge. Loss of language also has an impact on the social determinant of education, as some Inuit are not fully literate in English or Inuktitut.

Education

Education plays an important role in employability, income, health and self-esteem; however, traditional skills and indigenous knowledge should also be recognized when evaluating and measuring education levels in northern communities.

Using data from the 2003 Canadian Community Health Survey, the highest level of schooling among Inuit and non-Inuit aged 15 years and over living in Nunavut is presented in Table 1.1.

Table 1.1 Highest level of schooling in Nunavut among Inuit and non-Inuit over 15 years of age. Source: CCHS, 2003

	Inuit	**Non-Inuit**
University certificate, diploma or degree	2.1%	41.7%
College certificate or diploma	15.3%	23.8%
Trades certificate or diploma	4.0%	2.6%
High school graduation certificate and/or some post-secondary	17.8%	21.8%
Less than high school graduation certificate	60.8%	10.1%

The Nunavut Department of Health and Social Services Social Determinants of Health Report (2005) suggests that limited motivation to complete high school and limited availability for post-secondary education in most Nunavut communities may directly influence both levels of education and unemployment rates in the territory (NDH&SS, 2005).

Quality of early life

The foundations of adult health are known to be laid in early childhood and before birth. Evidence on the effects of early experiences on brain development, school readiness and health in later life have sparked a growing consensus about early child development as a powerful determinant of health in its own right (Wachowich, Awa, Katsak & Katsak, 1999). In addition, the Public Health Agency of Canada (PHAC) emphasizes the importance of highlighting determinants of health that affect the physical, social, mental, emotional and spiritual development of children and youth. For example, a

young person's development is greatly affected by his or her housing and neighbourhood, family income and level of parents' education, access to nutritious foods and physical recreation, genetic makeup and access to dental and medical care (PHAC, 2005a). Pervasive social determinants in Nunavut such as poverty, lack of adequate housing, food security and trauma are intermeshed with the quality of early life of Nunavut's children (NDH&SS, 2005).

Productivity

Earning money to sustain one's family or hunting for food to feed one's family both contribute to community health and give one a sense of pride in his/her accomplishments. In addition to formal employment, activities such as volunteerism, political involvement and advocacy are also common in Nunavut and are classified as "productive" (NDH&SS, 2005).

Data from the 2001 Census provide a picture of the employment status of Nunavut's population. The employment rate, also called the employment-to-population ratio, is the percentage of working-age or employable people who have jobs (Government of Canada, 2005). The employment rate for those in Nunavut over 15 years of age is 56.2%, compared to 61.5% in Canada (see Table 5.2). It is the fourth lowest in Canada, with Newfoundland and Labrador (45.1%), Nova Scotia (54.9%) and New Brunswick (55.2%) reporting the lowest Canadian employment rates in 2001.

The unemployment rates in Nunavut reflect the proportion of employable people actively seeking work, out of the total number of employable people in the territory. The proportion of the Nunavut population over the age of 15 years that reported

unemployment at the time of the 2001 Census was 17.4%, compared to 7.4% in Canada in general. This is the 2nd highest unemployment rate in Canada.

Table 1.2 Employment and unemployment rates in Nunavut among Inuit and non-Inuit. Source: 2001 Census

	Nunavut	**Inuit**	**Non-Inuit**
Employment rate	**56.2%**	47.4%	90.0%
Unemployment rate	**17.4%**	23.1%	3.1%

Examining Nunavut's work force by ethnicity, 90.0% of non-Inuit residents aged 15 years and over are employed, compared to 47.4% of Inuit of the same age (Langoise & Nowdlak, 2005). The unemployment rates in the same population, in the same time period were 3.1% among non-Inuit and 23.1% among Inuit. Examining the sex distribution of Nunavut's work force, according to the 2001 Census, 54.2% of women, compared to 58.1% of men, in Nunavut over the age of 15 years were employed. Types of employment in the community vary from working for the territorial and municipal governments to running private companies and businesses to hunting and trapping.

Income and its distribution

PHAC (2005) states that health status improves at each step up the income and social hierarchy. High income determines living conditions such as safe housing and ability to buy sufficient food (PHAC, 2005a). The healthiest populations are those in societies that are prosperous and have an equitable distribution of wealth (PHAC, 2005a).

The median income among those with income age 15 years and over in Nunavut is $17, 270, compared to the Canadian average of $22,120, according to Census data from 2001 (Statistics Canada, 2001). This is the second lowest median income in Canada,

with Newfoundland and Labrador reporting the lowest at $16,050 and the Northwest Territories reporting the highest at $29,030.

Food security

Food security exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active healthy life (PHAC, 2004). In Canada, 14.7% of people reported food insecurity whereas in Nunavut, 56% of residents reported food insecurity (Canadian Community Health Survey, 2001).

In developed societies, food insecurity is defined as "the inability to acquire or consume an adequate diet quality or sufficient quantity of food in socially acceptable ways, or the uncertainty that one will be able to do so" (PHAC, 2004). Food insecurity includes problems in obtaining nutritionally adequate and safe foods due to a lack of money to purchase them, or the limited availability of these foods in geographically isolated communities. In Canada, there is little information about factors associated with food insecurity in indigenous communities despite evidence that food insecurity may be highly prevalent among women and their children in these communities (Willows, Iserhoff, Napash, Leclerc & Verral, 2005). However it is well known that food cost in remote regions of Canada is high due to transport costs and the spoilage of perishable foods. The price disparity between northern and southern communities is very high and, depending on how far the food must travel, items such as milk, bread, and fresh vegetables can be from two to ten times the price in a northern community compared with southern Canada. In addition, a year’s supply of bulk foods arrive by ship every summer, and if the supply begins to run out before the next shipment arrives, the price of

food and sundries often become exorbitant. The Federal government has implemented ‘food mail’ programs in some regions of the Arctic, where it is possible to order food through a provider in southern Canada and have it shipped by air freight to the community once a week. This program, however, requires a credit card which many Northerners do not have to purchase the food.

Health care services

Waiting for care has been, and continues to be, a major issue in the health care sector in Canada (Statistics Canada, 2006). Recently, provincial and federal ministries of health adopted a range of policies and strategies to address lengthy waits for care. In Nunavut, however, the issues regarding access to timely health care services are not limited to wait-times for procedures. Three important elements of this health determinant, according to the Nunavut Department of Health and Social Services Social Determinants of Health Report (2005), are: 1) access to appropriate care in terms of the need to seek care not close to home, the lack of access to prevention education, prenatal care, and the clash of cultures in providing care; 2) participation in the health care system, i.e. northerners have limited control over decisions, health care delivery, and information; 3) loss of traditional medicine, care and birthing methods. In Nunavut, many health services require travel to other communities. For example, x-rays, ultrasounds, mammograms, surgeries, and other diagnostic tests and procedures require travel to central regional communities, such as Iqaluit or Rankin Inlet, or to larger southern Canadian hospitals in Ottawa, ON, Montreal, PQ, Winnipeg, MB or Edmonton, AB. As will be discussed later, pregnant women are flown from their home community a month before their delivery date to give birth in larger centres, such as Iqaluit.

Social safety net

The social safety net is increasingly becoming an important determinant of health of populations but, according to Raphael (2004), has not yet been incorporated into the current determinants of health framework. The social safety net is a term used to describe a collection of services provided by the government, such as welfare, employment insurance, universal healthcare, homeless shelters, and various subsidized services, such as transit, which prevent any individual from falling into poverty beyond a certain level (York University Determinants of Health as cited in Raphael, 2004). The social safety net is a determinant of how well governing bodies protect a society's most vulnerable populations and include the supports provided to those most in need (NDH&SS, 2005). In Nunavut, the majority of these services are provided by the federal government, such as welfare and employment insurance, while others, such as transportation and health care are administered by the Territorial government.

Home ownership and crowding

According to data from the 2001 Census, 65.8% of Canadians owned their own homes compared to 24% of Nunavut residents. Findings from the 2001 Aboriginal Peoples Survey illustrate that approximately 19% of Nunavut's total population is living in crowded conditions compared to 7% in Canada as a whole (Langoise & Nowdlak, 2005). Crowding is defined as more than one person per room in a dwelling (Statistics Canada, 2006). Crowding among Inuit in the Canadian North is a serious concern. Fifty-three percent of Inuit lived in crowded conditions in 2001, compared with 13% of all indigenous peoples living in urban areas across the country and 19% in rural areas outside the Canadian Arctic (Statistics Canada 2001). Although 53% is high, it has

decreased from 61% according to the previous census (1996) (Langoise & Nowdlak, 2005).

The conditions in which people live are vital to their well-being. When housing conditions fall below the acceptable norm, the result is increased susceptibility to infectious disease, poor mental health status, increased stress, and unsafe living conditions (NDH&SS, 2005).

Environment

The land provides many nutritious foods for residents of Nunavut. Inuit 'country foods' are those harvested off the land and from the water, such as caribou, muskoxen, seal, whale and fish. The changing seasons of the year mark the best periods for harvesting food; for example, fish are harvested in the summer and middle of winter and caribou are harvested in fall when they have become fat for winter and their fur is thick. In addition, animals are an important source for furs and skins for both income and warm clothing. Changes in the physical environment, such as those related to global warming, alter the migration patterns of animals and the weather, therefore jeopardizing food security for the people of Nunavut. In addition, contaminants have prompted fears of eating country food even though it is much healthier than processed foods.

Summary of health determinants

In this section, the population was assessed by the social determinants of health. Compared to the rest of Canada, Nunavut residents are: less likely to obtain a high-school diploma or attend post-secondary studies; less likely to hold a job; likely to have lower income and be less likely to own their dwellings; more likely to live in over-crowded

conditions; and are less likely to eat fruits and vegetables (NDH&SS, 2005). These factors play a role in determining the health of Nunavut's population.

In the following section, health research that has been conducted among Circumpolar Inuit will be briefly examined with a particular focus on research conducted among Canadian Inuit.

VI. Inuit health research

An exploration of the health research literature published over the last decade reveals several hundred articles and studies that have been conducted among the Inuit population. The literature features studies involving Inuit populations from Alaska, Greenland, Russia, Nunavik (northern Quebec), Nunavut, Northwest Territories, Newfoundland and Labrador, indigenous[4] peoples in general, and Arctic or Circumpolar populations as a group. The majority of the health research conducted specifically among the Circumpolar Inuit population has focused on cardiovascular (CV) disease and diabetes and associated risk factors (Young, 2003b; Bjerregaard et al, 2003; Pollex, Khan, Connelly, Young & Hegele, 2004); communicable diseases, such as tuberculosis and sexually transmitted infections (Healey et al., 2004) genetics and evolution (Arbour et al., 2004; Sellers, Sharma & Rodd, 2003); food, nutrition and contaminants (Dallaire et al., 2004; Bjerregaard, Young, Dewailly & Ebbesson, 2004; Dudarev et al., 2003); mental

[4] Aboriginal is a term often used in Canada to refer to First Nations, Métis and Inuit populations as a group (Willows, 2005). Alfred & Corntassel (2005) argue that the term 'aboriginal' is a construction of government and represents the "state's attempt to gradually subsume Indigenous existences into its own constitutional system and body politic…" (p. 598). Recognizing that the communities, clans, nations and tribes known as i*ndigenous peoples* are just that - indigenous to the lands they inhabit, all such communities will be referred to as 'indigenous' in this paper, unless a clarification between specific indigenous groups is necessary.

health or illness (Bjerregaard et al., 2003; Madsen, Gronbaek, Bjerregaard & Becker, 2005); and respiratory health, particularly as related to respiratory syncycial virus (RSV) Orr, Mcdonald, Milley & Brown, 2004; Banerji, 2001; Holman et al., 2004; Karron et al., 1999). In a review of the health of indigenous populations in the Arctic, Bjerregaard et al (2004) found that injury, suicide, violence, and substance abuse are also of significant importance when considering the picture of health in Inuit communities although they have not been studied as thoroughly in Canada (Bjerregaard et al., 2004).

The bulk of the health research conducted among Circumpolar Inuit populations has been among the Greenland Inuit and Alaskan Native[5] population, however, in order to fully understand the impact of the determinants of health for Inuit, and particularly Inuit women, in Nunavut, their health must be examined in the Canadian context. The literature reviewed is mainly restricted to Canadian Inuit populations, but not exclusively Nunavut.

Health research among Canada's indigenous peoples

There are a number of published papers that examine the health of Canada's indigenous peoples as a group under the rubric of 'Aboriginal health'. While this information adds to the body of knowledge in health research relevant to those identifying themselves as members of Aboriginal groups, it does not take into account the unique histories, cultures and health needs of the individual indigenous populations in Canada (Alfred & Corntassel, 2004). Inuit do not identify themselves as 'Aboriginal' and

many Inuit representatives advocate to have this nomenclature overturned given the unique history and cultural practices of the Inuit.

The current state of the health of Canadian Inuit is under investigation by researchers, government departments, and Inuit organizations in Canada. In a review of health research conducted with indigenous populations in Canada about their health needs, Young (2003a) reviewed 254 articles pertaining to the First Nations, Inuit and Métis populations in Canada. Of the articles reviewed, 122 (48%) were relevant to Canada's Inuit population, which constitutes a significant over-representation of Inuit studies in the literature given their relative proportion in the indigenous population in Canada.

The same review suggests, however, that the proportion of health research conducted on topics of primary concern to Inuit communities themselves, as opposed to those from outside Inuit communities, is disproportionately low. For example, Young (2003a) illustrates that the prevalence of smoking is very high (62%) among indigenous people in Canada, (64.8% among Nunavut residents) yet only 3% of publications deal with the issue of tobacco use (Young, 2003a). Past research has emphasized the anthropological study of Inuit (Wachowich, Awa, Katsak & Katsak, 1999), the examination of the role of contaminants in the Inuit diet (Dallaire et al., 2004; Duhaime et al., 2004; Kuhnlein, Soueida & Receveur, 1996; Young, 2003b; Young, Chateau & Zhang, 2002), and the study of genetics (Young, 2003a; Hegele, 2001), which mirrors the

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[5] A term used in research on the United States that refers to a member of any of the indigenous peoples of Alaska, including American Indian, Eskimo, and Aleut peoples (The American Heritage Dictionary of the English Language, 4th Edition, 2003)

research conducted in the Circumpolar Inuit populations discussed earlier. Research investigating the prevalence of chronic diseases such as cancer and cardiovascular disease has been increasing (Nielsen, Storm, Gaudette and Lanier, 1996; Healey et al., 2001; Young, 2003b; Bjerregaard et al., 2004), and diabetes, particularly Type 2, has become a research subject of interest in Inuit populations (Hegele, 2001; Naylor, Schraer, Mayer, Lanier, Treat & Murphy, 2003; Young et al., 2002), given the fact that the rates of Type 2 diabetes among the First Nations population are three to five times higher than the rest of Canada (Pollex et al., 2004). These rates have not, as yet, been mirrored in the Inuit population.

The incidence of infectious diseases has declined considerably since the first Europeans travelled to the Arctic, but is still high compared to the rest of Canada (Young, 2003a). For example, the Nunavut Department of Health and Social Services identifies tuberculosis (TB) as one of the main public health concerns of Nunavut, since the incidence rate is almost seventeen times that of the rest of Canada (Nunavut Department of Health and Social Services, 2000).

While there are a number of published studies examining the health of Canadian Inuit, there is a clear gap in research that examines determinants of health, particularly social determinants, in Inuit, or any other indigenous population in Canada (Young, 2003a). In addition, in his review of indigenous health research, Young (2003a) highlighted the paucity of research examining indigenous women's health issues (p. 421).

VII. Inuit women's health

Historically, health research has very much focused on examining the health of the population as a whole, and only in the past 10-15 years has women's health research and the specific health needs of women become a focus in the literature.

Women's health refers to issues affecting a woman's health and well-being. For the purposes of this study, women's health is defined as mental and emotional health, physical health, and social well-being. When health is defined as mental, physical and social well-being, and not merely the absence of disease and infirmity, cultural and social practices become critical contributing factors to health (Arctic Council, 2004).

Previous health research has illustrated that women living in poverty and/or who are homeless often have poorer health than women who do not share this socio-economic position (Thurston & Meadows, 2004). Indigenous women are often among the women in these groups (PHAC, 2002). Indigenous women in Canada have, for many centuries, faced social, political and cultural changes that have negatively affected their health, cultural identity, social structures and traditional values (Carroll & Benoit, 2005).

The rapid shift in health practices described in an earlier section help frame the discussion of women's health issues in Nunavut. Of the research published in the last decade that examined health among the Circumpolar Inuit population, less than 50 articles were found that specifically addressed women's health issues. These studies primarily addressed issues such as pregnancy; childbirth; exposure of the mother and foetus to contaminants; nutrition; and substance use. The handful of studies conducted among an identifiable population in Nunavut examined midwifery and traditional birthing practices in the region, such as the historical events that have led northerners away from

the tradition of midwifery; and evaluations the of the Rankin Inlet Birthing Centre in the Kivalliq (central) region of Nunavut.

