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Inuit Engagement in Nunavut and Canada: Struggles for Health and Citizenship

Sarah Tedford Gold

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STRUGGLES FOR HEALTH AND CITIZENSHIP

By

SARA TEDFORD GOLD, B.B.A, B.A., M.A.

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AUTHOR: Sara Tedford Gold, B.B.A., B.A., M.A.

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Abstract

This thesis is a post-structural analysis of Inuit engagement in health governance in the new territory of Nunavut. The creation of Nunavut brings decision-making power to a largely Inuit population through both a land claims agreement and the establishment of a public government. As such, it marks a new moment in the history of Aboriginal governance in Canada and in relations between North and South, Inuit and non-Inuit.

The establishment of Nunavut is the result of a decades-long Inuit struggle for self-determination. This struggle is an articulation of citizenship, of how Inuit think about who they are within communities and within the nation. This struggle does not suggest that citizenship is simply about membership in the nation, nor is it simply about the rights that come with that membership. It suggests, instead, that citizenship is how people engage in the governance of their lives.

This study is based on a qualitative methodology including fieldwork in three Nunavut communities, interviews, and document analysis. I consider how relations between North and South, Inuit and non-Inuit have shaped health governance in the Central and Eastern Arctic. I explore how various conceptions of health and self are implicated in how citizens participate in health governance in Nunavut.

This research makes several important contributions to the study of health, ethnicity, governance, and citizenship. It contributes to a current emphasis in the social sciences on notions of health and citizenship as contingent and variable. It points to the need for new research on the implications of citizenship struggles in remote communities for health governance. Finally, this research points to the instability of power relations and joins in efforts to rethink the way we organize and govern health and our lives.

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This research process has transformed my vision of the North, Canada, Aboriginal and non-Aboriginal relations, and my own work as a sociologist. For all of this I would like to thank everyone who participated in this project. I would like to thank them for sharing their stories with me and providing me with further direction when they felt I needed it. I am grateful to those who made space for me in their homes and introduced me to various aspects of their communities. I am especially grateful to those who invited me out on the land to pick berries, drink tea, talk, and watch the Northern Lights move across the great Arctic sky.

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Qujannamiit,
Sara

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CHAPTER ONE

Introduction

In April, 1999, the creation of the territory of Nunavut forever altered the geographical, social, and political landscapes of Canada. Nunavut is the result of the largest successful land claim in Canadian history. It covers one fifth of Canada's land mass – 60% of what was the Northwest Territories. Its creation brings decision-making power to a largely Inuit population (85%) through both a public government and the Nunavut Land Claims Agreement (NLCA). The terrain is set for new opportunities for Inuit to shape territorial governance. As such, the creation of Nunavut marks a new moment in the history of Aboriginal governance in Canada. It also marks an important moment in relations between North and South, between Inuit and non-Inuit. It challenges taken-for-granted assumptions about the divides between peoples and places, and points to new possibilities for how and where we place ourselves on our social, political and geographical maps.

The Arctic and the Aboriginal Peoples of the North have long held a prominent place in southern Canadian notions of Canada as a nation and who we are as Canadians. They have been central in the nation's exertion of sovereignty, the subjects of a breadth of scientific exploration, and instrumental in Canada's crafting of its international image. In her address to Nunavut's Legislative Assembly in March, 2000, the Governor General of Canada, Adrienne Clarkson, suggested that "the North defines us as Canadians. It is part of the feeling that we have when we're in the South that our country extends to the

North, and goes beyond cities, to another way of living" (Governor General, 2000). We treat the North as "an idea, not a location; a myth, a promise, a destiny" (Francis, 1997, p. 152). Along the busy commercial tourist areas of our major cities, galleries and shops with signs reading "Inuit Art" or "Arctic Art Gallery" speak to the centrality of the North and the Inuit in our visions of Canada. But these constructions of the North and northern peoples fail to capture the ways in which those constructions arise out of particular relations. Our reliance on the Arctic and Inuit as expressions of our nation's uniqueness hides their historical marginalization and exclusion from the governance of the nation, not to mention within their own communities.

Nunavut is the result of decades of negotiation between Inuit and the federal government and, as such, demonstrates that Inuit and the North are shapers of the nation. They are not simply reflections or constructions of the nation, they are of the nation, a nation that is unavoidably diverse. Moreover, Nunavut reminds us that our assumptions about Canada, its various spaces and citizens, are deeply connected to the relationships between them. It demands that we consider how relations between North and South, Inuit and non-Inuit contribute to the ways in which we think about ourselves and, in turn, how we govern ourselves.

Health governance provides a particularly salient point from which to explore the intersection between Nunavut's unique status as a largely Inuit territory and new territorial governance. Notions of health pervade discussions about new territory

building. One of the four territorial priorities outlined in the *Bathurst Mandate*[1] explains that "the health of Nunavut depends on the health of its physical, social, economic, and cultural communities and the ability of those communities to serve Nunavummiut in the spirit of *Inuuqatigiittarniq* - the healthy inter-connection of mind, body, spirit, and environment" (Nunavut, 1999a). Healthy communities are identified as key to building Nunavut while the success of Nunavut is referred to as being integral to the health of Nunavummiut (people of Nunavut). But what is this health? How do notions of health connect with perceptions of citizenship and self-determination? How do discussions of health link up with broader Canadian assumptions and priorities around health? And how do these linkages facilitate or complicate Inuit participation in health governance?

Contemporary social science has recently, and energetically, sought to explore diverse approaches to health and, in particular, connections between health and ethnicity (Cant and Sharma, 1999; Kleinman, 1995; Bakx, 1991; Anyinam, 1990; Wardwell, 1994). Researchers suggest that our ethnocultural backgrounds provide a familiarity with traditions other than Western medicine (Pawluch, Cain, Gillett, 1998). In doing so, such researchers decentre the dominance of biomedicine, not only in our assumptions about health and health care, but also as the starting point for social research. This work on ethnicity and health suggests that we rethink where our analysis begins. This work suggests that the ways we think about who we are will be implicated in the ways we govern ourselves.