In 2004, the federal Department of Indian and Northern Affairs conducted a meeting at which several health issues for indigenous women in Canada were discussed and identified to be: adequate housing, early childhood programs, abuse and family violence, women in urban areas, foetal alcohol spectrum disorder, and the rate of change from a traditional to a modern way of living (INAC, 2004).

This body of research also highlights that indigenous women's health in general is under-researched and that little, if any, literature (published or otherwise) exists that is specific to the determinants of Inuit women's health.

Inuit women's health context

> "[T]here is little Inuit-specific health data available in general, and even less specifically about Inuit women. Women play an integral and essential role in Inuit families and communities, traditional harvesting and the traditional economy. It is therefore important that Inuit women be involved in identifying health priorities from the beginning." (ITK, 2001).

The proceedings from the National Inuit Health Information Conference produced by ITK (ITK, 2001) and Pauktuutit Inuit Women's Association[6] have identified the following health issues for Inuit women: breast health; reproductive health (i.e., sexually transmitted infections, birth control and family planning, abuse and assault); life changes (menopause); child birth (away from families) and children's health; parenting,

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[6] Pauktuutit leads and supports Canadian Inuit women in policy development and community projects in all areas of interest to them, for the social, cultural, political and economic betterment of the women, their families and communities. Pauktuutit fosters greater awareness of the needs of Inuit women, advocates for

traditional values and raising children; balance of work and family; care-giving for aging parents and services for elders; housing and economic development; food security; mental health and depression; primary role for health and well-being; addictions and substance abuse; and foetal alcohol spectrum disorder.

Next, some issues that have been raised by various reports and the published literature will be examined in further detail.

Sexual health, pregnancy, childbirth (traditional vs contemporary) and adoption

Nunavut has a high rate of chlamydia, a sexually transmitted infection, (3623.4/100,000) among women, compared to Canadian women in 2000 (211.8/100,000) (Nunavut Bureau of Statistics, 2003). In addition, specific strains of human papillomavirus (HPV), a sexually transmitted infection that causes genital warts also causes cancer of the cervix. In a report profiling cancer rates in the period 1992-2001 in Nunavut, the most common cancer among women was cancer of the cervix, which accounted for 30% of all (malignant and in situ) cancers diagnosed in women (Healey, Plaza & Osborne, 2003). Approximately 75% of cervical cancer cases in Nunavut were diagnosed between the ages of 20 and 39.

Indigenous women have been identified as having poorer pregnancy outcomes than other Canadian women. Recent publications based on retrospective analyses of large databases have confirmed disparities in birth outcomes between indigenous women and all other groups (Wenman, Joffres, Tataryn & Edmonton Perinatal Infections Group, 2004). A study conducted by Muggah et al. (2003), examined women delivering infants

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equity and social improvements, and encourages their participation in the community, regional and national

preterm at that Baffin Regional Hospital in Iqaluit, NU. In a retrospective examination of data from 938 births at the hospital during 1999-2000, 95% of the mothers were Inuit women (n = 835). In this study, premature delivery of an infant less than 37 weeks completed gestation occurred much more frequently among Inuit women living in the Baffin Region compared to the general Canadian population. The premature delivery rate of close to 18% was almost three times the national average (Muggah, Way, Muirhead & Baskerville, 2003). The authors also identified several socio-demographic risk factors for preterm delivery including substance use, young age, single marital status, and poor nutrition, and found these risk factors occurred more frequently among Inuit women compared to non-Inuit women.

Many mid-life (40 to 65 years) Inuit women in Nunavut were born in *qammait* (large tents) in outpost camps on the land or in communities, as Inuit were resettled. As mentioned earlier, women are now required to leave smaller communities for bigger communities or go to southern hospitals with more advanced health care weeks before the birth of their child. This process was put in place to address the poor pregnancy outcomes among indigenous women in Canada. The government terms the process “obstetric evacuation”; however, one traditional Mohawk midwife familiar with the practice has termed the process “obstetric exile” to illustrate the impact she believes this procedure has on the women who are evacuated (INAC, 2004).

In a study of nursing perspectives on public health programming in Nunavut (2003), community health nurses we asked to identify reasons women in Nunavut were

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life of Canada (Pauktuutit Inuit Women's Association, 2005).

reluctant to leave their communities to give birth (Roberts & Gerber, 2003). They highlighted four common reasons: 1) women are unable to bring a birthing coach, their partner, or children when they leave the community and child care for older children is often an issue; 2) women are not given the choice as to where they deliver; 3) women do not receive prenatal teaching, support or recreation during the weeks before delivery; 4) women feel isolated while away from their homes and families (Roberts & Gerber, 2003). In the proceedings of an Indian and Northern Affairs meeting on indigenous women and health (2004), it was reported by one participant that just as the residential school experience has left many scars on successive generations of indigenous people in Canada so too will the practice of obstetric evacuation (INAC, 2004).

In traditional Inuit custom adoption, Inuit families give a child to a family member, such as an aunt and uncle or grandparents. In Inuit society this practice has none of the guilt and stigma associated with it in typical Canadian or European culture. Birth parents often see their adopted children daily and often have close relationships with them. Custom adoption is an ancient tradition and there are many motives behind it. If a family, for example, had too many births too close together, and felt they wouldn't be able to feed all their children, they might give one away to someone better able to care for it, or a family with all girls might decide they want a boy too (Bennet & Rowley, 2004). By adopting a child into the family, one was increasing chances of survival. A family may potentially adopt their biological child out to another family, and then later adopt someone else’s into their family. This is especially common among families who want to strengthen ties to each other (Bennet & Rowley, 2004). Custom adoption strengthened community ties, helped create families, and ensured children had the best possible home.

In recent years, however, some community members have expressed concern that custom adoption is becoming a way to deal with unwanted pregnancies in Nunavut (Rideout, 2000).

Alcohol and substance abuse

Alcohol and substance abuse have been identified as a serious problem among many indigenous groups in the Circumpolar region (Bjerregaard et al., 2003; Bjerregaard et al., 2004; Class, 2004; Kirmayer, Brass & Tait, 2000; Parks, Hesselbrock, Hesselbrock & Segal, 2001). In a cross-sectional study of Alaskan Native women leaving centres for alcohol treatment, Segal (2001) conducted structured interviews with 122 participants in accordance with the treatment centre's patient assessment protocol. In this study, the author found that behavioural and lifestyle problems among those interviewed arose from having to deal with the impacts of cultural change resulting from alterations in traditional roles that have contributed to a loss of personal, familial and cultural identity. A common way of coping with these problems for many Alaskan Native women, according to the author, is to turn to alcohol and other drugs, which puts women and their children at high risk for physical and sexual violence (Segal, 2001).

Nunavut also has the third highest proportion of heavy drinkers[7] over the age of 12 compared to all other provinces and territories, as reported by the Canadian Community Health Survey (2003). Nunavut's proportion of heavy drinkers is 31.0%, third only to the NWT at 39.9% and Newfoundland at 32.2% (Langoise & Nowdlak, 2005).

Alcohol abuse contributes substantially to rates of death from all types of injury, liver disease (cirrhosis), homicide, suicide, other types of psychiatric illness, and foetal alcohol spectrum disorder (Young, 1991). In a cross-sectional survey of 200 Alaskan Natives (103 male, 97 female) in residential treatment for alcohol dependence, women tended to rate themselves to be in "poor" or "fair" health (25.3%) more often than men (18.3%), whereas 45.6% of men rated themselves as in "very good" or "excellent" health, compared with only 31.6% of the women (Parks et al., 2001). Forty-nine percent of the women also reported experiencing some form of personal violence and, the authors state, in general their victimization was related to drinking both by themselves and by the perpetrators (Hesselbrock, Hesselbrock & Segal B., 2003). The question remains as to whether drinking immoderately is the consequence or cause of some health related and wellness issues of these women.

Tobacco use, smoking, and environmental tobacco smoke (ETS)

Tobacco use and environmental tobacco smoke (ETS), commonly known as second-hand smoke, are the leading cause of preventable death in Canada (Canadian Council for Tobacco Control, 2005). Although the prevalence of smoking has been decreasing over the past 2 decades, mortality and morbidity related to tobacco use remains very high, especially among Canadian indigenous peoples (Indian and Inuit Health Committee, 1999). Lung cancer is the most common cancer in Nunavut, accounting for 39% of the invasive cancer cases in a 10-year period (Healey et al., 2003; Friborg, Koch, Wohlfarht, Storm & Melbye, 2004). Nunavut also has the highest

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[7] Heavy drinking is defined as consuming 5 or more drinks on one occasion, 12 or more times a year,

proportion of smokers over the age of 12 in all of Canada. In the 2003 Canadian Community Health Survey, 64.8% of Nunavut's population over 12 years of age reported being smokers, which is an alarmingly high rate given that the next highest proportions of smokers over 12 years of age were 36.6% and 27.5% in the Northwest Territories and Yukon Territory, respectively (Langoise & Nowdlak, 2005).

Exposure to ETS is also known to increase risk of respiratory and other infections in children in Canada (Canadian Council for Tobacco Control, 2005). ETS poses a significant public health concern given the proportion of the Nunavut population that are smokers.

Contaminants, diet and nutrition

Indigenous peoples throughout North America and other parts of the world have experienced changes in their food use patterns and nutritional status over the last century. Documented changes include a decrease in the use of locally-harvested traditional, cultural food, commonly referred to as country food in Northern Canada (Kuhnlein, Soueida & Receveur, 1996). These changes are paralleled by an increase in the use of food provided in markets and stores. Traditional diets, composed of high fat and protein with minimal carbohydrate intake, are rapidly being replaced by a diet comprising processed and store-bought foods. As discussed earlier, food insecurity is a concern in Nunavut, and access to high-quality, nutritious store-bought foods is difficult in many remote and isolated communities in Northern Canada. In a descriptive study that combined both retrospective chart review and a cross-sectional follow-up survey, 245

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among current drinkers (CCHS, 2003) (Langoise & Nowdlak, 2005).

Cree mothers with 9-month old infants in Northern Quebec were asked about infant feeding practices, the health of their infant, and the question, "Do you ever worry you don't have enough money to buy your children food to eat?" Affirmative responses to the question were considered by the authors to be evidence for anxiety about food supply. One-fifth of participants in the study reported experiencing anxiety regarding their food supply (Willows, Iserhoff, Napash, Leclerc & Verral, 2005). This study was conducted among the Cree population in Northern Quebec, which experiences many of the same challenges to obtaining reasonably priced, nutritious foods that are faced by Nunavut residents. As traditional indigenous dietary patterns continue to adapt to contemporary social circumstances, and the traditional diet continues to have less prominence, Duhaime et al (2004) have identified that special attention needs to be given to the quality and accessibility of store-bought foods in these remote communities (Duhaime et al., 2004).

Over the past two decades, there has also been growing concern regarding the levels of contaminants in country foods and the potential toxins to which northerners may be exposed when consuming these foods (Arctic Council, 2004; Dudarev et al., 2003). The Northern Contaminants Program (NCP), a branch of the federal department of Indian and Northern Affairs Canada (INAC), was established in 1991 in response to studies that found questionable levels of contaminants in the Arctic ecosystem (Indian and Northern Affairs Canada (INAC), 2006). Many of these contaminants have no Arctic sources and yet some are found at high levels in animals at the top of the Arctic food chain and in humans. The three main contaminant groups of concern are persistent organic pollutants (POPs), heavy metals and radio-nuclides (INAC, 2006).

In a qualitative study by Egan (1998), Inuit women's perceptions of health risks from potential contamination of the Arctic food chain were explored through in-depth interviews with 47 women in an undisclosed Canadian Arctic community. The author found that many of the Inuit women they interviewed suggested that pollution can appear in a variety of forms, from visible air and water contaminants and possible invisible contaminants in Arctic wildlife, to pollution of the human body through drug and alcohol consumption (Egan, 1998). The author concludes that Inuit concepts of pollution are influenced by a complex of socio-cultural factors arising from historical and contemporary community life. This study highlights the way Inuit view the world, view the concept of pollution and the connection between body, land and spirit.

There is limited epidemiological information available regarding levels of contaminants in Nunavut's population; however concern regarding contaminants has been particularly well-researched in the Nunavik region of northern Quebec. In 1992 Dewailly et al (2001) conducted a cross-sectional study to evaluate blood levels of lead and mercury in 492 Inuit adults of Nunavik (209 men, 283 women). Exposure to lead and mercury levels is hypothesized to be particularly high among populations who consume marine animals (i.e., fish, ringed seal, narwhal, walrus, and beluga whale), as lead and mercury are widespread environmental contaminants in aquatic environments (Dewailly et al., 2001). The authors found that 26% of 18-44 year old women had blood levels of lead and mercury concentrations that exceeded those that have been reportedly associated with subtle neurodevelopmental deficits in other populations (Dewailly et al., 2001). As Inuit in Nunavut consume the same diet and share the same waters as Nunavik residents, the results of this study are a concern for Nunavut residents as well.

As a result of this and other research, the regional government implemented a plan to encourage Nunavik residents to replace country foods with store-bought foods in their diet (Duhaime et al., 2004). This has caused some controversy among policy-makers, researchers and community residents. In a study assessing the impact of this policy on the Nunavik population, Duhaime et al. (2004) stated that the consumption of country foods has many health, social, economic and cultural benefits, such as participating in traditional activities and community feasts. Duhaime et al. concluded, therefore, that it is important to fully understand the levels of contaminants in country foods and the risk they may or may not pose to humans, before implementing such policies throughout the Arctic.

Mental health, wellness, suicide and stress

Mental health plays a significant role in the overall health of women. In an editorial on women's mental health, Goodman (2005) discussed mental health in terms of depression and suicide, mood disorders, eating disorders, and hormone-related mood fluctuations, such as menopause and premenstrual symptoms (Goodman, 2005). Mental illness is under-diagnosed by doctors, and the World Health Organization (WHO) reports that less than half of those who meet the diagnostic criteria for psychiatric disorders are identified by doctors (WHO, 2005).

Distinction between mental health and wellness:

While some literature does not distinguish between mental health and wellness, there are very important delineations between the two concepts. 'Mental health' is often used in a clinical context, such as in reference to depression, mood disorders, and similar clinical conditions (Goodman, 2005). Wellness, however, is a concept that is much more

all-encompassing and holistic. Wellness affects every part of our daily lives, and how well we feel every day plays a major role in our health and how we get along with others or react to events. Wellness is an interactive process of becoming aware of and practising healthy choices to create a more successful and balanced lifestyle, and includes the social, spiritual, physical, intellectual and emotional aspects of life.

A study conducted by Lavallee (2000) comparing Santé Quebec survey data (collected between 1990 and 1993) from three populations, James Bay Cree (n = 1999), Inuit of Nunavik (n = 1567) and southern Quebec residents (n = 23,564), found that Inuit women in Nunavik were more likely than non-indigenous southern Quebec women to experience lifetime suicidal thoughts (13.9% compared to 8.4%) and lifetime suicidal attempts (14.4 % compared to 4.5%). The same study, however, found that Inuit women were less likely to report high levels of psychological stress than non-indigenous southern Quebec women (25.5% and 30.4%, respectively) (Lavallee & Bourgault, 2000). The Santé Quebec survey also illustrated that suicidal thoughts were reported more often by females (17.1% for women, 15–24 years; 5.1% for males, 15–24 years), however, Tester (2004) argues this fact does not imply that young Inuit women are more vulnerable to suicide, because disclosure is more common among Inuit women than men.

According to data available from the Canadian Community Health Survey (2003), the proportion of women over 18 years of age who reported experiencing ‘quite a lot of life stress’ was 21.2%, compared to 15.6% of male respondents. In the Northwest Territories, however, this comparison differed, with men reporting experiencing “quite a lot of life stress” (23.0%) more often than women (19.3%). In both territories, however,

these proportions are lower than the Canadian national statistics of 25.0% for women and 23.9% for men responding to the same question (Langoise & Nowdlak, 2005).

Suicide is a serious issue of concern in Inuit communities. In an article examining the social constructions of Inuit suicide, Tester et al. (2004) examined statistics from the former Northwest Territories (including Nunavut), Nunavik and Greenland. They found the rate of suicide in the area comprising the former Northwest Territories (N.W.T.) in 1999 was 6 times greater than southern Canada. The Baffin region of the N.W.T. had the highest male suicide rate at 133.9/100,000 individuals, and the highest female suicide rate at 47.1/100,000 individuals. Within the area comprising the former N.W.T, Inuit accounted for 87% of all suicides, which is high considering Inuit comprised approximately 35% of the territorial population, according to the 1996 Census. A 12-year analysis revealed that suicide rates in Nunavut region have risen over time, and that rates in the western part of the former N.W.T. had declined. Rates in Nunavut have risen dramatically from 48.7/100,000 (1985–1987) to 66.7 in the following 4 years, 75.1 (1991–1993) and 85.5/100,000 from 1994 to 1996 (Tester & McNicoll, 2004).