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[1] The *Bathurst Mandate* is the result of a June 1999 Cabinet meeting in Baker Lake to develop territorial priorities which were further revised at Bathurst Inlet.

How we think about health is fundamental to how we organize around it. The Canadian claim to some sort of national identity hinges partly on our health care system which has biomedicine at its centre and specific assumptions about health and health care delivery. In the introduction to the report of the Commission on the Future of Health Care in Canada Roy Romanow links citizenship to values of equity, fairness, and solidarity in health care (Commission, 2002, p. xvi). In doing so, he suggests that our conceptions of ourselves as citizens inform our health care values. Through my own work on alternative and ethno-cultural conceptions of health I have come to understand these constructions as being deeply connected to the ways in which people identify as individuals *and* how they identify as part of communities or groups. This connection has implications for the ways in which people plan and organize health care. Aboriginal movements for self-determination challenge our notions of equity, fairness, and solidarity: they speak to diverse notions of citizenship and health. As a manifestation of Inuit struggles for self-determination, Nunavut forces us to rethink our visions of health and citizenship and how the two connect.

Inuit struggles for self-determination are articulations of citizenship, of how they think about who they are within communities and within the nation. These struggles for self-determination do not suggest that citizenship is simply about membership in the nation, nor is it simply about the rights that come with that membership. They suggest, instead, that citizenship is the ways in which we engage in our communities and in the nation. It is, therefore, a set of practices linked to governance (Brodie, 2002). It is about how we participate, or not, in that governance. Later in her address to the Legislative

Assembly, the Governor General speaks of the "problem of identity" among Canadians – of the difficulties in thinking about who we are and how we fit in. Nunavut expands the "problem" beyond who we are, to how our constructions of ourselves, and each other, enable or disable people's capacities to think about who they are and how they can engage in the governance of their lives. This is an exploration of how subjectivity and conceptions of health connect in the shaping of health governance in a new, largely Inuit territory. I am interested in how health is implicated in the ways Nunavummiut think about who they are and the consequences of this for their engagement in health governance.

Recently, social scientists and policy researchers have called attention to the current and potential roles of public participation in health governance (Abelson and Eyles, 2002). Valadez (2001) suggests that deliberative democracy, in which citizens participate in governance, is particularly suited for multicultural societies because of the existence of deep and enduring differences in conceptions of "the good" in these societies (p. 6). But we know little about what contributes to how people in rural and remote communities participate or engage in governance of their lives. Nunavut offers an opportunity to explore how engagement is made possible in remote and largely Aboriginal communities.

The reshaping of health governance offers a unique and important opportunity to explore governance in remote communities. Nunavut's relationship with colonialism and Aboriginal self-determination movements provides for a study of how relations of power are implicated in the ways Nunavummiut govern themselves. Such an exploration

requires consideration of the relations that contribute to governance regimes and health practices. Nunavut is the product of Inuit and non-Inuit relations. Its boundaries and communities have been defined both by Inuit history and colonial administrative practice. Its land claim and public government are the results of decades of negotiation between the federal government and the Inuit. We must carefully examine past and present relationships between Aboriginal and non-Aboriginal peoples so that we can understand what is required to move beyond the colonial relations upon which this country is based (Monture-Angus, 1999, p. 22). How health governance unfolds within this context will depend on how relationships continue to unfold. Whether or not Inuit become leaders in the shaping of health governance will depend on how these relations encourage or impede their participation.

Citizenship struggles are about the ways in which we think about ourselves as part of collectivities. Inuit self-determination and Nunavut as a territory are political expressions of a people's vision of themselves as part of Inuit, regional and national collectivities – of their citizenship within Nunavut and Canada. An exploration of the link between the building of a new territory and participation in health governance is an exploration of how people think about who they are. Nunavummiut suggest that such an exploration requires consideration of how Nunavummiut and Nunavut are situated within the context of North-South relations, colonialism and Aboriginal mobilization. They draw attention to a diversity of health perspectives that are implicated in the ways they think about who they are. And they argue that these multiple perspectives and subjectivities underlie their potential for participation in a complex web of health

governance. In exploring the intersection between Nunavut's unique status as a largely Inuit territory and health governance, I ask the following questions:

- How have relations in Canada between North and South, Inuit and non-Inuit shaped health governance in the Central and Eastern Arctic over the past one hundred years?
- How do Nunavummiut think and do health in the new territory and how is health implicated in the ways in which they think about who they are?
- How is health governance unfolding in Nunavut and how is citizen participation enabled or disabled?

What follows:

These three questions require an approach that is open to a diversity of perspectives and is attentive to the ways in which relations of power give shape to those perspectives. In the following chapter, I frame my study within several theoretical and substantive shifts in the social sciences. In so doing, I situate this study within specific areas of social thought and research.

My approach is guided by a post-structural treatment of meaning as indeterminate. It links with the post-colonial challenge to dominant colonial narratives. I am also guided by current shifts in the sociology of health and ethnicity and analyses of citizenship within struggles for self-determination. These shifts align in their challenge

to objectivist efforts to discover the specific truths or underlying structures of our social world.

Rather than seek out the true meanings of things, post-structuralists treat meaning as constantly shifting. As such, I am not interested in seeking out the truth of health or governance in Nunavut. I am interested in the ways in which people talk and do health and governance. I am not looking for an underlying structure of meaning or power. Instead, I think of these as indeterminate, continually reshaping each other. As we relate to one another we construct meaning and through these meaning-making processes, come to govern ourselves in particular ways. In governing ourselves in particular ways we relate to each other in particular ways.

Post-colonialism complements post-structuralism by engaging specifically with questions about colonial relations. Together these approaches provide a framework for the exploration of health governance within the post-colonial endeavour of Nunavut. Colonialism is about a way of governing and, in turn, relations between peoples. This approach suggests that health, health governance, self-determination, identity, Nunavut *and* Canada are neither pre-determined nor determining; they are constructions constituted through unequal relations. They are therefore unstable.

This study contributes to the contemporary focus of social science on health beliefs and practices within medically and culturally pluralistic environments. In pointing to the inextricable link between ethnicity and health, social scientists call for research that attends to the ways in which our ethnic and cultural identifications can complicate or facilitate our relationships with dominant health approaches. They suggest

that we need to consider how our notions of ourselves intersect with how we govern ourselves and our health. More and more, social scientists are considering questions of health, citizenship and governance through post-structural and post-colonial lenses (Brodie 2002; Denis, 2002; Lupton and Tulloch, 2002; Petersen, 1997; Nettleton, 1997; Osborne, 1996; Rose, 1996; Tyler, 1993).

This framework gives rise to a methodological approach that is distinctly qualitative. In Chapter Three, I describe the specific methods I employ and introduce the communities, participants, and texts that comprise the "field" in this project. I have chosen methods that prioritize a multiplicity of voices and perspectives and that call attention to my own location as a researcher. I approach health governance as a complex web constituted by and constituting Nunavut, Nunavummiut, and relations between North and South and Inuit and non-Inuit. In this way, I connect with others who are applying post-structural theoretical approaches to pragmatic questions (Seidman and Alexander, 2001).

In Chapter Four, I explore how relations between North and South, Inuit and non-Inuit have unfolded over the past one hundred years. I consider the ways in which colonialism has shaped health governance in the North as well as Inuit engagement in this governance. I explore the ways in which Inuit and non-Inuit have constituted themselves and each other, Nunavut, and Canada. Over these one hundred years, tensions and struggles emerge as various forms of expertise and experience collide. I examine how health care in the North comes to be shaped by Inuit, other Aboriginal communities, European trade and exploration, religious missions, the RCMP, Canada and its

expressions of national sovereignty, growth of northern media, the growing dominance of the medical profession and the southern push for public health care.

These tensions and struggles between Inuit and non-Inuit, the North and South highlight the instability of notions of health. In Chapter Five, I explore how Nunavummiut talk about and address health in Nunavut and how they link up with or challenge broader ways of talking and doing (organizing, providing, managing, seeking out) health in Canada. In this chapter I examine how health is talked about. I look specifically at six techniques or strategies that Nunavummiut use to engage in discourses of health. I look at three techniques through which Nunavummiut align themselves with dominant assumptions about health and three techniques that attempt to shift the conversation away from health. The challenges posed by these techniques and incompatibilities in the ways that Nunavummiut talk about health highlight relations of power, through which Nunavummiut see themselves. These techniques, I suggest, are ways of crafting selves or subjectivities in multiple ways.

The exploration in Chapter Five ends with a question. If these techniques are part of webs of discourse within which Nunavummiut are inserted in multiple, shifting ways, what does health governance look like? In Chapter Six, I examine how the discourse of health examined in the previous chapter is shaping health governance in Nunavut. I treat governance as a web of institutional contexts that go beyond formal government. More specifically, I look at five institutional contexts including the Government of Nunavut, the Nunavut Land Claim Agreement, the federal government, regional and community level factors, and front-line health care provision. I consider the ways in which

participation is encouraged in these contexts, what this participation consists of, and how it is enabled or disabled. Finally, I explore how these factors influence participation in two cases of health governance: (1) early childhood and parenting education, and (2) maternity care. I end with a look at how Nunavummiut perceptions of and actual engagement in health governance are linked to building Nunavut as a largely Inuit territory and in working toward Inuit self-determination.

To conclude, I highlight how this study contributes to both theoretical and substantive issues in the sociology of health and ethnicity, and the broader post-foundational shift in the social sciences. I consider how this research contributes to explorations of citizenship and citizenship movements. And I outline how this research calls for further research on citizen participation and health governance and health governance in rural and remote communities. The Commission on the Future of Health Care in Canada (2002) suggests that rural and remote communities not only experience poorer health, they also suffer from the tendency to apply "urban" approaches to rural and remote communities (p. 164). I consider how this study raises new questions about health governance for rural and remote communities. And I end with some thoughts on relations between non-Aboriginal and Aboriginal peoples in research processes.

Some final notes on terminology:

In the following chapters I have italicised Inuktitut words that are not names of people or places. When I refer to project participants I use "Participant." Where speakers are not project participants but interviewed in other contexts (e.g., the Igloolik

Elders Project, explained in Chapter Three) and fully identified. I acknowledge them and their perspective by including their name. I would like to acknowledge the perspectives of those who participated in this project as their own but I respect the preferred anonymity of those who chose to participate in this project. I use Aboriginal rather than aboriginal when I am referring to a person as being linked with time, place, and history in a particular way. I treat it the same way we treat national identifiers like Canadian or Irish.

In the following pages, "west" and "western" are "codenames", as Spivak (1999) suggests, for Western European traditions; so western medicine is medicine which is rooted in European medical traditions. I understand these to be predominantly "biomedical." Having said this, I tend to use the word Southern more than Western because it locates the practice or assumption in Southern Canada more specifically. "Southern assumptions" refer, therefore, to approaches that I connect with Southern Canada. And by this I mean the Southern Canada in its dominant, institutionalized form, not the diversity of perspectives and ways of living that characterize Southern Canada.