Violence and trauma

Domestic violence is a serious problem for many women around the world. The National Centre for Injury Prevention and Control in the United States identifies four areas of intimate partner violence: physical violence; sexual violence; threats of physical or sexual violence; and psychological/emotional abuse (National Centre for Injury Prevention and Control, 2006). Domestic violence can occur between family members and/or partners, also called intimate partner violence (IPV). IPV can occur among heterosexual or same-sex couples and does not require sexual intimacy. IPV can vary in

frequency and severity. It occurs on a continuum, ranging from one hit that may or may not impact the victim to chronic, severe battering[8].

While there is published literature that examines domestic violence among the First Nations populations in Canada and Native American populations in the United States, the literature relevant to Arctic communities is very small. In a review of the health of indigenous peoples of the Arctic, Bjerregaard et al. (2004) found that "interpersonal violence in all its forms (homicides, assaults, abuse), with or without sexual context, directed at strangers or family members, is now an issue of major public health concern in most circumpolar indigenous communities" (p. 393). The authors discuss different possible explanations for violence in these communities, such as the stress of rapid social change, and an inadequacy of traditional conflict resolution behaviours in the new, more urbanized environments (Bjerregaard et al., 2004). Additionally, while both men and women suffer from intimate partner violence, a greater proportion of women are victims than men. In a Greenland study analyzing population health survey data from 1993-94, Sundaram et al (2004) found that among 18-24 year olds, 58.8% of females and 44.0% of males reported lifetime experience of violence and/or threats of violence (669 and 604 female and male respondents, respectively) (Sundaram, Curtis, Helweg-Larsen & Bjerregaard, 2004).

In Nunavut, there is little data on the actual numbers of men and women experiencing violence and/or living in violent situations; however the local health

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[8] Repeated abuse is also known as battering (American Heritage Dictionary of the English Language, Fourth Edition, *2000)*

authorities recognize that while they have little pertinent data on the subject, it is a significant concern for many in Nunavut (Osborne, 2004).

Risk factors for cardiovascular disease and diabetes

Available data on cardiovascular disease risk among Inuit are conflicting given today's clinical understanding of the risk factors for the disease. For example, the Lavallee and Bourgault study (2000) discussed earlier found that Inuit women of Nunavik were less likely than southern Quebec women to have high blood pressure (4.8% compared to 12.8 %) or high cholesterol (14.6% compared to 17.7%), but were more likely to have excess weight (defined as a BMI <30) (23.9% compared to 12.3%) and be physically inactive (47.9% compared to 26.4%) (Lavallee & Bourgault, 2000). There are many similarities between Nunavik and Nunavut residents as some Nunavik residents were resettled to areas in Nunavut during the resettlement program in the 1950s. In addition, there are similarities among the two Regions when comparing community size, infrastructure and recreational activities available in the communities.

High rates of type 2 diabetes in the First Nations population in Canada have prompted research into the prevalence of diabetes among Inuit. It has been documented that Inuit have a lower prevalence of diabetes and age-adjusted mortality from cardiovascular disease than the general population (Pollex et al., 2004). In a Canadian study using data from a cardiovascular survey conducted in 1989-1991, 168 Inuit participants (48.2% women) and 53 Caucasians (38.5% women) were compared. Inuit

participants were found to have lower prevalence of metabolic syndrome[9] (13.1 %) than their Caucasian counterparts in the study, (20.8%) (Pollex et al., 2004).

While these risk factors for cardiovascular disease and diabetes are still being researched among Inuit, the evidence thus far indicates that some risk factors, such as high blood pressure and cholesterol, may not yet be as big a concern among Inuit as it is among the First Nations and Metis population in Canada.

VIII. Summary and research question

Inuit women's health is a crucial part of the health of their communities. There exists an urgent need to better understand the mechanisms through which determinants of health affect Inuit women. Inuit women face serious health issues related to reproductive and sexual health, such as high rates of sexually transmitted infections and challenging circumstances surrounding childbirth. Wellness, suicide and stress are more significant issues for Inuit women compared to non-Inuit women. Food security and accessibility is an issue for all northerners, however, it is a particular concern for Inuit women as they often have sole responsibility for children and, therefore, many mouths to feed. Alcohol and substance abuse and exposure to violent situations endanger both the health and safety of Inuit women in Nunavut. The challenging circumstances facing Inuit women and their health are numerous; however, literature examining these contexts and processes through which health is affected is virtually non-existent. Additionally, no research to date has been conducted that examines women's perspectives about how the

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[9] A cluster of symptoms including a variety of criteria such as elevated fasting blood sugar; high blood pressure; elevated triglycerides and HDL cholesterol; and large waist circumference.

determinants of health affect Inuit women's day-to-day well-being. Inuit do not see themselves as part of the general term 'Aboriginal', therefore it is important to examine their health in the context of Circumpolar Inuit and the Arctic region, and not subsume their experiences into the 'Aboriginal' health literature in Canada.

Given these issues, the research question that remains to be answered is: "What factors do Inuit women in Nunavut identify as contributing to their health? and What are the determinants of health for Inuit women in Nunavut?"

As well as adding to the body of knowledge on health determinants in Canada, answering these questions will provide valuable information for health policy decision-makers and program development in the Territory, and facilitate the direction of resources to the necessary areas of health services provision in Nunavut.

The study design and data collection methods followed for this study are set out in the next chapter.

CHAPTER 2 - METHODS

I. Introduction

In this chapter, a detailed description of the methods used in this study is presented, including a discussion about the study design; partnerships and community-based research; sampling strategy and recruitment; data generation and analysis; and finally ethical considerations.

II. Study purpose

The purpose of this study was to explore the determinants of health for Inuit women in Nunavut. This is a field of study for which there is very little existing literature; therefore this research opens up new possibilities for understanding health and its determinants for Inuit in Nunavut.

Research question

What are the determinants of health for Inuit women living in Iqaluit, Nunavut?

III. Definitions

Inuit: Persons identifying themselves as being of Inuit descent. The participants recruited for this study were Inuit women.

Nunavut Resident: A participant that has spent three or more years in Nunavut (definition from Government of Nunavut) or in the Northwest Territories, as Nunavut became a separate territory in 1999.

IV. Partnerships

Key Inuit organizations in Nunavut, such as the Qikiqtani Inuit Association (QIA), Pauktuutit Inuit Women's Association, the Qulliit Nunavut Status of Women Council and others, were informed of the study and consulted during the development of the project. The QIA and the Nunavut Department of Health and Social Services also provided letters of support for this study. This study is also a part of a larger Canadian Institutes for Health Research (CIHR) funded study at the University of Calgary examining Inuit women's health in Nunavut communities.

In addition to acquiring ethical approval from the University of Calgary's Conjoint Health Research Ethics Board, the Nunavut Department of Health and Social Services and the Nunavut Research Institute issued a research license before the research went forward.

V. Role of the researcher

It is important to describe the role of the researcher in this study, as the researcher is the analytical instrument in qualitative research. I was born and raised in Iqaluit, Nunavut, the community in which the study took place. During the past five years, I have had the opportunity to work in different areas of the health field in this community, including working in the laboratory and radiology departments in the community hospital, and working as a health promotion specialist for the Nunavut Department of Health and Social Services. My work experience and personal background provided me with a unique understanding of health services in Iqaluit, both as a health professional and as a recipient of health care in the community. I believe this insight into northern

medical services, my sensitivity to community expectations and protocols, and my understanding of the health issues that exist in northern communities were an asset to the study.

As I am a member of the community, there may have been concerns among participants about disclosing personal information during the interviews. Participant names are kept anonymous (i.e., they were asked to use an alias), as well as any information that may allow the participant to be identified in the community, such as number of siblings or place of employment.

VI. Community involvement in research

Approval of research at the community level is an essential part of ethical practice and should be considered an on-going process that is confirmed at various stages of the research. It is also integral to share results of the research with the community, with partnering organizations and other stakeholders to ensure the information is given back to the community (Inuit Tapiriit Kanatami, 2001). The results of this study will be shared with community groups that supported the study in Iqaluit, and translated into summaries provided in both English and Inuktitut to health care providers and other interested people in the Territory.

A Participatory Action Research (PAR) approach was used in this study (Macaulay et al., 1999). One of the most important aspects of qualitative research is that it can be participatory in nature (Creswell, 2003), marked by the fact that individuals are afforded the opportunity to participate directly in the study by sharing their knowledge and providing their perspectives on the research question. Participatory research attempts

to negotiate a balance between developing valid generalizable knowledge and benefiting the community that is being researched, and to improve research protocols by incorporating the knowledge and expertise of community members. Collaboration, education and action are the three key elements of participatory research. Such research stresses the relationship between researcher and community, the direct benefit to the community of the potential outcome of the research, and the community's involvement as itself beneficial (Macaulay et al., 1999). A goal is that research subjects should 'own' the research process and use its results to improve their quality of life.

VII. Study design

Qualitative study design

Qualitative methods are important for determining what is important and why, what variations exist, and what lived experiences mean to individuals and groups. These questions are the domain of qualitative methods, which include interviews, focus groups, participant observation and document analysis (Crabtree & Miller, 2004).

In qualitative research, the investigators usually start with a problem or issue that emerges from a story or some experiential context. These problems and issues give rise to research questions. What distinguishes qualitative research from quantitative approaches is that it seeks to search inductively for understanding and meaning. An additional distinguishing feature is the iterative process of gathering and interpreting data that usually occur concurrently (Crabtree & Miller, 2004).

Little is known about Inuit women's health in the Canadian Arctic, therefore an exploratory qualitative health research design was appropriate for this study. This

qualitative case study used elements of ethnography and a number of established qualitative techniques to gather data to describe the current perspectives of Inuit women on the determinants of their health.

Individual face to face interviews were used to gather data from a sample of Inuit women living in Iqaluit, Nunavut between August 2005 and January 2006. Interviews were audio recorded with permission and transcribed verbatim. Data were analyzed using a process of immersion and crystallization (Borkan, 1999). Issues of rigour were addressed using established qualitative techniques (Creswell, 2003; Creswell, 1998; Meadows, Verdi & Crabtree, 2003; Bjerregaard, Young, Dewailly & Ebbesson, 2004). Qualitative research is iterative, with recruitment, data collection and data analysis occurring concurrently. These elements will be described separately.

VIII. Sampling and recruitment strategy

Population

There are approximately 22,000 Inuit in Nunavut Territory, of which approximately half are female. Nunavut has a very young population, in fact approximately 60% of the population is under age 30 (Nunavut Bureau of Statistics, 2003). The target population for this study were Inuit women over 18 years of age living in Iqaluit, Nunavut at the time of the study.

Recruitment

The researcher discussed the research project with community members and they either volunteered to participate in the study or recommended family members, friends, or colleagues they thought would be willing to participate.

Sampling strategy

Maximum variation sampling strategies were employed in this study. Maximum variation sampling is a purposive form of sampling (Kuzel, 1999) whereby the researcher purposefully selects a wide range of variables that are representative of the variables of interest in the population with respect to the research question (Creswell, 1998). In this study, some variables of interest were age, marital status, women who do and who do not have children, women from varying educational backgrounds and women who may or may not originally be from another outlying community. This method of purposeful sampling is viewed as beneficial for ensuring extremes of the population are represented in the sample.

The study was designed to recruit participants until the data reached saturation, or until new interviews no longer contributed to the themes identified in analysis (Creswell, 1998; Morse, Swanson & Kuzel, 2001). Typically a study will require 6 to 12 interviews before reaching saturation, with an iterative cycle of data collection and analysis being a critical feature of the method (Crabtree & Miller, 2004).

IX. Data collection

Data were collected through unstructured interviews with women in Iqaluit, Nunavut. The in-depth interview is ideally suited when the research focus is narrow, the

respondents are relatively homogeneous, and the respondents' context is already known (Nunkoosing, 2005). The participants in this study were homogenous as they were all Inuit women living in Iqaluit, NU. An interview guide with five central questions and topics of interest was used (See Appendix F).

Interviews were conducted by the researcher, who is trained in qualitative interviewing techniques, in a natural setting or a comfortable location for the participant (i.e., in their home, place of work, or a coffee shop). The information was recorded digitally with the permission of the participants.

Participants were asked to comment on the contexts and issues that affect their health, e.g., the broad determinants of health. In particular, the participants were asked to comment on how these issues contributed to their well-being and impact their daily lives. The participants were then asked to comment on what aspects of their health they believe could be improved and how this might be achieved, as well as to comment on these issues for women in the community in general. The researcher took the opportunity to examine the topics raised during the interviews by taking field notes in order to modify the interview guide during the study process. Thus the process of data collection, data analysis and interview guide revision was an iterative one.

Because many people in Nunavut do not speak English or speak English as a second language, an interpreting company was engaged during the interview process, in case need for a translator arose. The consent form is presented in both English and Inuktitut in Appendix E.

The interviews were transferred to the transcriptionist through Blackboard, a confidential file-sharing program used by the University of Calgary. The researcher

uploaded the interviews in Iqaluit, and they were then downloaded by the transcriptionist in another location. The reverse process took place to return the transcripts to the researcher in Iqaluit.

X. Data analysis

The goal of the analysis is to return to the research question, and examine the data in the context that was set at the beginning of the study. Thematic analysis using memoing and coding was applied to the data in combination with techniques of immersion and crystallization (Borkan, 1999). The transcripts were imported into qualitative data analysis software QSR*N6®. After this step, the process was multi-stage (Creswell, 2003). Transcripts were read and re-read several times and reflected upon. In addition, the researcher listened to the interview and re-read the transcript to ensure transcription were verbatim and to fill in missing data. Techniques of immersion and crystallization were used during the data analysis proces. Borkan (1999) asserts that the investigator must be immersed in the data, reading and rereading the transcripts, to identify recurring themes. Initial coding captured topics such as culture, sexual health, midwifery, food security, and relationships. QSR*N6® analysis software was used to facilitate the open coding process of selecting sections of the interview and assigning labels to words or phrases (codes) in the transcripts. The researcher formed initial categories of information about the phenomenon being studied by segmenting information (Creswell, 1998). This initial part of the analysis process resulted in the development of 130 codes. The researcher's thesis supervisor coded transcripts in order to compare to the codes of the researcher. This process provides another 'angle' for

examining the data to see if similar concepts are being identified in the data and is a process of ensuring rigour in the study (Creswell, 1998).

As a next step, codes relating to a similar field were grouped into categories, which resulted in the development of 20 categories. The categories were analysed to identify topics that were discussed in each interview and across all interviews (Morse & Richards, 2002). In order to be considered a theme in the data, the concept must have been discussed by all of the study participants in some way. The themes were then reflected upon in comparison to the original research question and examined in the context that was set at the beginning of the study in terms of a thorough literature review. This was part of working with the descriptive data to bring it to an analytical level.

Debriefing sessions with colleagues were essential to the process and provided insight and expertise into the analysis of the data. The researcher returned to the community to share descriptive results with the organizations that supported the study for member checks (Creswell,1998). Member checks are a way to verify the data and involve returning results to the participants to review for accuracy. As the researcher received training in community health and epidemiology, the researcher's interpretation of the data would likely be different from that of the participants, therefore member checks would not be a useful method for ensuring correct interpretation of the data. Discussions were held with community organizations to aid in interpretation of the data.

XI. Rigour

Rigour is essential in both qualitative and quantitative epidemiological studies and, in this study, was addressed through several means. An extensive review of the

literature regarding women's health in Nunavut, in the other territories, in indigenous populations in Canada as well as in other Circumpolar countries was conducted before the study began in order to present a thorough description of the setting or context in which this case study is being examined (Morse, Swanson & Kuzel, 2001). Clearly articulating the literature and the methods applied throughout the study increase readers' ability to transfer the results of the study to other contexts, thereby maximizing the rigour of the study (Bjerregaard, Young, Dewailly & Ebbesson, 2004).

Researcher responsiveness is a part of ensuring rigour in qualitative studies and refers to the researcher's creativity, sensitivity, flexibility and skill. The researcher remained open and willing to relinquish any ideas that are poorly supported, regardless of the excitement and the potential that they first appeared to provide (Mayan, 2001). The lack of responsiveness of the investigator at all stages of the research process is a hidden threat to reliability and validity (Mayan, 2001).

Methodological coherence ensures congruence between the research question and the components of the method. Meadows et al. (2003) state that the interdependence of qualitative research demands that the research question match the method, which in turn must match the data and the analytic procedures. The key for this study was ensuring that questions, methodology, sampling and analysis were clearly articulated and appropriate for addressing the research question (Meadows, Verdi & Crabtree, 2003; Mayan, 2001)

Documenting and setting aside one's own assumptions about the research topic in order to minimize personal influence on study results is known as bracketing (Meadows, Verdi & Crabtree, 2003). As the researcher is a member of the community it required careful attention to bracketing and reflexivity during the analysis process to recognize

that the women were using illustrations of topics to bring forward larger points and concerns in the community. Throughout the data analysis process, 'debriefing' meetings were arranged with various members of the thesis advisory committee to discuss the analysis process, emerging themes in the data, and for potential directions to explore in the literature.

Field notes were taken during data collection. Results were compared with the original field notes to provide context and reflections on the interview and ensure that the underlying intent of the respondents remained intact (Meadows, Verdi & Crabtree, 2003).

In qualitative research, external validity refers to the degree to which the audience or reader is able to transfer the research findings context outside of the study situation to other settings (also known as transferability) (Mayan, 2001). In order to accomplish this, the researcher must provide a substantial amount of clear and detailed information (thick description) about the issue or phenomenon being studied and the setting in which the issue/phenomenon was studied. When the reader knows and understands the context of the research, then s/he can decide whether the findings are transferable between settings. The degree of transferability is a direct function of the similarity or fit between two contexts (Mayan, 2001).

XII. Ethical considerations

Guidelines for research involving indigenous peoples emanate from Australia, Canada, the United States and an international forum, the Inuit Circumpolar Conference. The Association of Canadian Universities for Northern Studies (ACUNS) (2003) states that these guidelines are motivated by three considerations. First, indigenous

communities are often geographically isolated and possess histories, cultures and traditions distinct from dominant culture. Second, there is an evolving political consciousness and aspiration to self-determination in indigenous communities. Third, indigenous peoples are increasingly concerned that research may adversely affect them and their values. It was very important in this study, therefore, to be respectful of all of the ethical guidelines set forth by both the organizations that represent indigenous peoples, and the guidelines of the University of Calgary. In addition to seeking the approval of the University of Calgary's Conjoint Health Research Ethics Board, this research project was guided by the Ethical Principles for the Conduct of Research in the North, published by the Association of Canadian Universities for Northern Studies (Association of Canadian Universities for Northern Studies, 2003). Above all, participants in this study were treated with respect, appreciation, and dignity.

XIII. Summary

The design and implementation of this study were structured to explore determinants of Inuit women's health. The steps outlined in this chapter include a description of the design, details on participant recruitment, sampling, data collection, analysis and interpretation, rigour and ethical issues. The results of the study are presented in the following chapter.

CHAPTER 3 – RESULTS

I. Introduction

The results of the analysis of data derived from nine individual in-depth interviews with women who are residents of Iqaluit, Nunavut are presented in this chapter. Inuit women in this study discussed their health in terms of mental, emotional, spiritual and physical health, illustrating both positive and negative influences on health. They talked about the strains that they, and other women in their community, experience as mothers, grandmothers, spouses, students and career women, and the physical and emotional burdens that these issues can bring. In all of the interviews, women discussed their health concerns in terms of gender roles, traditional beliefs and values, and education and knowledge. Participants used stories that illustrated their issues or their experiences or of others they knew, to share their perspectives on the determinants of health and well-being of Nunavut women.

In this chapter, a brief summary of the demographics of the participants is presented, followed by the categories of responses obtained through the data collection process. The results are presented using the three themes that were identified in the data analysis: Tradition and Culture; Knowing; and Wellness.

In the following section, I describe the participants to provide the reader with a context for understanding the research results.

II. Participants

All nine women, currently living in Iqaluit, Nunavut, self-identified as Inuit and each had at least one Inuk parent. Women were born in a variety of Nunavut communities including Rankin Inlet, Arctic Bay, Kimmirut, Igloolik, Pangnirtung and Iqaluit (see map, Appendix C), and had moved to Iqaluit for school, work opportunities or with family. Women in the study were given the option of conducting the interviews in English or Inuktitut; they universally chose to conduct the interviews in English. Women ranged in age from 27 to 51 and came from various family and educational backgrounds. Demographic information of the participants is included in Table 3.1.

For the purposes of this analysis, when women are described as ‘younger’, they are between the ages of 27-39, and women described as ‘older’ are between the ages of 40-51. Most of the women in the older group were born on the land in an outpost camp and moved into communities as children. As illustrated in the map of Nunavut provided in Appendix C, Nunavut communities are remote and geographically isolated from one another. Women in the older age group were usually sent away from their families for high school and experienced a different upbringing than the younger women. The younger women were born in the hospital or health centre in their community, attended school in their home community, and most have spent some time living in southern Canada attending college or university.

Table 3.1 Participant demographics

Characteristic	**n (9)**
Age (years)	
20-39	4
40-59	5
Spoke Inuktitut	
Yes	7
No	2
Highest Level of Education	
Post-secondary or higher	2
Some post-secondary or college	5
High school	1
Some high school	1
Marital Status	
Single/divorced	3
Boyfriend/common-law/married	6

III. Presentation of Results

Women in the study shared both personal and family experiences, and spoke of health issues at both the individual and population health levels through examples about women in the community or the experiences of other people. The open coding of the interviews and field notes yielded 130 codes that described the issues raised. The codes were collapsed into 20 categories, as described in an earlier section. The initial categories identified in the analysis are provided in Table 3.2.

Table 3.2 Categories of responses identified during the early stages of data analysis

• Nunavut communities • Demographic information • Food Security • Education issues • Family • Individual lifestyle choices • Chronic disease • Wellness • Healthy relationships • Issues in Nunavut and South • Gender roles	• Old ways and tradition • Isolation • Health services and relationships with health professionals • Sex and pregnancy • Injury • Acculturation (and/or Colonialism) • Spiritual Health • Aging • Knowledge

Three themes were identified from the data: 1) Tradition and Culture, 2) Knowing and 3) Wellness. The first two themes were discussed by women in the context of relationships, reproductive and sexual health, and food accessibility. The third theme, Wellness, was universally identified by participants as the desired health outcome for women in Nunavut. The theme of Wellness incorporates elements from the first two themes into the larger day-to-day context of health and will be presented later in the chapter. In the presentation of results, topic headings describe different areas of the discussion within each theme. Subheadings highlight specific stories or examples women provided to highlight issues related to the three themes. Examples include stories about teen pregnancy and parenting; country foods and store-bought foods; and sewing parkas, among others.

Quotes presented in the results are verbatim. I have not corrected the participants' grammar, nor have I edited or changed any words in the comments reported here, unless the words allowed the participant to be identified.[10]

1. Tradition and Culture

Culture was discussed by the participants in terms of shared practices and beliefs and the use of common language. Women discussed an array of topics in the context of tradition and culture, including teen pregnancy, healthy (unhealthy) pregnancy, birthing practices and traditional midwifery, and custom adoption.

A. Pregnancy, birthing practices and traditional midwifery

Some women expressed concern for Inuit women engaging in unhealthy lifestyle behaviours while pregnant and the potential effects that may have on the unborn child.

> … a lot of women I see, when they're pregnant, they smoke, they do drugs … they're eating but I don't know if they're eating the healthiest meals and types of foods … because, in turn that affects the baby and now we're seeing a lot of babies who are born premature or have a heart murmur or have some sort of asthma or breathing problems …
>
> -- *Participant #2*

Midwifery was presented by women as a credible option to help women deliver their children in their home communities instead of being flown to one of the four major centres for delivery.[11]

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[10] Any words that were altered for more generic words are shown in "[ ]". In the quoted text passages in this article, my verbal and nonverbal words of encouragement have been removed for readability (e.g., "right" and "mm-hm"), in addition to "um"s or "ah"s. Many women often inserted "you know" into their sentences. These phrases are often removed for readability; however, I wish to acknowledge that these "you knows" have been interpreted as participants' requests for understanding.

> … I hope in the future they will have midwifery programs so these women can have their children at home … they can make a whole lot of difference to the families, like I say, birth rate is kind of still high and having to fly back and forth and being away from your family for one whole month and the kids are suffering, even the lady is too stressed out being here worrying about her kids, her husband … I hope they'll have that program some day. So the women can have their children in their home communities.
>
> -- *Participant #7*

One participant, in particular, expressed deep regret for not having a midwife accompany her in the hospital when she delivered her first child. She felt she had missed out on important and valuable traditional teachings related to perinatal care, such as special remedies to improve flow of breast milk or ways to ensure a child is born happy. This participant also discussed many traditional remedies and practices related to birthing about which she was personally knowledgeable.

B. Custom adoption

Older women were more likely than younger women in the study to discuss reproductive and sexual health in terms of custom adoption and personal experiences with the tradition – illustrating both positive and negative experiences. In traditional custom adoption, Inuit families give a child to a family member, such as an aunt and uncle or grandparents, and the tradition is generally perceived to provide children with the best possible home. There are, however, exceptions to custom adoption for some individuals, such as one of our participants who was treated 'like a black sheep' in her family. While she acknowledged the importance of the custom by adopting children into

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[11] As discussed earlier in this thesis, obstetric evacuation is a mandatory practice in all Nunavut communities except for Iqaluit, where there is a hospital, and Rankin Inlet, where a low-risk delivery

her own family, she felt that if children are situated with the wrong family, then there could be negative consequences, making this an issue of wellness. Generally, however, women talked about custom adoption as a positive tradition that ensured children were well taken care of and raised in good homes. However, they also felt this tradition is being abused today as a means to deal with teenage pregnancies. Teenage pregnancy and parenting were often discussed as an example of a health issue in the community that shed light on other underlying concerns related to cultural practice, as illustrated in the next section.

Teen pregnancy and parenting

Young women spoke about Inuit teenage pregnancy in the context of cultural tradition. Participants felt that teenage pregnancy was accepted in the community and that it was not seen as a negative repercussion for a young woman to drop out of school to have a child.

> … this is something I think about … [teenagers] having kids but not being able to care for them … 'cause either they're very young or maybe they didn't have strong parenting either. Or they don't mind having kids because they know other people have kids and they know that someone else is going to care for them anyway, so the direct responsibility isn't on them …but it's like having babies is not a bad thing … there's no real [deterrent]…
>
> -- *Participant #8*

Several participants raised the need to talk about teenage pregnancy as an issue of concern in communities and in families, implying that when dialogue is open on an issue,

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birthing centre is located.

people are more likely to respond and become engaged in prevention activities. They felt the traditional practice of approaching issues as a community is disappearing.

> … women in Nunavut, we have to really start looking at our reproductive and sexual health. I think this is really a big important issue and I'm not just talking about STDs and teenage pregnancy …we have to start talking publicly … it's something that really has to be discussed in the community and in families. Let's talk about having sex too early. Let's talk about STDs. Let's talk about pregnancies and … abortion … [talking about sexual health] says a lot about personal respect … and I just think that it's just a really big area that we've allowed to kind of run away from us and have to take that back.
>
> -- *Participant #1*

C. Positive images and health influences

When prompted to discuss positive aspects of women's health, the importance of using beautiful imagery of the land and water in disseminating health messages was mentioned, as were messages with a positive approach to health promotion activities.

> We just need more information and positive messages … we sometimes concentrate on the negative side of things. When we see a beautiful flower, we feel better … even though we may be depressed … when you go out in the sunshine and see beautiful flowers, beautiful people, beautiful things, you feel better … in our traditional saying, "If we dwell on negative aspects of certain things, then these negative things come alive, and they become being." So the moral is not to let that happen. Let's concentrate on the positive things so that the positive things can grow and come alive.
>
> - *Participant #6*

Women also talked about positive attitudes in terms of treating oneself well, by taking walks with friends, for example. Participants suggested that a positive approach to health was better for one's confidence and sense of self, and that people are far more

likely to pay attention to positive messages than messages that are hurtful or imply blame.

Women discussed family planning and the availability of contraceptives as positive and already existing health resources for women in the community. They felt, however, that many women in Nunavut choose not to use these options and they did not understand why this was so. Many women also felt that custom adoption was generally a positive influence, as long as the child is given to a good home.

D. Identity and the 'old ways'

Identity was always tied to notions of culture for women in this study. Women felt they were caught between wanting to respect their cultural traditions and awareness that they live in a changing world where formal education, gainful employment, and growing communities have changed the way of life for Nunavummiut[12].

> [W]hat I've been realizing a lot is that for Nunavut or for any part of the Arctic, it's a cultural shock. Things are going so fast like this is like a rat race to us. Now back then [it] wasn't a rat race. It was like the … community used to mingle more … there used to be more activities … [T]here's [a] lack of communication between elders and the younger generation and when we listen to our parents talking about how it was back then, I say wow. It makes me want to be in that life and see, actually see it myself.
>
> -- *Participant #5*

Inuit women are facing internal struggles to figure out where they belong, and how they can be true to the two cultures, Inuit and non-Inuit, that are coming together in Nunavut. In some cases this tension comes from having one parent who is Inuk[13] and the

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[12] Inuktitut word meaning 'people of Nunavut'
[13] Inuit is the Inuktitut word for 'people'. Inuk is the singular form meaning 'person'.

other non-Inuk, in others from having education and travel experiences in the South, or the growing population of non-Inuit in the Territory.

> Knowing your culture, it'll affect your health mentally and knowing who you are and if you know who you are, then … you'll have more confidence in yourself … I know with me I went [away for high school] … which I'm happy about but … I had a lot of struggles in finding out who I am … I'd say I'm an Inuk but I'm living in a qallunaat [white person] world. Where does that leave me .. am I betraying my Inuk culture or what am I doing? I had a lot of personal struggles and finding out who I really am.
>
> -- *Participant #2*

Women in the study strongly associated the ability to speak Inuktitut with the strength of their cultural identity and the extent to which they "are an Inuk", and vice versa.

> I knew how to speak Inuktitut but … for me it wasn't really good so that really affected my confidence in being considered an Inuk … I felt kind of stupid for not being able to speak Inuktitut … and kind of shy. [Y]ounger people … they don't really know their language. They do but they don't really know how to speak it properly in full sentences and it does affect them … I've seen many teenagers trying to speak and then they get frustrated and give up and just start speaking English and … that has a real impact because they're considered Inuk but can't speak the language … I'm supposed to be Inuk and I can't speak my language fully. It kinda, I kind of got lost ...
>
> -- *Participant #2*

Women acknowledged the importance of the 'old ways' and teachings that are not being passed on from elders to the younger generation. While some women felt very strongly about this issue, others felt that relying on the 'old ways' would be akin to taking steps backward. Those women who wanted to move beyond the old ways felt that progress and positive changes had been made regarding gender roles in families,

women's participation in the work force, and the treatment of issues such as sexual abuse in society and, therefore, going back to the old ways would be counterproductive to these advancements.

E. Summary

Inuit women used stories and examples of teenage pregnancy and parenting issues to illustrate points about the importance of traditional practices related to childbirth and child-rearing in Nunavut communities. Women described the importance of having learned Inuktitut, the indigenous language of the Eastern Arctic, and teaching it to their children. They associated the ability to speak Inuktitut with their ties to cultural tradition, for example, sharing stories and history, and felt that without it many young people are left with a sense of not belonging. Women talked about the grief that is experienced from loss of culture that can cause significant problems related to identity, social inclusion, wellness, and suicide.

2. Knowing

The idea of 'knowing' and 'knowledge' was central to the participants' description of the gaps in both health practice and regarding Inuit women's wellness. This knowledge took primarily four forms: health information and education; Inuit Qaujimajatuqangit (traditional knowledge); life skills and knowledge; and understanding.

A. Health Information and Education

Women discussed the need to share basic health education about several public health issues, including sexually transmitted infections (STIs) and birth control, what is

needed for a healthy pregnancy, and knowing how to be a good role model and parent. From their perspective, participants felt that this information is shared in the community primarily through public health education, formal education in school, and from parents or community members. Women universally discussed reproductive and sexual health in terms of an immense gap between education and practice regarding safe sex and pregnancy among young people.

Sexually Transmitted Infections (STIs) and sexual behaviour

Sexual health was very much discussed in the context of health education. Participants did not speak about specific sexually transmitted infections in their discussions, except for some mention of Acquired Immune Deficiency Syndrome (AIDS). When speaking of AIDS, they spoke of it in fear, primarily for their children and young people who become sexually active at a young age. One participant linked the high rates of teenage pregnancy in Nunavut to the fact that many young people are not having protected sex and are, therefore, at risk for sexually transmitted infections. The message from these women regarding sex and STIs was simple: women don't know enough about prevention, and if they do, they aren't practising it. In addition, some participants discussed educational issues in terms of literacy and the number of older women who did not complete high school and aren't fully literate in either English or Inuktitut.