I capitalize North and South where I refer to these as places, not simply directions. I use the 60th parallel of latitude, as Nunavummiut do, to distinguish between the North and the South. In this way, the North comprises the three territories, extending from the 60th parallel to the North Pole (Francis, 1997). While "North" is often used, in Canada, in a way that includes the northern parts of many provinces, I feel it necessary to highlight the great distances between, not only southern Ontario and Iqaluit for instance, but also between Timmins and Iqaluit. While there is great diversity within the

provinces, there is a greater geographical, social, and political divide between provinces and territories. Air travel highlights this distance. While you can fly to Churchill, Manitoba (very close to the Nunavut border) year round with very little difficulty, you may find yourself stranded there in February on the way to Rankin Inlet if there is a blizzard not so far up the coast. If you travel to Rankin Inlet in June, you may enjoy a much longer visit than you planned if flights north of Churchill are cancelled due to the fog brought on by the melting sea ice. While you can drive to Timmins almost any day of the year, you can never drive to Nunavut. I recognize, however, that the words North and South fail to capture the diversity *within* the places they identify. Moreover, they reify the divide between the two. My intent here is to challenge such dichotomies. So when I write of the North in the following pages, please note, that I am thinking about the North that I know – one that is constituted by my experiences in diverse communities across the Central and Eastern Arctic, Nunavut. Read this as one interpretation among many.

CHAPTER TWO

Framing the Study

This is an exploration of how subjectivity and conceptions of health connect in the shaping of health governance in a new, largely Inuit territory. I am interested in how health is implicated in the ways Nunavummiut think about who they are and the consequences of this for their engagement in health governance.

In exploring health governance in Nunavut, I align myself with the contemporary, "post-foundational" theoretical shift in the social sciences. This shift challenges social science efforts to mirror the objectivism of the hard sciences and demands that we acknowledge our socially-situated points of view (Seidman and Alexander, 2001, p. 1). Where foundational approaches claim to know something, post-foundational thinkers see truth claims as claims. Post-foundationalism embraces theoretical fragmentation and attempts to link meta-theoretical issues to practical and even policy-related studies (Seidman and Alexander, p. 13). Post-structuralism, post-colonialism, current shifts in the sociology of health and ethnicity, and the challenge of self-determination struggles to notions of citizenship are all various articulations of this post-foundational shift.

In aligning myself within this contemporary theoretical context, I draw largely from Foucault's post-structuralism. Post-structuralism provides a particularly salient way to explore the contingency of health and ethnicity, and to respond to current shifts in the sociology of health and ethnicity. Post-colonialism complements this approach by attending to the ways in which colonialism (like gender, sexuality, and race) constitutes

identities (Seidman and Alexander, 2001, p.20). Post-colonialism provides for an interrogation of colonial relations and calls attention to my position as a non-Aboriginal researcher. In the following pages, I first explain the post-structural framing of my approach. I then consider how this responds to current work in the sociological study of health and ethnicity and what post-colonialism brings to this project. Finally, I consider how the combination of these approaches provides a way of attending to new questions around self-determination and citizenship.

I Post-structuralism

Post-structuralism has grown out of resistance[2] in the social sciences and humanities to traditions that attempt to attain truth and delineate structure in social behaviour and meaning-creation. It calls into question presumptions about knowledge as neutral, bounded, true, and perspectiveless (Grosz, 1995). Post-structuralism attempts a non-totalizing form of theorizing and challenges logocentrism – the claim to an unmediated knowledge of the world (Fox, 1998).

The "post-" in post-structuralism refers to its subversion of, or challenge to, structuralism. Structuralism rests on the assumption that there is an underlying structure of meaning in the process of signification. It claims that a *signifier* such as the word "m-

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[2] This resistance is often referred to as a "crisis" of reason, representation, and/or legitimation (also referred to as the interpretive, linguistic, and rhetorical turns in social theory). It is one of representation in that lived experience is seen as created rather than captured, and of legitimacy as we rethink terms such as validity, generalizability, and reliability (Denzin, 1998a, p. 22).

o-t-h-e-r" refers to a *signified* – a fixed meaning – the meaning of "mother." Post-structuralism, on the other hand, suggests that there is no fixed notion of mother. Our notions exist through our continual, changing constructions of them. Post-structuralism replaces the a priori fixed signifieds of structuralism with meaning that constantly differs and defers. Mother, a signifier, *differs from* and *defers to* other signifiers. This differing and deferring is what Jacques Derrida refers to as *différance*. *Differance* highlights how we learn to see one pattern or set of meanings rather than another (Shawver, 1996). It is the differentiating (setting off) from, and deferment (pushing away) of the shape or pattern of all that is *not* being defined (Spivak, 1999: 424). Derrida refers to this pattern as the "trace" and it is this trace that Foucault attends to in his deconstructive approach. Derrida coined "deconstruction" as a strategy for showing how the elaboration of a definition as a theme or an argument, sets the defined item apart from all that it is not (Spivak, p. 423). It is the process of bringing *differance* to the foreground. To deconstruct a text is to show its potential for multiple, shifting meanings. In this way, we see the social world as a realm of ongoing conflict (Seidman and Alexander, 2001, p. 7).

For the post-structuralist, the word and idea of mother are discursive. They are *of discourse*. Discourse is how we talk about something. It is not merely a conversation between two people but how that conversation links up with broader conversations. It is the rules and practices that govern what is said. Discursive practices are the ways we engage in discourse; they are meaning-making practices. Laclau and Mouffe (2001) describe discourse as any practice that establishes a relation between elements, and in turn modifies the identity of those elements (p. 77). It is both constitutive of and

constituted by relations of power. Discourses constitute "regimes of truth" or a "general politics" of truth (Foucault, 1980). "Dominant discourse" is the most pervasive conversation, one that is embedded in the institutions and daily activities of our lives. Government, health, Nunavut, and Canada are discursive in that they are of discourse, constituted by and constituting discourse. Thinking of discourse in this way necessitates an examination of relations of power rather than models of language, signs, and relations of meaning (Foucault, 1980, p. 114).