> It's important to educate, especially the older group too. Sometimes we forget the school dropouts, the women that have dropped out early only at like twelve, thirteen, fourteen [years of age]. Sometimes we forget those women when they get older because they're not educated, they can't read or write - they look after themselves okay, it's just that they're not educated about [sexual health] and don't know how to go about [getting information on the subject].

-- Participant #7

B. Inuit Qaujimajatuqangit (traditional knowledge)

Inuit Qaujimajatuqangit or traditional knowledge is knowledge that is part of Inuit tradition and has been passed on to younger generations for centuries. Many women spoke of either wanting to know more about certain traditional Inuit activities, such as making a parka or skinning a seal, or wanting to share their knowledge about perinatal care and midwifery, as well as their other skills. Knowing and speaking Inuktitut was also an important focus of women's discussions of Inuit knowledge. Inuit Qaujimajatuqangit was seen as an important connection to one's culture and identity and, therefore, of paramount importance to one's health and well-being.

Sewing parkas, cleaning skins, sharing experiences

One participant discussed her feelings about traditional knowledge, not knowing enough, and wanting to know more. She felt she had certain expectations of herself based upon what Inuit women would have accomplished in earlier generations and discussed her own struggle with those emotions.

> …Inuit culture, like traditional lifestyle, is not around anymore, so language that's [our] ties to [the] root of the culture … like having skills of making parkas and qammaqs [big tents]. I don't know how to do that and … I'm supposed to be Inuk, I should know how to do this kind of thing and it still affects me now … because I think back in the day when they would have done one by now. I'm [under 30]. I should have been able to make parkas. I would have had like how many kids and you know have a hunter husband [by my age] … so that affects me now … even just making anything, traditional clothing, being able to skin [animals for clothing]. I don't know how to skin a seal and then stretching it or whatever they do. That kind of knowledge, cultural knowledge, I don't have. It still affects me like, kind of brings me down a little.
>
> -- *Participant #2*

Participants also discussed the importance of teaching about health through the sharing of experiences among community members, which is a traditional method for passing on knowledge in Inuit culture. Using this method within the community or in classrooms to communicate knowledge incorporates the use of old ways to facilitate the dissemination of new health information. For example, one participant felt that bringing a teen parent and baby into an elementary school classroom to talk about the challenges of being a parent at a young age would help educate children about how difficult it is to experience parenthood as a teenager.

C. Life Skills and Knowledge

Life skills and knowledge in this study were described by participants to be the basic tools one needs to look after one's social, emotional, and physical well-being, such as knowing one's self-worth and one's identity; knowing how to communicate with friends/family/children/spouses; knowing about and deserving respect from others; coping with with stress and emotions; and knowing where to get

help when needed. Women felt that life knowledge can be learned from parents/caregivers and friends, life experience, sharing stories with community members, and some from formal education in schools and public health education.

Country foods and store-bought foods

One example many women discussed as a life skill was that of eating good food. For women in the study, the accessibility of healthy food was a concern, either for themselves or for women in the community. The importance of eating country foods (traditional foods such as caribou, seal, whale and fish) was highlighted. Some women expressed concern for the pollution of the land and water, and the effect contaminants may have on foods they are eating. They also expressed a concern for single moms who may not have a hunter in the family and, therefore, may not be able to access country foods.

Food, food security and food access are meaningful and on-going issues for those living in Nunavut, even in a large community such as Iqaluit. Inuit women spoke of wanting to eat healthy foods and the difficulty in making the choice to eat them if family members buy junk food for the family (such as chips, pop or chocolate). Women also discussed the lack of availability of healthy foods in communities – it is far easier to purchase junk food than healthy food, as there is a larger selection of junk food and 'heatables' or microwavable dinners available in Nunavut stores than nutritious fruits, vegetables and dairy, especially in the smaller communities in Nunavut.

> I think to some degree [that knowing what are the right foods to eat may be a problem for young people], yeah. Well I shouldn't say, "Just younger people," but even the older

> people. I will say as an example that traditional food is, of course, the best in terms of consumption of food in the north, because [we're] used to it. And traditional food, there's no bad food in that sense. But since the introduction of southern foods, there's all kinds of choices now … just look at the stores, I can give you an example of one store, a little store that has aisles and aisles of stuff. I can't even say that they're food. They're stuff. But you consume through your mouth, but they're not really healthy at all. They're just all junk food.
>
> -- *Participant #6*

Although healthy food mail programs have been implemented by the federal government to facilitate the purchase of healthy foods directly from a provider in the South, not all community members can meet the qualifications for participation.

> I think the only way you can get [food or formula] cheaper is if you order it on food mail now and the only way you can get food now is if you have a credit card. So accessibility - like it's still more expensive to have a child here than anywhere else in the country I think. (Laughter) and it's just not fair 'cause we have to pay for all the shipping and all the everything else and the companies make a profit and we get the hook. We're the ones who struggle just because we want to have kids …
>
> -- *Participant #4*

Inuit women were concerned that basic education was missing about healthy foods, reading labels and knowing what store-bought foods are best for children and families, implying that even if healthy food choices were available in greater quantities in Nunavut stores, some families would not benefit without more and better information about nutrition and healthy eating. Also, the opportunity to learn about proper preparation of foods, such as through cooking classes, was described as a valuable skill many would like to have, but that was not currently available in the community.

D. Understanding

Women raised many questions about why women stay in violent relationships, or why they get pregnant as teenagers when they have the basic knowledge about safe sex and teenage pregnancy. Why do women have the information and choose not to use it? Through their questions, women illustrated their knowledge of important health issues and resources, and articulated the gaps in their current environment. They want to know more about these aspects of life and society in order to understand why these things happen in their community and how they can work to make it better.

Why don't women know better?

Participants discussed wanting to understand why women are getting pregnant at such a young age, i.e., at 13, 14, 15 years of age. They also discussed 'understanding' in terms of adolescent mothers not knowing how to be good parents and taking proper care of their babies. Some provided examples, when prompted, of women feeding soda pop or coffee whitener to babies in baby bottles and, while they felt that the girls just didn't know better, they wanted to understand why they didn't know better.

Participants also asked questions about why domestic violence happens in an attempt to try to understand it. They raised questions such as, "If men are committing assaults, does anyone examine why?" "What are the factors contributing to their mental well-being and why is the issue not examined from the point of view of *both* men and women suffering in these relationships (for different reasons)?"

In the quest for understanding, women are identifying issues in their communities, acknowledging their need for more information and reinforcing their commitment to each other as women of the community.

E. Summary

Knowledge, as discussed by the participants, moves beyond simply receiving information and comes from many sources including formal education, parents, life experience, traditional teachings and community sharing. It is the collection of knowledge from these different sources that helps contribute to the health and well-being of Inuit women.

3. Wellness

Wellness was discussed in terms of a transition from traditional to Southern or 'modern' values and ways of living; changing gender roles in families and in the work force; and issues of identity related to the feeling that they are torn between two cultures. Women discussed wellness in terms of self-esteem and self-confidence, relationships with family, partners and the community, and alcohol and substance abuse.

A. Self-esteem and self-confidence

Participants were concerned that low levels of self-esteem and confidence develop as children for Inuit females (e.g., already present at elementary school levels) and continue throughout their lives. They identified this as a problem; however they did not provide a reason for why these low levels of self-esteem exist,

other than to reason that perhaps more supportive parenting and encouragement may play a role.

> I sometimes think [Inuit women] really believe they don't deserve any better. Sometimes I think they don't really believe … they can do any better … and maybe their focus has been so much family and relationship … I don't know if every woman has ever come to that realization 'I had these skills, I'm good at this, I can go back to school, I am still a good mother'…
>
> -- *Participant #4*

Women were concerned with a general lack of parenting skill among parents in the community. Women speculated that poor parenting may be a result of young people entering relationships and becoming parents at a young age (i.e., while in high school, as young 13 years) or from parents dealing with their own health issues at home and, therefore, acting as inappropriate models for their children.

> … anything in your life affects your mental wellbeing and your child … if a woman is having a rough life at home … abused and stuff … that has a major effect [on the child].
>
> -- *Participant #2*

Younger participants, in particular, discussed wellness and self-esteem in terms of what one participant called living a 'dramatic lifestyle' – characterized by a combination of drinking, partying, drug use, and high-risk sexual activity in the community. Engaging in this type of activity is often viewed by community members as a means for women to seek validation, particularly from men, and/or to mask underlying personal problems. This risk-filled lifestyle may put women at risk for sexually transmitted infections and unwanted pregnancies, and exposes them to situations where it is likely that they might consume alcohol during pregnancy, be

sexually assaulted, or end up in situations of violence. In addition, the 'drama', also referred to community gossip, which is inevitable in many small towns. Community gossip results from (or leads to the gossip about) an individual's choices and risky lifestyle and only contributes negatively to the self-esteem of women.

> … understanding how people conduct themselves in their relationships with whomever, I think is a really big determinants of how you expect your life will be... if you have a constant presence of unhealthy relationships … that unhealthiness that comes with living an unnecessarily dramatic lifestyle. I think that's clear that … if you live in that kind of constant uncertainty and drama, I think that really plays a toll on you … these are the things that you have to challenge and you have to work through yourself … I think that's the hardest thing about being healthy is that you have to make the commitment to yourself to work through those problems or those lifestyle choices. I think once you have figured out how to take care of yourself that way, that's when you're really, really healthy …
>
> -- *Participant #1*

B. Relationships

Women spoke of relationships in terms of family dynamics; personal and intimate relationships with partners; and relationships within the community.

Family

Inuit women very often have sole responsibility for children in separated relationships, and even in partnered relationships, which was identified as a source of both mental and financial strain for many women in the community. Mothers in the study had both biological and/or adopted children and spoke of stress as a considerable wellness issue for women, and for men, as well. Women discussed 'worrying' about their children, about their health, their education, their exposure to

sexually transmitted infections, and their choices in relationships. When prompted to discuss stress, they said that it was largely a result of family dynamics and relationships.

Women discussed family relationships in terms of multiple generations, including their own parents, siblings and children. Family relationships were discussed as very valuable but very challenging to manage and a source of stress in their lives. Women perceived poor relationships between parents and children. They felt these poor relationships resulted from poor communication skills, low education levels and a lack of traditional values.

> I think [managing family dynamics] is a big part of health issues … as part of life. I think it's also a good way to start moving towards healthier life, stronger living. With partners, children, childrearing practices … having good communication with the family network. [Traditional beliefs with respect to childrearing and family] are not being learned, they're not being shared, and they need to be shared more. And we need to hear the values, the family values in them more from our traditional background, because they are so very important and very important to be passed on. They're not being passed on enough.
>
> -- *Participant #6*

Prominent traditional Inuit values women discussed in interviews related to the valued place children hold in families; respecting elders and seeking their advice; and the importance of not talking about others in your community in a negative way.

Partners

Women highlighted the particularly demanding role of intimate partner relationships in their lives and in the lives of Inuit women in the community. For example, suicide among young Inuit men and women was discussed in this context.

> There's a lot of things that affect relationships like a lot of people are jealous … they're isolated [geographically] so … It kind of gets lost and just sucked in and just feel like they can't get out or that's all that they have and if they lose that person then their whole life is destroyed … they need to be able to kind of think positively …
>
> -- *Participant* #2

Participants felt many Inuit women are dealing with violence and anger in intimate relationships, yet some women shied away from or were reluctant to discuss the topic in the interviews. One participant stated that in Inuit culture,

> [I]t almost seemed like men were allowed to do anything they wanted to do and women just had to take it and divorce was not an option. Once you were with that person, you were with them through thick and thin and no matter how black and blue you became, you're still with that person 'cause that's your husband.
>
> -- *Participant* #4

Some women described similar situations where a woman acquaintance was reluctant to leave a violent relationship because she did not have her own money and could not afford to take her children and leave. If she did leave, she and the children may have to rely on friends or family members for a short time, becoming part of the 'hidden homeless'[14] in Nunavut.

A number of participants in the older age group highlighted the importance of communication with partners, saying that poor communication in partnerships came from either not knowing its value or needing guidance in effective communication.

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[14] The 'hidden homeless' is a term used in Nunavut to describe single-parent families, primarily single moms, who have no permanent residence. They 'surf' from relative to relative, taking shelter with whomever will help them. They are considered to be 'hidden' because they do not live on the streets, but are cared for by their friends and family, as is typical in northern communities (Aylward, 2005).

> … communication is important … it gives us a healthier home environment, family environment and I feel that communication is … one of the medications for your life. That's how I would say it. A medication 'cause without that communication, I think it'll be like … two dogs. They don't communicate and they go for one food and they'll fight over it. Without the communication at home, that's how it would be like … anger will build more if you don't communicate. I think … it's lack of communication that causes … anger. So that communication is like one of the medications that we have for a healthy life.
>
> -- *Participant* #5

This woman added:

> Lack of communication, lack of trust and [the effect of] two cultures mingling together are the three factors I could think of for [contributing to] unhealthy relationships.
>
> -- *Participant* #5

When older women spoke of domestic violence it was primarily in terms of the male partner's need for help. Several participants noted that Inuit men are coping with personal trauma and pain, which may be the reason they are violent; some women felt these underlying issues needed to be addressed.

> We have to respect them a lot so my [male family member] … he was the big dog kind of thing so I think it's part of culture sort of thing so that women always respect them. Have to do this, have to do that. But I find it's changing now … some men need help too. Yeah, they do need help … I only hear about women being abused but men are being abused by their wives too. 'Cause women get angry. I know [men] need help too 'cause I think they're both the same sort of thing. Well, it's depending on how they were raised I guess by their family and by their parents.
>
> -- *Participant* #3

Community

The importance of having strong relationships within the community to share experiences and facilitate the teaching of health knowledge was clearly articulated. However, there were aspects to community relationships that women also described as negative. For example, women spoke of how the community views a person and judges his/her life decisions, or how family members may band together against an individual or another family over a personal issue. As communities in Nunavut are so small, one's life is rather transparent.

> You're really frowned upon when you split up … I had a friend of mine who actually helped get a friend the maintenance money from her ex 'cause she had [children] and he wasn't financially supporting her. Anyway, it worked out for her but she had to go away [leave town]. His family was saying 'Well so and so split up with so and so and my sister split up with so and so, she doesn't get any money. Why are you different?' They were frowning on her for going outside the family to get financial help from her ex even though he's obligated to do that, he wasn't doing it … but they looked at her like an enemy and they really, really made her life very difficult for her and all she was trying to do was support her children.
>
> -- *Participant #4*

C. Substance use and coping

Substance use, such as alcohol, was often brought into the conversation indirectly through issues dealing with sexual abuse or the supports that are needed to cope with emotionally difficult times.

> [My family member's illness] reinforced the importance of being [with family] and being in your mind all the time … you have to deal with the emotions as they come and something like [a family member's illness] they come all the time you know … people are so much more than their physical selves

> …you know if they're hurting physically, they must be hurting mentally somewhere or their family must be hurting … do they have the tools or do they have access to the supports that allow them to deal with that hurt and that pain? …
>
> -- *Participant #1*

A few older women had participated in addictions recovery programs and had sought counselling to help them address their anger and hurt resulting from childhood sexual abuse. These participants described sexual abuse as a terrible and wide-spread issue that affects both men and women in many communities in Nunavut, and is often ignored.

> It takes a lot of work to get over that kind of [abuse] because in smaller communities family is involved. Your abuser is part of the family so, for us women, it's slowly getting better where sexual abuse used to be just swept under our carpet, and if you voice about it you're considered [a] "shit disturber." …you always had to watch yourself because … even though you're the victim, they'll turn on you and say, "You're wrecking the family … just sweep this under the carpet." And your abuser, they don't even bother with that person regardless of how much damage they have done. So, that's the unhealthy part.
>
> *Participant #7*

Additionally, sexual abuse and its repercussions (both for the victim and the aggressor) on a person's wellness in later life were linked to domestic violence.

> I know some of these poor women that do get beaten up badly… the majority of the women that I have known over the years that are violently beaten and [are in] really bad violent situations when … their spouses have been involved in sexually abusing someone … GUILT ridden beat ups, for no reason. Those abusers have to deal with their issues as well, because … there are women out there that have been beaten up for no good reason. And I know that [the abuser] has sexually abused someone over the years … they need help too. It's not just the women that are in the violent situation. So it's [an issue] for both.

-- Participant #7

One participant described losing many years of her life to alcoholism in her attempt to cope with years of sexual abuse as an adolescent. She felt that this issue was not uncommon and described situations of other women known to her that use alcohol to cope with their own personal history of abuse. Relating these issues to her current state of well-being, she talked about seeking help to recover and now draws on her personal experiences to encourage other women who are close to her to seek help as well.