Foucault is concerned with "discourse formation" – relations between statements or connections among techniques that we employ to carry out meanings (Foucault, 1972; Hutton, 1988, p. 127). He does not look to identify consistent reference to the same object or a particular way of making statements, nor does he seek out a system of permanent and coherent concepts or the persistence of themes (Foucault, 1972; Laclau and Mouffe, 2001). He looks instead for interplays of difference, distances, forms of division, and incompatibilities. Foucault traces the ways in which meanings are battled out over time (Hutton, 1988, p. 129). He attends to relations of power rather than relations of meaning. In other words, he is not concerned with how one meaning is different from another – how the meaning of mother arises through its difference from the meaning of father. He attends instead to the processes of meaning-making which, he suggests, are ways of thinking about ourselves and, in turn, governing ourselves.

Foucault's analysis of *governmentality* is an exploration of the unfolding of meaning-making processes that are implicated in the ways we govern ourselves and each other. In this analysis, government is the sum of the practices that regulate conduct

according to particular rationalities (Eide and Knight, 1999, p. 540). It is about how we think about ourselves, how we act on these thoughts, and the consequences of these actions (Dean, 1996; Rose, 1996). Foucault looks, specifically, at how "problematics of rule" have taken shape in the West over the last three centuries – those ways in which the exercisers of rule justify and explain that rule and the motivations behind it (Rose, 1996, p. 41; Foucault, 1991).

Governmentality, Foucault suggests, began to emerge in Europe in the sixteenth century with a new approach to social regulation and control (Lupton, 1999, p. 85). It is the shift in Western society from sovereign power (the power of the king or the state) to *disciplinary power* (the surveillance of the school, factory, prison and hospital, or social survey) (Bury, 1998, p. 13). To explain disciplinary power, Foucault refers to the "panopticon", a prison design where, from a central location, guards can observe everything. Surveillance becomes permanent and prisoners, knowing they are constantly observed, become observers of themselves (Foucault, 1979, p. 201). They internalize the watchful gaze of the prison guards. To ensure the internalization of this gaze, individuals must see themselves as part of the collective being observed. In this way disciplinary power is both individualizing and totalizing (Fox, 1994). Governmentality also involves *pastoral power*, a caring view of the person's subjective state. This notion of pastoral power arises out of Foucault's reading of the early Christian concept of pastorship as a "complex exchange of sins and merits" and individual responsibility to God (Foucault, 1988a). Pastorship looks after each and every individual member of the flock and needs to know people's minds, souls, secrets, and details of their actions (Nettleton, 1997, p.

211). The state now functions as "a modern matrix of pastoral power" and the officials of pastoral power, who were previously members of religious institutions, are spread out into family, medicine, education, and employers (Foucault, 1982 in Nettleton, 1997, p. 211).

Governmentality involved a change in who had power but also, and perhaps more significantly, it involved a change in how people understood and rationalized (discursive practices) relationships of power. From the Eighteenth to the Nineteenth Century, the European focus shifted from rules to preserve individual or local health to general regulations for preserving the collective health of the nation with state-provided infrastructure to ensure security (Osborne, 1997). The political subject was reconceptualized as a citizen, with rights to social protection and social education in return for duties of social obligation and social responsibility (Rose, 1996, p. 49). This provided the foundation for what we understand today as liberalism. Liberalism is not a theory or a set of policies. It is a "rationally reflected way of doing things that functions as the principle and method for the rationalization of governmental practices"; it makes government "both thinkable and practical as an art" (Burchell, 1996, p. 21).

In his analysis of the shift from sovereign power to governmentality, Foucault (1988a) treats power not as a substance, but as a certain type of relationship between individuals. He breaks with the notion that power is ultimately located within the state, and calls attention to the infinitesimal mechanisms of power, their histories, and how they continue to be invested, colonized, utilized, transformed, and displaced (Foucault, 1980). For Foucault, power is a "moving substrate of force relationships which by virtue of their

inequality constantly engender states of power but the latter are always local and unstable" (Clough, 2001, p. 383). Power relations are characterized by inequality (without resistance there is no power) and, thus, are unstable. Because power is not a substance, something held by those at the top, power relations are always local. Rather than provide us with a general formula for the operations of power, Foucault's work directs our attention to the different ways in which power is exercised in particular sites and institutions (Barnett, 1999, p. 370).

Foucault's analysis of governmentality examines relations between the state and citizens. Considering how subjects are constituted through governing discourse, he asks how particular practices modify subjectivity. This approach does not aim to discover the true nature of identity, what it is to be Inuit or to be Canadian. Foucault is interested in the conditions in which people are led to problematize their world, who they are, what they can and should do, and how these problematizations make certain arts of governing possible (Dean, 1996, p. 225). To problematize is not simply to construct a problem but how we experience that problem as well (Osborne, 1997, p. 174). Similarly, Ernesto Laclau and Chantal Mouffe are interested in how we come to think about our identity, but they offer a more fluid, multiple concept of the self or subject than Foucault (Seidman and Alexander, 2001; Laclau and Mouffe, 2001). They suggest that we are inserted into webs of discourses that always position us in multiple, intersecting ways. In this way power is discursive.

In the following chapters, it is not my intent to explain what kind of subject Inuit or non-Inuit are, to explain or define the Inuit of Nunavut or the non-Inuit of Nunavut.

Instead, I explore how health is implicated in how Nunavummiut think of themselves as Nunavummiut and how this relates to the unfolding of health governance in the new territory.