D. Summary

Self-esteem is established and built upon in youth; relationships are a necessary part of life and are negotiated through the life spectrum; substance abuse is an issue for many women who face challenges and struggles in this environment. Women in this study talk about moving toward and achieving wellness by facing and dealing with one's personal issues, and helping others to do the same.

III. The complexities of Inuit women's health

As the previous sections have illustrated, women in Nunavut experience their day to day well-being in an environment that is complex, at both interpersonal and societal levels.

The themes presented separately in this chapter are more realistically overlapping spheres of influence that act as mechanisms through which the determinants of health affect Inuit women's well-being. Women who shared their insight in this study clearly illustrated the importance of culture in their lives, yet also

illustrate the tension between traditional and non-traditional (or Southern) influences on their health. At the same time women identify and recognize as sources of harm to their health their knowledge deficits and, viewed as a resource for health, they have suggestions for how knowledge can be gained. Well-being is described holistically yet, in their words, women illustrate how it is undermined in personal and cultural interactions and injuries. Women shared health experiences through stories and used examples to illustrate points about underlying health-related issues, such as knowledge and education. Recognizing the pathways through which women communicate not only health information, but the stories of their lives are an important aspect of learning more from women about the determinants of their health.

Modelling Inuit women's health and well-being

The Ulu

The ulu is a traditional tool used by women and is typically made with a stone (slate) or metal blade and a handle made of bone or antler (See Figure 3.1).

Figure 3.1 An ulu knife

Source: The Hudson Bay Company Digital Collection, Manitoba Museum of Man and Nature

The ulu is passed on from woman to woman (provided it lasts that long) and carries with it the knowledge of the previous owner. Inuit women use their ulu for preparing food for the family, making clothing for their children or husband, and for skinning animals; it was, historically, a necessary tool for survival. It contributed to and is representative of the roles of women in relationships, family, in the community. It represents a traditional aspect of the lives of Inuit women - the knowledge of how it is used is passed on from generation to generation - and it was a tool that allowed women to provide for their families.

The themes presented in this thesis are represented by the properties, use and shape of the ulu, as well as the sharing of knowledge represented by the tool, as illustrated in Figure 3.2.

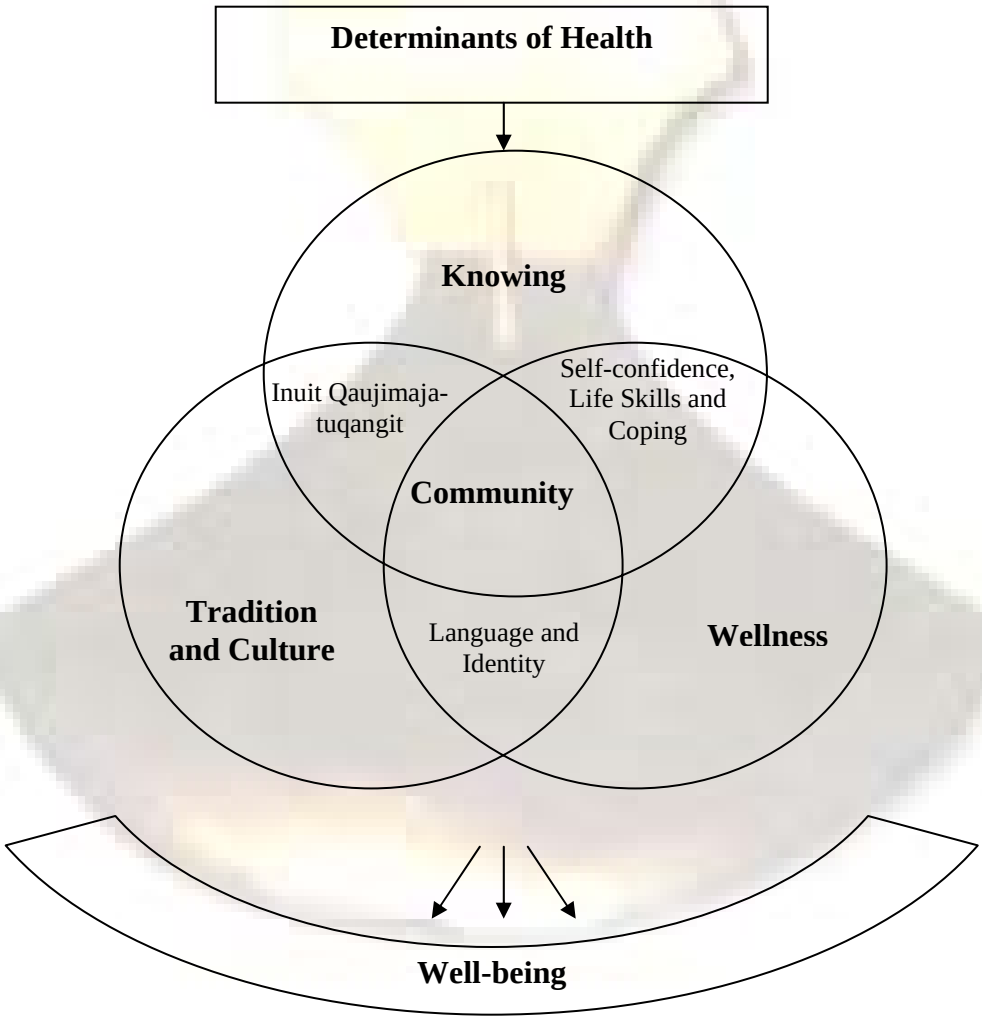

Figure 3.2 A model for presenting the determinants of health for Inuit women in Nunavut follows the shape of the ulu

The determinants of health are factors that influences the overall the health of individuals and communities. Determinants of health are personal, social, economic and/or environmental factors that determine the health status of individuals or populations (WHO, 2006). The three themes, Tradition and Culture, Knowing, and Wellness, are the mechanisms through which the determinants of health affect the

day-to-day lives of Inuit women. Tradition and Culture, Knowing and Wellness are important health issues in the lives of the women in this study and impact their overall well-being. These three themes overlap on many issues, including Inuit Qaujimajatuqangit, language and identity, and issues relating to life skills, self-confidence and coping. These three themes intersect in the idea of community: a place where knowledge is shared; supportive networks are developed and fostered; and the health and well-being of all members of the community is encouraged and promoted or undermined.

Today, ulus are still used for many traditional tasks, such as the preparation of skins, and remain a relevant and prominent symbol in the Canadian Arctic for the representation of Inuit women in life and in art, as seen in Figure 3.3. Yet loss of traditional practices means that not all women have, or use an ulu, just as not all women in the community have optimal health or resources for it.

Figure 3.2 "Ulu spirit women" by Lucy Ango'yuaq (1962-), 2005, Baker Lake, NU (coloured cotton thread on wool duffel)

In the next chapter, the three themes and the idea of story-telling will be discussed in the context of existing knowledge and literature in the field of Inuit women's health.

CHAPTER 4 - DISCUSSION

I. Introduction

This study was designed to explore the determinants of health for Inuit women in Nunavut, with a focus on how these determinants impact their day-to-day lives. An exploratory qualitative approach was used in order to obtain an understanding of women's perspectives on their own health and the health of women in the community. Techniques of immersion and crystallization were used to analyse the data and develop categories of information that lead to the identification of the three themes in the data: Tradition and Culture; Knowing; and Wellness.

This chapter provides a review of the three themes and discussion of them in the context of existing research literature. The chapter concludes with an examination of the strengths and limitations of the study and directions for further research.

II. Determinants of Health

A population health approach to health and well-being focuses on the entire population and includes an examination of health inequalities in populations in order to improve the health status of population groups (Public Health Agency of Canada (PHAC), 2005b). Population health recognizes that health is affected by factors at individual, family, community and society levels of influence. This approach also recognizes the full range of health determinants, factors and influences that shape the health of individuals and communities. Determinants of health are personal, social,

economic and environmental factors that determine the health status of individuals or populations (WHO, 2006).

In Chapter 1 Section V, the outcomes of a meeting of representatives from a variety of fields in Nunavut related to health, well-being, policy and Inuit culture who met in March 2005 to discuss the determinants of health for the Nunavut population were presented. The report produced from this meeting identified the following health determinants as influencing health in Nunavut: acculturation/self-determination, education, quality of early life, productivity, income and its distribution, food security, health care services, social safety net, housing, and environment (NDH&SS, 2005). In this study, by exploring the determinants of health of Inuit women, we investigated the influence of these determinants on the day to day lives and well-being of Inuit women in Iqaluit.

III. Discussion of Results

1. Tradition and Culture

The nine Inuit women who participated in this study valued traditional practices and talked about them in the context of their own health and the health of women in the community. Participants used stories and examples of reproductive and sexual health issues to illustrate many points about the importance of traditional practices related to childbirth and child-rearing in Nunavut communities. Midwifery, traditional knowledge, and traditional approaches to perinatal care are important and already existing tools for Inuit women to draw upon for their health.

Women associated the ability to speak Inuktitut with their ties to cultural traditions, such as sharing stories and history, ways of hunting and preserving food, and sewing and making parkas. Women also described the importance of having learned Inuktitut and teaching it to their children. Participants felt that many young people who do not speak Inuktitut are left with a sense of not belonging. Some women discussed the traditional practice of custom adoption and how the practice has impacted them both as children and as parents. They highlighted how these losses may lead to significant problems related to identity, social inclusion, wellness, and suicide, as well as people turning to addictive substances to cope.

A recent book, *Uqalurait: An Oral History of Nunavut* (2004) compiled the thoughts and memories of elders from across Nunavut to document traditional Inuit customs, values and knowledge (Bennet & Rowley, 2004). In this book, the authors argue that relatively recent events (within the last 60 years) in the history of Canadian Inuit, such as the resettlement program, formal schooling and wage employment, have badly damaged the chain of communication for the transmission of traditional knowledge. This idea is supported by the women in this study who commented that traditional knowledge and values are not being learned or passed on and described their disappointment with not knowing enough about their own culture.

The potential loss of cultural traditions has been recognized by many in Nunavut and several means to preserve them have been implemented by different government bodies. In an effort to protect Nunavut's languages, Inuktitut (the indigenous language of the Eastern Arctic) and Inuinnaqtun (the indigenous language of western Nunavut) were named official languages of Nunavut when the territory

was created in 1999. All publications, print materials and other educational handouts used in the Territory are produced in English, French, Inuktitut and Inuinnaqtun. Inuktitut is taught in elementary schools in Iqaluit, and CBC North radio provides both English and Inuktitut programming that is broadcast throughout the territory.

In an effort to document important aspects of Inuit life and traditions, the Nunavut Arctic College conducted and published a series of interviews with elders across Nunavut (Interviewing Inuit Elders, 2001). The interviews included discussions on traditional medicine and justice, views on spirituality and shamanism, as well as knowledge about health, wellness, and the history of Inuit. These documents have been made available to the public at no cost by the Nunavut Arctic College library and are available online in order to ensure these valuable stories are shared with Nunavummiut (http://www.nac.nu.ca/main.htm). In addition, with the signing of the Nunavut Land Claims Agreement in 1993, there was much discussion about cultural expectations in the governing of the territory, and Inuit Qaujimajatuqangit (traditional knowledge) became one of the guiding principles for the Government of Nunavut. As a part of this governance structure, a position was to be created in every government department that is reserved for a knowledgeable community person or elder who provides the staff with Inuit Qaujimajatuqangit and consultation on anything from the text in an educational pamphlet to community and territorial program development. These institution-level changes and protective measures take time to filter down to the public and become recognized and acknowledged by community members. The results of this study encourage these and

other on-going measures that ensure Inuit ways and traditions are protected and shared in Nunavut communities.

Traditional midwifery and childbirth were topics of discussion in the study. Women expressed concern for women or mothers who have to leave their community to give birth, often leaving their partner, family and older children behind. In a study of the perspectives of community health nurses in Nunavut, nurses identified four primary reasons women were reluctant to leave their communities to give birth including: women are unable to bring a birthing coach, their partner or children with them; women are not given a choice as to where they deliver; women do not receive prenatal teaching, support or recreation in the weeks prior to their delivery; and women feel isolated while away from homes and families (Roberts & Gerber, 2003). One program that aims to address these concerns is a new midwifery program beginning at the Nunavut Arctic College in the fall of 2006, to be based in Rankin Inlet, NU (See map, Appendix C). Graduates will become licensed midwives and be located at the birthing centre in Rankin Inlet, NU, and potentially other Nunavut communities in the future (Prentice, 2006). This will provide an opportunity, over time, for comparison of current and future service delivery and experiences of women.

Women in this study identified loss of traditional practices and language as affecting their well-being and that of their community. McMillan and Chavis (1996) describe a sense of belonging as an essential element of experiencing a ‘sense of community’ (McMillan and Chavis, 1996). This is echoed in this study of Inuit women who found that by not speaking in Inuktitut, they did not belong to the

community and questioned where or to what community they belonged. In a Canadian study of 152 school children and 88 adults in two Nunavut communities, Dorais and Sammons (2000) examined how language behaviour may be understood as an expression of Inuit identity. Between 1995 and 1996, the authors engaged Inuktitut-speaking students and community members to conduct interviews with community participants. The authors found that English was viewed to be more useful than Inuktitut, as it paves the way to better employment and opens a window on the wider world. However Inuktitut was generally perceived as essential in defining Inuit identity (Dorais & Sammons, 2000). In previous research from the Greenland Population Health Study, researchers found that language was a very important part of the identity of the Inuit participants in the study (Bjerregaard & Curtis, 2002).

While women in this study primarily discussed the value of traditional practices and customs in a positive way, they recognized that not all practices are appropriate in today's world, particularly ones that do not promote health and wellness.

2. Knowing

Knowledge, and the different forms it takes, was highlighted by the study participants as playing an integral role in Inuit women's health. Nelms and Lane (1999) examined women's way of knowing following a model described by Belenky, Clinchy, Goldberger & Tarule, 1986. They highlight the main points of the book which describe seven ways of knwing: silence (i.e. unable to express opinions);

received knowing (learn by being told and listening); subjective knowing (everyone can have an opinion and they are all equally valid); procedural knowing (how one goes about making a decision is more inportant than what one decides); separate knowing (detached and critical, assuming anyone and everyone can be wrong); connected knowing (work to accept others and remain connected even when there is disagreement); and constructed knowing (listening to own voice as well as others) (Nelms Lane, 1999). While an examination of the nature of knowledge is beyond the scope of this thesis, it is interesting to note the different ways of knowing described by the women in this study. Participants felt that, through knowledge, women acquire the resources and the skills they need to cope with life, make healthy decisions, and take care of themselves and their families. Knowledge can empower women with the tools to look after their health and well-being, from knowing about safer sex and how to read a food label to understanding about self-respect and self-worth. Women in this study differentiated between information, which is static, and knowledge, that implies a reciprocal process of information exchange. The participants in this study described knowledge in holistic terms that include social understanding, compassion, community and culture.

Women in this study emphasized the importance of learning and sharing health information, particularly in the context of reproductive and sexual health. In Iqaluit, two Community Health Representatives (CHRs) conduct much of the sexual health education at the elementary and high school level, in addition to what is already taught in the schools (Koonoo, 2005). The CHRs also meet with pregnant teenagers to provide prenatal care advice and instruction on what to expect during and

after the birth of the child. In addition, a newly formed group of Iqaluit high school students called Youth Educating About Health (YEAH) educate their peers about safer sex, sexual rights and responsibilities, and explore different topics of curiosity to students (Seguin, 2005). These programs are only available in Iqaluit and are yet to be offered in other Nunavut communities. While these programs provide educational information to young people in Iqaluit, women in this study identified a gap in knowledge among older women with poor literacy in both English and Inuktitut. Therefore consideration needs to be given to how the full range of women in the territory can benefit from education opportunities.

Inuit Qaujimajatuqangit means “knowledge that has been passed on to us by our ancestors” (Bennett & Rowley, 2004), and in English is commonly referred to as traditional knowledge. This knowledge is passed on orally from generation to generation. Many women in this study spoke of either wanting to know more about certain traditional Inuit activities, such as making a parka or skinning a seal, or wanting to share their knowledge about perinatal care and midwifery, as well as their other skills. For example, learning to use the ulu, the Inuit women’s knife, to prepare skins and food is a traditional skill for Inuit women that has been passed on for generations. These women are highlighting the gap in their ability to obtain and their difficulties in finding a means to share Inuit Qaujimajatuqangit.

Life skills and knowledge are described by the participants as the basic tools one needs to look after one’s mental and physical well-being, such as knowing one’s self-worth and identity; knowing how to communicate with friends, family, children or spouses; knowing about and deserving respect from others; knowing how to cope

with stress and emotions; and knowing where to get help when needed. Life skills can be learned from parents, caregivers and friends, life experience, sharing stories with community members, and some from formal education in schools and public health education. One example provided by participants was that of obtaining country foods and knowledge about choosing and eating store-bought foods. Much of the available research on food in the Canadian Arctic pertains to levels of contaminants in country foods (INAC, 2006; Dallaire et al., 2004; Dewailly et al., 2001; Duhaime et al., 2004). While pollution was occasionally mentioned in their stories, what women in this study highlighted was the high cost of food and an existing gap in knowledge among the public about healthy food choices.

Another aspect of knowing that women described was that of understanding more about what is happening in the community, particularly about how women are making decisions about their health and how they are managing family, partner and community relationships. These comments and questions provide a clear direction for further research in Nunavut.

The information discussed in this section highlights the need for culturally-relevant programs that address domestic violence, healthy family relationships and communication, coping strategies, and parenting for community members of all ages.

3. Wellness

Wellness includes the mental, physical, emotional and social health and well-being of people. The wellness issues women discussed included: self-esteem and self-confidence, substance abuse and coping, and particularly relationships were

highlighted in terms of Inuit women's wellness. Wellness determines how we interact with our families, friends and the world around us and, thereby, factors very strongly into our overall health and well-being. Participants in this study used stories and examples relating to family, partner and community relationships to illustrate points about health topics that were important to them.

Women in this study described low self-esteem as a considerable health concern for women in Nunavut. One participant felt that women didn't believe they deserved better than what they had, be it a bad relationship, low level of education, or some other aspect of their lives. They viewed as problematic the acceptance of teen pregnancy within the community, especially because young girls tend to drop out of school to have the child, limiting future potential. Teenagers also tend to have less parenting skill than older women, a source of concern for both maternal and child well-being. Community members may live up (or down) to the expectations of the community, therefore if this behaviour is the norm, there is little incentive for women to do otherwise. As past research has shown,

> People seek a social setting where they can be themselves and safe from shame. As communities begin to form, potential members search for those with whom they share traits. Bonding begins with the discovery of similarities. If one can find people with similar ways of looking, feeling, thinking and being, then it is assumed that one has found a place where one can safely be oneself. (p. 320) (McMillan, 1996).

For young women in Iqaluit, the local acceptance of young childbearing seems unquestioned; for women in our study, particularly the older participants, it was a source of concern around a traditionally accepted practice that needed to be directly assessed or questioned as a public community health issue in contemporary times. In

addition, women in the study discussed parenting and family dynamics in the context of many issues, illustrating its potential role in wellness and well-being for both men and women in Nunavut. The issues of custom adoption and teenage pregnancy raised by participants are linked to the issue of parenting. Future examination of parenting roles and skill including the sharing of knowledge, tradition, and culture may shed further light on this issue in Nunavut.

Women in this study discussed substance use primarily in the context of coping with a family member's illness or experiences dealing with past childhood or adolescent sexual abuse. Participants discussed relationships as an important health determinant in terms of the management of family dynamics and intimate partner relationships. While women discussed partner relationships as being difficult and stressful, many shied away from discussing the issues of domestic violence in communities. Participants' reaction to the topic could have been a result of the stigma attached to the issue; the close proximity of some participants to family or friends in violent situations; or the perception that it is not a health problem, but a problem for the court system and the police. In a review of the health of indigenous peoples of the Arctic, Bjerregaard et al. (2004) found that

> "interpersonal violence in all its forms (homicides, assaults, abuse), with or without sexual context, directed at strangers or family members, is now an issue of major public health concern in most circumpolar indigenous communities" (p. 393).

The authors discuss different possible explanations for violence in these communities, such as the stress of rapid social change, and an inadequacy of traditional conflict

resolution behaviours in the new, more urbanized environments (Bjerregaard et al, 2004).

In consultation with representatives of government and community organizations prior to this study, domestic violence was identified as an area of much-needed research in Nunavut (Osborne, 2004). In the limited discussion of violence and relationships, women in this study talked about the issue in the context of men's health and wellness. They talked about men suffering from trauma and requiring help as much as women. This underscores the importance of recognizing that these are not only women's issues, but issues relating to male partners, family and community, and they must not be addressed in isolation from each other.

Finally, the model of well-being informed by women's experiences, illustrates the tensions and interplay of history, tradition and modernity that contextualize women's lives. The ulu is more than the parts that constitute the instrument: it has a broader cultural meaning and multiple uses, just as women in this study discuss their culture and experiences of their well-being. When discussing a woman's ulu, questions come to mind such as: Does she have an ulu? What is it made from? Where did she get it? Does she know how to use it? If not why? If so, who taught her? How does she use it and how does she feel when she uses it? Does she have one and know how to use it, but chose not to?

These questions mirror discussions raised in the study about the determinants of Inuit women's heath: Do women feel healthy? What factors contribute to their health? Do women have access to health information, and if not, why not? If so, where do they get it? How do they feel about their health and the health of their

family/community? Do they have information or health supports and choose not to use them? As with an ulu, health choices and the pursuit of well-being are informed by health information, our support network and our skill to manipulate, hold and use the knowledge we gather throughout the various aspects of our lives.

IV. Methodological Insight

While this study was not designed to specifically examine how women communicate their health experiences, it became apparent in the analysis process that women used stories to explain health issues conceptually. For example, they used the stories to describe situations or events that illustrated underlying issues in the community, where a story is defined as, “a narrative, true or presumed to be true, relating to important events and celebrated persons of a more or less remote past” (Oxford English Dictionary, 1989). While the topics they discussed were childhood pregnancies, country and store-bought foods or wanting to know how to make a parka, the issues they were identifying were the present harms or benefits of traditional practices and the need for communication skills around gender relations and the loss of culture. Although some cultural practices may be disappearing, the use of these stories to communicate information remains part of the culture. Inuit have a very strong oral history and oral culture. The telling of stories is a millennia-old tradition used not only for entertainment, but for the sharing of information and is an essential aspect of the Inuit culture (Bennet & Rowley, 2004). This tradition was reflected in the way women in the study talked about health issues. As described above, participants drew upon examples from the community and used stories to

illustrate points about important health issues, such as teenage pregnancy and custom adoption, which illustrated aspects of the broader health context involving the community and society relating to education and cultural practice. Understanding this mechanism for sharing information allowed more insight into the data, the meaning of the stories, and brought a different lens to the interview data.

Women who were over the age of 55 years who were approached for this study did not want to participate and did not look fondly upon research. There is a strong likekelihood that this is the result of researchers, including anthropologists, who have visited communities in the past and mistreated local community members. Berg (1999) states that under-researched cultural groups' lack of participation in research projects has been attributed to language barriers, to distrust of the research process, and to criticism that research advances the researcher's career but does little to benefit the community (Berg, 1999). The memory of pain and disrespect left by previous researchers lives on in many communities today, creating a challenging environment for community-based health researchers working in the North.

Research Setting

As a large community, Iqaluit has direct connections via air travel to southern Canada, and thereby has increased access to many commodities, including nutritious foods, newspapers, and illicit drugs, than do the smaller Nunavut communities. Iqaluit has the largest population of non-Inuit residents compared to any other community in Nunavut. Iqaluit houses the only prison, hospital, and women's shelter in the territory. These elements, when examined together, underscore the uniqueness

of the experience of living in this community. Smaller and more remote Nunavut communities will likely have different socio-cultural experiences with more stable populations, and further research should continue to examine women's experiences in these Nunavut communities. While all the participants in this study lived in Iqaluit, many had lived or were raised in other Nunavut communities.

VI. Significance

Previous research in Canadian Inuit women's health has primarily focused on specific issues, such as nutrition and contaminants, alcohol and substance use, or pregnancy and childbirth. In a review of published research in this field, there was no published literature to be found that examined a determinants of health perspective on the health of Canadian Inuit women.

This study has highlighted the importance of several key issues in Inuit women's health including the role of culture and traditional knowledge; the need for health information; the mental and emotional strains women experience due to family and personal relationships; as well as the role of wellness and community support. Women also reinforced the notion that women's health is only one part of community health and that efforts must be made to approach health holistically and inclusively in Nunavut communities. The results of this study will help decision-makers, health professionals and caregivers to further understand these women's health issues and help identify priorities for policy and program development that will target their specific needs. Furthermore, the insight into the health perspectives of Inuit women in Nunavut has the potential to carry-over into other Arctic regions both in Canada

and in the Circumpolar community. They may also inform questions related to the health of northern Frist Nations and Metis Canadians.

VII. Future Research Directions

The results of this study lay the foundation for further research exploring Inuit women's health in Nunavut and in Canada. Women in this study raised important questions about health in Nunavut, such as *why* women decide to stay in violent relationships, or *why*, when they have the basic knowledge about safe sex and teenage pregnancy, they still become pregnant as teenagers. Many young women have information about sexual health, *why* do they choose not to use it? Participants want to know more about these aspects of life and society in order to understand why these things happen and how to make it better. By asking these questions, women have indicated directions for further research. Research is needed to build on these results and explore health determinants in this population to help explain health outcomes in Iqaluit and in Nunavut and to develop resources for addressing both Inuit and non-Inuit women's health issues in this region.

VIII. Summary

Through this study, we have learned about the value women place on Inuit traditions and values; that important resources for health include formal, informal and public health education; and that the strategies used by communities for communicating information include the sharing of stories, examples and personal experiences. These local practices are important to recognize and encourage.

The knowledge generated by this study will make an important contribution to policy and programming initiatives in Nunavut, and add to the growing body of research on Inuit health in Canada. It is important to note, however, that further community-driven research addressing local health needs is required to improve the health of Nunavut communities. Future research should investigate the concerns raised by women in this study, including sexual behaviour decision-making among teenagers; men's and women's experiences with sexual abuse and domestic violence; and further explore social determinants of health in Nunavut communities.

This research is the first of its kind to examine how health determinants impact the day-to-day lives of Inuit women in Canada. Furthermore, this research is the first to examine these issues among a group of women in contemporary Inuit society whose life experiences exemplify the dramatic changes Inuit have undergone during the last few decades. The contributions made by the participants in this study were invaluable and the results of this work underscore the importance of talking to women, men, families and communities in the North about their health. What has been made more explicit through this study is the considerable role that Inuit culture and knowledge plays in the lives of these women, including both the traditional and historical contexts of the Inuit commonalities and differences among Canada's indigenous peoples.

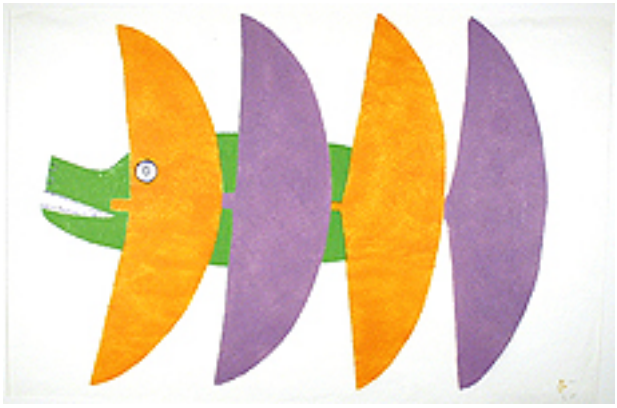

Figure 4.1 Fish with Ulus, Jesse Oonark (1906-1986) 1981, Baker Lake, NU (stencil on paper)

GLOSSARY OF TERMS

Inuit – the indigenous inhabitants of the Arctic from Alaska to Greenland; 'people' in Inuktitut language

Inuk – singular of Inuit; 'man' or 'person' in Inuktitut

Nunavut – the Territory created in Canada in 1999 resulting from a division of the Northwest Territories into 2 parts; Nunavut and the NWT

Nunavummiut – Residents of Nunavut Territory

Iqaluit – capital city of Nunavut; 'many fish' in Inuktitut language

Iqaluk – 'fish' or 'Arctic char' in Inuktitut language

Inuktitut – language of the Inuit of the Eastern Arctic region of Nunavut

Inuinnaqtun – language of the Inuit of the Western Arctic region of Nunavut

Qallunaat – 'white person' in Inuktitut language

Qammaq (qammait) – summer tent for a family, typically made of canvas today.

Qamutik (qamutiit) – a sled for carrying supplies, food, skins, animals, or people, typically pulled behind a dog team or snowmobile

Kamik (kamiit) – boots made from seal and/or caribou skin, typically mid-calf to knee high

Inuit Qaujimajatuqangit – traditional knowledge; 'knowledge that has been passed on by our ancestors' (Bennett and Rowley, 2004)

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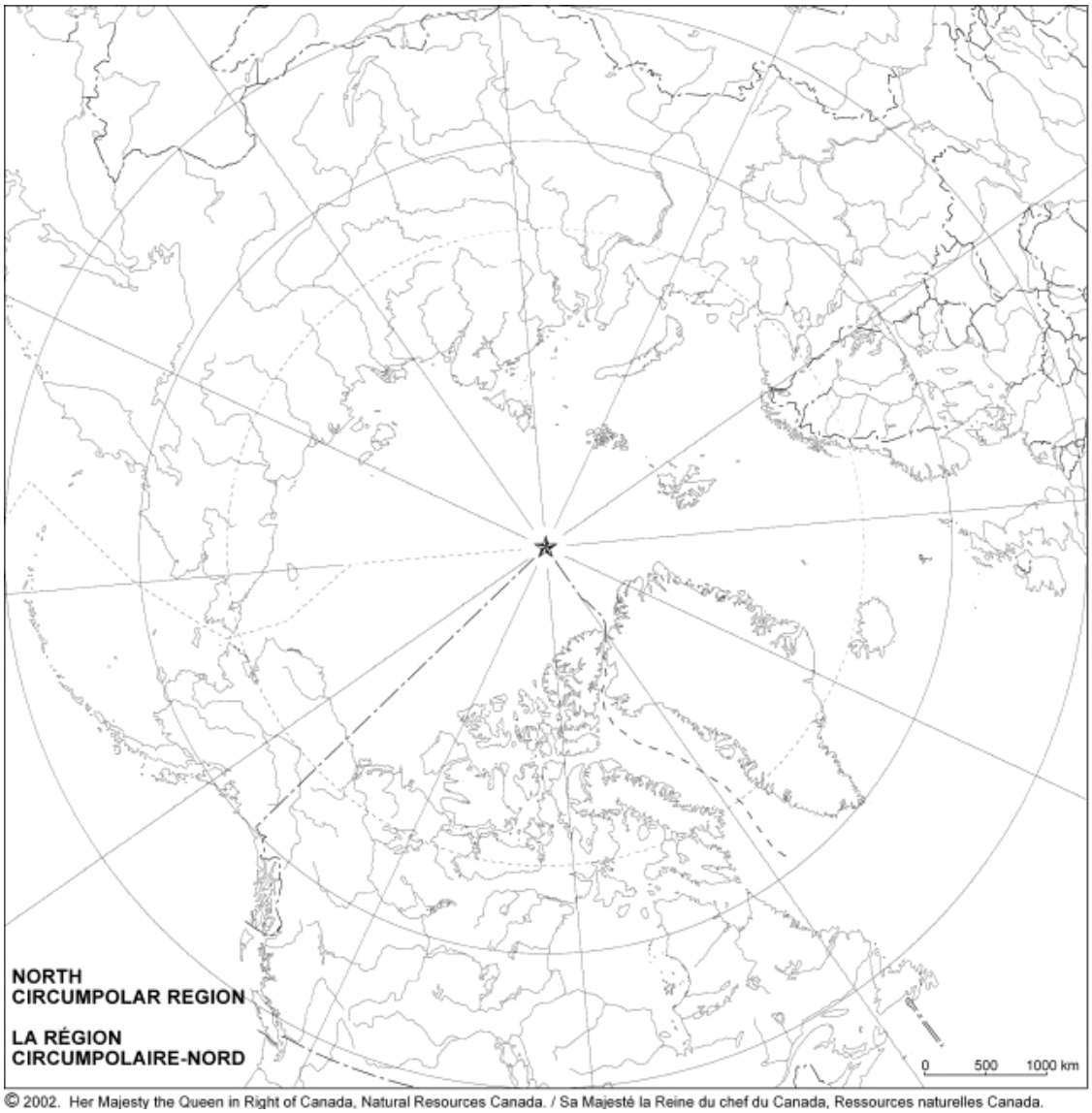
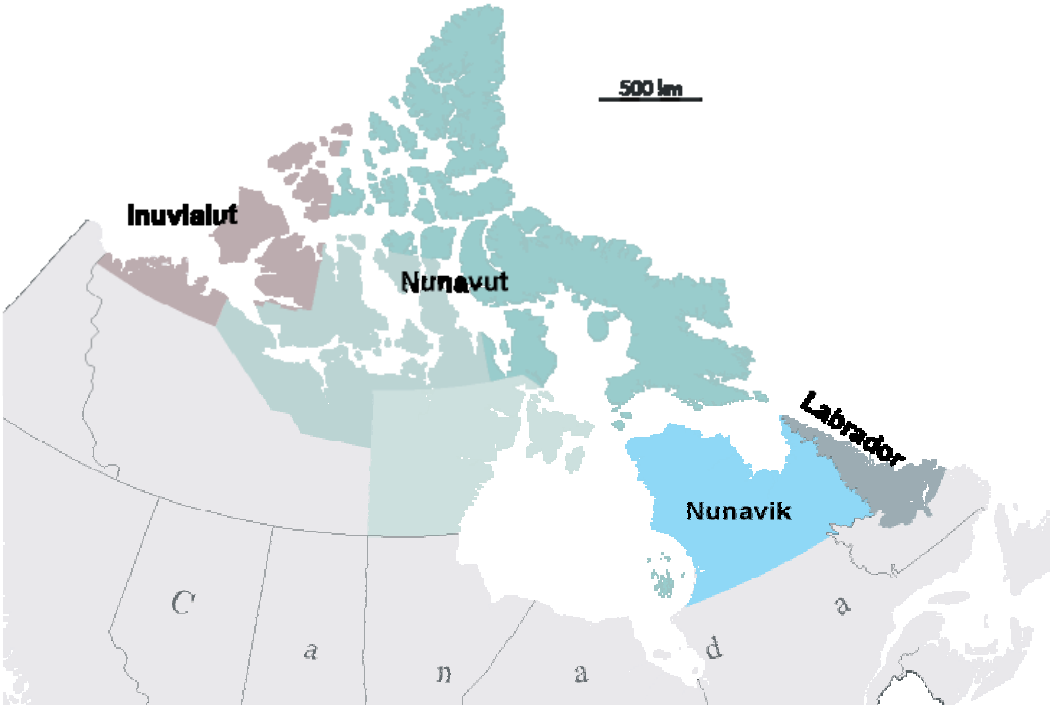
APPENDIX A – MAP OF CIRCUMPOLAR REGION