Foucault works out the process of subject creation in his exploration of "technologies" (Foucault 1988b; Barnett, 1999). He identifies four types of "technologies" through which we constitute ourselves: (1) technologies of production, which permit us to produce, transform or manipulate things; (2) technologies of sign systems through which we use signs, meanings, symbols, or signification; (3) technologies of power, which determine the conduct of individuals and submit them to certain ends or domination, (objectivizing of the subject); and (4) technologies of the self, through which individuals transform themselves in order to attain a certain state of happiness, purity, wisdom, perfection, or immortality (Foucault, 1988b, p. 18). While each technology implies certain modes of training and modification, Foucault is particularly interested in the last two. These technologies are "truth games" – practices through which we come to understand or construct truths about ourselves. Through techniques of the self, we constitute ourselves as a society, as part of a social entity, as part of a nation or of a state (Foucault, 1988b, p. 146). These technologies are discursive. Governmentality is the relationship between these last two – between techniques that determine the conduct of others and techniques that we use on ourselves.

Post-structuralism draws attention to how health, health governance, self-determination, identity Nunavut *and* Canada are discursively created, indeterminate, and relative. These can be seen as emerging through discourse where they become

possibilities rather than realities (Fox, 1998; Osborne, 1997). They are not outside of discourse but *are* discourse. From this perspective, an examination of health policy, planning and delivery in Nunavut must problematize or investigate the context of and assumptions upon which health and health care, Nunavut, Inuit, Nunavummiut, and Canada are constructed, as well as the forces that make them what they are; linking taken-for-granted notions to the rationalities that create them (Osborne, 1997)

II The Shifting Ground of Contemporary Sociology of Health and Ethnicity

The ontological and epistemological challenges posed by post-structuralism reflect current shifts in the sociological study of health and ethnicity. Sociologists, and others in the social sciences, are calling attention to the socially constructed nature of health and ethnicity and how relations of power shape our understandings or constructions. Biomedicine is treated as one approach among many and there is renewed interest in multiple interpretations (folk, lay, complementary, traditional) and in questions of hierarchies of credibility among those who offer competing interpretations.

From the late nineteenth century until the 1960s, medical knowledge "lay behind a seemingly unbreachable conceptual barrier;" medicine was not treated as an object of sociological enquiry (Wright and Treacher, 1982, p. 1; see also Gerhardt, 1989). Talcott Parsons was one of the first sociologists to explore illness and medicine. His interest was not so much in health or medicine, as it was in how health, medicine and the sick person served particular functions in society. The 1960s saw a rise in sociological attention to health and medicine. Sociological explorations of health and medicine began to divide

themselves into two theoretical currents: (1) social forces that produce illness and health; and (2) the socially constructed nature of health, illness, and medicine.

In the first camp, (often referred to as "social productionist") sociologists focus on the social determinants of health, health and illness behaviours, and the health care system. They examine relationships between health and political economy, professionalism, and institutional structures (e.g., McKinlay, 1984; Navarro, 1976). They address medicine as an institution of social control and the social origins of illness (Bury1997; Gerhardt 1989; see also Illich, 1976; Mechanic, 1991). Others have explored Indigenous health by linking health to colonialism and political economy. They attempt to identify social "causes" of Aboriginal health problems, linking illness to political economy. Satzewich and Wotherspoon (1993) conclude that Aboriginal access to health care is restricted by the dominant structure of medicine and health care under capitalism (Satzewich and Wotherspoon, p. 47; Jenkins, Gyorkos, and Culman, 2003). Saggers and Gray (1995, 1991) link Aboriginal health problems to Australia's political economy and its history with colonialism. John O'Neil (1986) argues that the structure of health services in the Canadian Arctic reflects an internal colonial political economy. He examines control and conflict between regional and territorial levels in his study of the devolution of health services in the Baffin region of Arctic Canada (O'Neil, 1990). He and others have explored the relationship between devolution of control over health services and health status, and the implications of self-government for health and health care (Tupper, 1988; O'Neil and Postl, 1994; O'Neil, 1988). This research has developed alongside health policy research that emphasizes the need for increased health care access

for Aboriginals and raising Aboriginal health status to that of other North Americans (O'Donoghue, 1999; Lehtiniemi and Mundee, 1988; Dear, 1976). Recently, there has been a significant increase in epidemiological description of Aboriginal health problems and an emphasis in both social science and medical research across Canada on specific conditions such as diabetes, cancer, and issues such as tobacco use (Waldram, Herring, and Young, 1995).

Alongside this attention to the social production of health and illness, Herbert Blumer's symbolic interactionism and his suggestion that illness is what medicine defines as such (Gerhardt 1989, p. 85) fuelled a growing interest in perceptions of self, sickness, and health as symbols. Interest turned to the intersubjective or social construction of reality and perceptions of self, sickness and health as symbols. Most recently, social constructionists have raised questions about issues which appeared as self-evident and uninteresting to earlier writers; they asked how certain areas of human life come – or cease – to be regarded as 'medical' in particular historical circumstances (Wright and Treacher, 1982, p. 9). Interest in the intersubjective construction of reality continues to contribute to a significant body of research both in the social sciences and medical sciences on patient-practitioner relations (Cass, Lowell, and Christie, 2002; Kaufert and O'Neil 1993, 1998).

A growing appreciation of the socially constructed nature of meaning and knowledge within the social sciences has contributed to a body of research on varying health beliefs and practices within medically pluralistic environments. This research raises questions around choice, access, and differences between Aboriginal and

biomedical perceptions of health. Researchers explore belief systems of indigenous or traditional health care (Adetunj, 1996, El Tom, 1996). Such work suggests that biomedicine exists "amidst a range of alternative therapeutic forms whose ideology and practice comprise a series of rather different responses to, and explanations of, health issues generated within wider societies" (Comaroff, 1993, p. 55). It argues that in failing to identify biomedicine as one approach among many, we entrench a dichotomy, fuelled by the dominance of biomedicine in Western culture, where biomedicine sits at one end and all other approaches at the other – labelled "alternative", "complementary", or "traditional." In claiming exclusivity between "alternative medicine" and biomedicine (Aniyam, 1990), we effectively subsume or marginalize all other ways of understanding health. In failing to problematize biomedicine, the sociology of health or medicine furthers biomedicine's dominance.