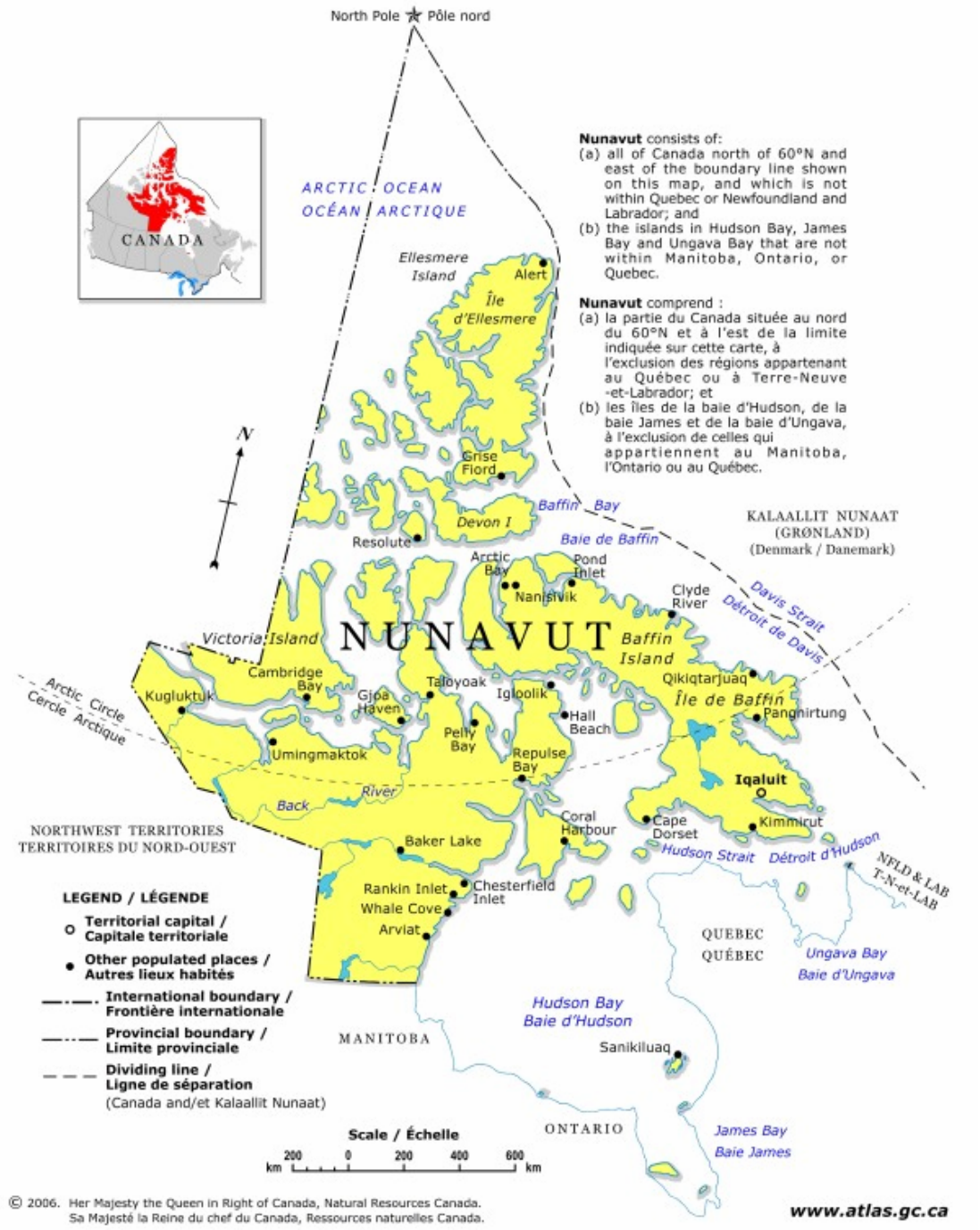
Source: Natural Resources Canada, Government of Canada, 2002

APPENDIX B – MAP OF INUIT-INHABITED REGIONS OF CANADA



Source: Inuit Tapiriit Kanatami, 2005

APPENDIX C – MAP OF NUNAVUT



Source: Natural Resources Canada, Government of Canada, 2006

APPENDIX D – RESEARCH LICENSE

Nunavummi Qaujisaqtulirijikkut / Nunavut Research Institute
Box 1720, Iqaluit, NU X0A 0H0 phone:(867) 979-7279 fax: (867) 979-7109 e-mail: slcnri@nunanet.com

SCIENTIFIC RESEARCH LICENCE

LICENCE # 0401905N-M

ISSUED TO: Lynn Meadows
Department of Family Medicine and Community Health Sciences
University of Calgary
HM06 3330 Hospital Drive NW
Calgary, AB
T2N 4N1 CA
403 220-2752

TEAM MEMBERS: L. Mrkonjic, G. Healey, L. Lagendyk

AFFILIATION: University of Calgary

TITLE: Developing Linkages to Increase Capacity for Inuit Women's Health

OBJECTIVES OF RESEARCH:
There is little published research about Inuit health, and even less about Inuit women's health. However, Inuit women face multiple challenges that impact their health including geographic environment, remote location, and social and cultural differences that may impact their health and well-being. We are a multidisciplinary team of researchers who have worked with diverse groups of women (such as immigrant women, women with disabilities, rural women and First Nations women) on a variety of women's health projects. Through development of strong connections to the Nunavut community of Iqaluit, we will work with northern stakeholders who are interested in participating in women's health research in Nunavut and provide training on qualitative health research interview tehniques. We have been working with community organizations and health professionals in Nunavut for the development of this project and will continue to involve these groups for the duration of the project. In the short term we will develop linkages between university researchers and the Nunavut community, provide research skills to local research assistants, and an Iqaluit born graduate student, and gain information from which other health research proposals can be developed. We will also provide education on bone health to community members through a number of meetings and in-service opportunities. In the long term, this project has the potential to begin the work of raising awareness of northern and Inuit women's health issues. It will provide information that is community-based, culturally sensitive and responsive to locally identified women's health needs that can be used by decision makers and program planners.

DATA COLLECTION IN NU:
DATES: June, 2005-May, 2006
LOCATION: Taloyoak, Cambridge Bay, Iqaluit

Scientific Research Licence 0401905N-M expires on December 31, 2005
Issued at Iqaluit, NU on July 19, 2005

per Earle Baddaloo
Science Advisor

APPENDIX E – INTERVIEW GUIDE

Interview Guide

Hello, thanks for agreeing to talk to me today. As you know, I am talking to women about their health in order to understand what affects women's health in Nunavut. When I talk about health, I'm referring to physical health as well as mental and emotional health. Most importantly, I want to know what health means to you.

1. Tell me a little bit about yourself.
2. Tell me about a typical week for you. Does any of this affect your health?
    - *Mental*
    - *Emotional*
    - *Physical*
3. Can you tell me more about your health and well being? What sort of things do you think affect your health? Do you find that you are stressed? What causes your stress?
4. Do you think there are things you can do to improve your health?
    - *Exercise*
    - *Counseling*
    - *Meds*
    - *Diet*
5. What would you say are the most important health issues for women in your community? In Nunavut? Have you ever lived in another community? If so where? Tell me about any differences you found w.r.t. health
    - *Influence of being Inuk and living in Nunavut*
    - *How being in different places affect their well-being…. Moms, sisters, aunts, etc.*
6. Are there cultural issues that affect your health? What are they and how?
7. What do you think women in Nunavut need to improve their health?
8. Where do you go to get answers to your questions about health? Is it easily accessible? What information do you think would help you or other women address their health problems? (programs, pamphlets, radio specials, etc.)
9. Women have identified several big negative influences on health, such as smoking, alcohol and substance abuse, and violence. These are issues for women across Canada, as well. Do you think there is something different happening in Nunavut? If so, what?
    - *How does being in Nunavut specifically affect these issues? Are these issues worse for people in Nunavut? If so, why? Small towns? Cold, long winters? Gossip? Isolation?*
10. Do you think there are there positive influences on women's well-being? If so, can you give some examples?

11. Is there anything else you would like to share with regarding women's health in your community or in Nunavut?

APPENDIX F – CONSENT FORM (ENGLISH AND INUKTITUT)

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

INFORMATION REGARDING PARTICIPATION IN INUIT WOMEN'S HEALTH STUDY

RESEARCH PROJECT TITLE: The Perspectives of Inuit Women on Health and Well-being

INVESTIGATORS: Gwen Healey and Lynn Meadows

COMMUNITY PARTNERS: Nunavut Dept. of Health and Social Services; Qikiqtani Inuit Association; Qulliit Nunavut Status of Women Council

Thank you for agreeing to meet with me today. I belong to a research team that includes members from the community (for example, the Nunavut Dept. of Health and Social Services; Qulliit Nunavut Status of Women Council) and the University of Calgary. We are working together to gather information from Inuit women about their well-being, health issues and health concerns. We invite you to take part in this research study.

I will gather information by talking to women in the community. I will also gather information from community organizations and health care providers. This information will be used to create a list of local women's health issues and concerns. When the list is developed, the research team will present the findings to the community. Community members will be invited to discuss the results of the study, and to work with the research team to decide the next steps.

At this time we are asking your permission to speak with you face to face about your health experiences and issues. Translation services are provided, so you may use Inuktitut or English in the interview. With your permission our conversations will be audio-recorded. This allows us to listen freely to what you are saying instead of taking notes, as well as to review the information again. During our meeting, brief notes will be taken, as well.

The questions we will ask invite you to share your stories and ideas about women's health and well-being. You can ask us to turn off the tape recorder at any time, or ask us to stop the meeting at any time. You may choose to take part in as much or as little of the study as you wish. You can refuse to answer any questions that make you uncomfortable or for any other reason. Identifiable information will only be available to members of the research team for this project, and will not be released without your

written consent. The data collected in this study will be grouped and presented in ways that individuals cannot be identified. No harm should come to you from participating in this study. You may withdraw from it at any time.

Do you have any questions regarding being part of this study? Would you like to share information with us in this meeting today? May we record this meeting?

If you have any questions about this study after the meeting, please feel free to contact Gwen Healey at 867 975 5783.

I have been fully informed of the objectives of the project being conducted. I understand these objectives and consent to being interviewed for the project. I understand that steps will be undertaken to ensure that this interview will remain confidential unless I consent to being identified. I also understand that, if I wish to withdraw from the study, I may do so without repercussions.

Participant Name (please print)	Witness Name (please print)
Participant Signature	Witness Signature
Date	Date

Gwen Healey
Department of Community Health Sciences, University of Calgary
3330 Hospital Drive NW
T2N 2N1
Telephone: (403) 703-4936
Fax: (403) 270-7307

A COPY OF THIS CONSENT FORM WILL BE GIVEN TO YOU FOR YOUR RECORDS

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3330 Hospital Drive NW
T2N 2N1

: (403) 703-4936
: (403) 270-7307

APPENDIX G – CHREB ETHICAL APPROVAL

FACULTY OF MEDICINE | UNIVERSITY OF CALGARY

2005-07-21

OFFICE OF MEDICAL BIOETHICS
Room 93, Heritage Medical Research Bldg
3330 Hospital Drive NW
Calgary, AB, Canada T2N 4N1
Telephone: (403) 220-7990
Fax: (403) 283-8524
Email: omb@ucalgary.ca

Dr. L.M. Meadows
Department of Family Medicine
University of Calgary
Calgary, Alberta

Dear Dr. Meadows:

Perspectives of Inuit Women on Health and Well-Being in a Nunavut Community

Grant ID: 18557
Student: G. Healey

The above-noted research proposal, including the Research Proposal (Version dated June 13, 2005), the Information Sheet, the Interview Guide Draft (Version dated June 13, 2005) and the Consent Form (Version dated June 13, 2005) has been submitted for Committee review and found to be ethically acceptable.

Please note that this approval is subject to the following conditions:
(1) appropriate procedures for consent for access to identified health information has been approved;
(2) a copy of the informed consent form must have been given to each research subject, if required for this study;
(3) a Progress Report must be submitted by 2006-07-21, containing the following information:
- i) the number of subjects recruited;
- ii) a description of any protocol modification;
- iii) any unusual and/or severe complications, adverse events or unanticipated problems involving risks to subjects or others, withdrawal of subjects from the research, or complaints about the research;
- iv) a summary of any recent literature, finding, or other relevant information, especially information about risks associated with the research;
- v) a copy of the current informed consent form;
- vi) the expected date of termination of this project.

(4) a Final Report must be submitted at the termination of the project.

Please note that you have been named as a principal collaborator on this study because students are not permitted to serve as principal investigators. Please accept the Board's best wishes for success in your research.

Yours sincerely,

Christopher J. Doig, MD, MSc, FRCPC

Chair, Conjoint Health Research Ethics Board

CJD/km

c.c. Adult Research Committee Dr. T Noseworthy (information) Research Services G. Healey (Student)

APPENDIX H – STEPS TAKEN IN ANALYSIS

1. As transcripts of the interviews were returned to me, I listened to the interview over again, while reading the transcript, to fill in any misunderstood sentences, gaps where the women switched to Inuktitut, or where there were other noises on the tape that made it difficult for the Transcriptionist to decipher.
2. Open-coding of the interviews as the transcripts were received (almost one after the other), during the data collection process (130 codes). The open coding was done with the help of QSR*N6.
3. Collected the codes into categories of health-related topics, demographics and others (20 categories)
4. I returned to my field notes to determine if the categories were in line with the notes I took during the interviews.
5. Examined the data with frequency tables to identify subject areas that women spoke of more then others, and examined the contexts. The matrices helped to provide a visual image of the breakdown of the data for each category. The tables illustrated the number of women who spoke of each category of data.
6. Examining the data, certain categories stood out more then others, such as mental health, relationships, reproductive and sexual health, and food security. All of the women mentioned or discussed in detail these topics in the context of women's health issues, traditional values, and gender roles in families.
7. I immersed myself in the data, and examined these categories further through different 'lenses', such as age or level of education.

8. Met with different members of the thesis advisory committee, students and colleagues to discuss the analysis process, subject areas in the data that required more direction in the literature, and different topics that were coming forward in the data.
9. After spending a number of time examining these topics through varying lenses, the idea of different ways of knowing or obtaining knowledge began to crystallize, and I returned to the data to examine how ‘knowing’ was discussed by the participants. I observed that they discussed knowing in terms of formal education; Inuit Qaujimajatuqangit or traditional knowledge; life skills and knowledge; and understanding.
10. Another debriefing session and long discussion about the data brought forth discussion about the fact that women were telling stories and using stories to illustrate topics in the data. Returning to the data and viewing the data from this perspective resulted in the development of the three themes of Tradition and Culture, Knowing, and Wellness. The themes were compared to original field notes and transcripts to confirm they were representative of the data.