Sociologists and anthropologists are becoming increasingly aware of the role we play in dichotomizing biomedicine and all other approaches (Cant and Sharma, 1999; Kleinman, 1995; Baky, 1991; Anyinam, 1990; Wardwell, 1994). To subvert this dichotomization, they attempt to place biomedicine alongside other approaches, calling attention to a diversity of interpretation and perspective that is part of a myriad of understandings of health and approaches to health care. Many do this by looking at lay perspectives of health. This work has set a new direction for exploration, one in which we attend to the ways in which people constitute health and health care in their daily lives, and how individuals are constituted within the day-to-day practice of health care. In the early 1990s, Patricia Kaufert and John O'Neil (1993) made a significant

contribution to the shifting ground in Aboriginal health research in Canada by calling attention to the ways in which the language of epidemiology constructs portraits of Aboriginal sickness and misery, in turn, acting as powerful social instruments for the construction of Aboriginal identity. This coincided with recognition of the ways in which discourses of health and medicine are constitutive of the "social" (Rose, 1994, Osborne 1996; 99).

When we recognize biomedicine as social phenomena, we can examine assumptions that inform its dominance. Central to the polarization of biomedicine and other approaches is the assumption that biomedicine is "of modernity", reflecting the modern ideal of progress. In contrast, all other approaches are "of the past". They are often referred to as "traditional", in the sense of being pre-modern, a kind of presumed truth "antithetical to ordinary 'rational enquiry'" (Giddens, 1994, p. 66). But recent research on healing systems suggests that they are flexible, changing, and continuously hybridizing[3]. This research challenges the notion of "Aboriginal" and "Aboriginal knowledge" as static, and subverts the modernity-tradition dichotomy. For example, Ayora-Diaz (2000) argues that while NGO personnel and other foreigners imagine local medicines practised by healers in Chiapas, Mexico, to be culturally authentic and rooted in the past, these medicines are actually best characterized by their hybridity. This notion of hybridity is prevalent in current social science work on health and ethnicity. It refers

[3] Such tradition, perhaps best thought of as that which "is transmitted", must be understood in its present-day context while recognizing the dynamic interaction of cultural traditions within global and local processes of social change (Dybbroe, 1996, p. 48).

to the way in which two or more things (cultures, people, communities) interact with one another to give way to something different from any of them but consisting of all of them. This hybridizing process is unending. When we think in terms of hybridity instead of construction, we can better appreciate the myriad processes and contextual factors that shape meaning.

Just as health needs to be explored as a social phenomenon, so too does ethnicity. Social science explorations of aboriginality have been dominated by two models: the Chicago School tradition and the internal colonial model (Satzewich and Wotherspoon, 1993). The Chicago School examines how and why groups of people become more culturally alike, or resist becoming more culturally alike, and the social and economic consequences of cultural differences and conflicts (Satzewich and Wotherspoon, 1993, p. 2). James Frideres presents the internal colonial model as an explicit alternative to "micro" models like the Chicago School. He links aboriginal peoples' experiences to larger structural processes occurring within Canadian society (Frideres, 1994; Satzewich and Wotherspoon, 1993). A political economy approach has dominated sociological studies of Aboriginal health in the 1980s and 1990s with explorations of the changing material circumstances which shape and are shaped by aboriginal life experience (Satzewich and Wotherspoon, 1993, p. 13). O'Neil (1986) explores the ways in which the structure of health services in northern Canada reflected an internal colonial political economy. Das Gupta (1997, p. 573) places all of these approaches under the term "ethnicity paradigm", suggesting that such approaches focus on the loss or persistence of ethnicity, assimilation or cultural pluralism. Such approaches assume the same meaning

of ethnicity for men and women, posit one nation-state (i.e., Canada) as "the significant context of immigrant identity formation", and assume that tradition is easily identifiable and transparent (Das Gupta, 573). These assumptions render invisible the fluid nature of identity and the intersection of various aspects of people's lives such as gender or age.

Struggles for self-determination and self-government call into question assumptions of identity and aboriginality that suggest "pristine," unchanging traditions and notions of "self" (Denis, 1997). Comaroff and Comaroff (1992) propose that we consider ethnicity to be rooted in historical forces which are simultaneously structural and cultural (p. 50-61). They suggest that ethnicity is not primordial nor a unitary "thing"; it describes a set of relations and a way of thinking. Piot (2001) highlights this shift in thinking about ethnicity in his look at the Comaroffs' two-part exploration of missionaries in the colonial encounter with Tswana in South Africa. In Volume I, the Tswana were subtly ("hegemonically") colonized by new modes of thought and forms of discourse (Piot, 2001, p. 86). In Volume II, Tswana are represented as actively transforming – 'hybridizing' – European attempts at colonization, indigenizing and pluralizing the signs and practices of European modernity (p. 86). Like the Tswana, Inuit identity is in constant relationship with European attempts at colonization, indigenizing and pluralizing the signs and practices of European 'modernity'.

Ethnicity, or Aboriginality, is not just about relations between peoples. It is also about relations between peoples, places, and spaces. In Aboriginal sovereignty, political spaces are hybridized – "ordered in part by Aboriginal definitions of 'home place' yet simultaneously transformed in negotiation with mainstream canons of jurisdictional and

property rights" (Scott, 2001, p. 8). Gupta and Ferguson (1997, p. 13) argue that identity does not grow out of rooted communities, nor is it something to be possessed. They suggest that by stressing that place-making always involves a construction, identity can be explained as a mobile, often unstable relation of difference. This growing attention to relations between peoples is coupled by an interest in the social sciences to question and challenge relations between researchers and researched.

Sociologists and anthropologists are working to include, and sometimes collaborate with, Aboriginal communities in research processes (Kaufert, Commanda, and Elias, 1999; Henderson, Simmons, Bourke, and Muir, 2002). Most recently, and perhaps more significantly, a growing body of Aboriginal researchers, health practitioners, and communities are taking research into their own hands (Smith 1999, 2000; Battiste and Henderson, 2000). They frame their work as a response to colonialism and suggest that Aboriginal struggles to "maintain and regain control of their lives and institutions extend to research, information, and data" (NAHO, 2002, p. 2). Much of this work suggests that in order to appreciate and respect Aboriginal struggles for governance over such things as health and health care, we must conceive of "health," "illness," and "health care" as negotiated and contested concepts, inextricably linked to fluid identifications with ethnicity. Health, illness, and health care are constituted through an array of discursive practices where health becomes a "possibility" rather than a reality and relations of power are central (Fox, 1998; Osborne, 1997). This requires that we question the traditional assumptions around words such as health, illness, and health care as well as self-determination, north-south, and Aboriginality.

Post-structuralism allows us to explore health as it relates to ethnicity. Foucault's post-structuralism is interested in how health and health care are implicated in the discursive constitution of subjectivity. Complexity suggests that consideration of Aboriginality should locate Aboriginality within fluid, unstable and fragile identities (Tyler, 1993). A Foucauldian post-structuralism addresses how relations of power give rise to subjects. But alone, this approach is inadequate in addressing colonial relations of power. Post-colonialism complements post-structuralism by engaging specifically with questions about colonial relations.

III The Post-colonial Shift

The past several decades have seen a shift in how colonialism, as it relates to peoples' lives, is examined. The 1970s and 1980s saw a great deal of interest within the social sciences, in the relationship between colonialism and "tradition" in North America and the South Pacific (e.g., Clammer, 1973; Ranger, 1983; Beckett, 1988; Thomas, 1989). The 1990s brought a shift in focus to decolonization and counter-colonial discourse (e.g. Keesing, 1994; Kidd, 1997; Linnekin, 1992). This shift gave rise to post-colonial theory. Post-colonial theory insists upon analyzing nations in their interdependence, in particular in relation to their history of colonialism (Seidman and Alexander, 2001, p. 25). Post-colonialism is rooted in movements to resist and challenge dominant master narratives of the "West". It confronts both methodological issues and epistemological concerns (Smith, 1999, p. 169). Post-colonialism interrogates the West

and the Western gaze, deconstructing Western narratives and master narratives. It problematizes historical accounts and questions strategies of representation.

Indigenous thinkers use the term "post-colonial" to refer to strategies to shape a desirable future while acknowledging the persistence of the colonial influence (Battiste, 2000, p. xix). Many indigenous and non-indigenous people in Australia and New Zealand are crafting a post-colonialism that aims to identify and map colonialism, develop post-colonial visions, explore processes of decolonization, respect and empower indigenous knowledges, and build research capacity among aboriginal researchers (Battiste, 2000; Smith, 1999). In Canada, Aboriginal identity and struggle is being examined within the context of decolonization, struggles for self-determination and self-government the recolonization of Aboriginal knowledges, and relations with the Canadian nation state (Cairns, 2001; Monture-Angus, 1999; Lavoie, 1999; Denis, 1997). In her exploration of the impact of colonization on Aboriginal health in British Columbia, Kelm (1998) suggests that "Aboriginal ideas about the body, disease, and medicine were not just remnants of some pre-contact past but were ways of viewing the world, ways of viewing that contested the colonizing discourse of Western medicine as it came to be articulated in British Columbia during the first half of the twentieth century" (p. 83).

Post-colonialism informs and guides my approach in important ways. It draws attention to dominant assumptions around health and government, and to hybridity, alternative modernities, and the agency of the colonized (Piot, 2001, p. 87). It highlights the lack of Aboriginal voices in social science research on Aboriginal health and heightens my awareness of my voice as a non-Aboriginal and the resulting limitations I

face. It reminds me that my capacity to participate in the rethinking and challenging of relations and processes that are rooted in colonialism is framed by the fact that I am a Southern non Inuit Canadian of European-descent; that I must take my cues from Aboriginal struggle and from my participants; and that I must be honest about the limitations in my capacity to understand, as well as in Inuit interest in engaging with me. Throughout my research I have attempted to engage in dialogue with Inuit and non-Inuit of Nunavut as well as with myself. I aim to present an analysis here that challenges and deconstructs dominant Western, non-Aboriginal, and Southern Canadian narratives. To adopt a post-colonial standpoint is both to claim a distinct social identity rooted in a colonial experience and to claim a unique social perspective (Seidman and Alexander, 2001, p. 25). I use the term post-colonial to describe a symbolic strategy to shape the future, to acknowledge colonial attitudes that persist today, and to explore conceptions of nation and citizenship in relation to colonialism.

Post-colonialism is about challenging colonial processes of subjectification. It is not simply about recognizing images or representations as positive or negative. Homi Bhabha (2001) frames post-colonialism as an exploration of *processes of subjectification* – the construction of the colonial subject in discourse, and the exercise of colonial power through discourse (p. 388). Because colonial discourse relies on the recognition and denial of racial/cultural/historical differences, post-colonialism must articulate forms of difference (Bhabha, 2001, p. 389). From this perspective, colonialism is a form of governmentality that constitutes an Aboriginal subjectivity in order to justify conquest.

This view of colonialism ties the colonizer to the colonized as the colonized constitutes the colonizer and vice versa.

In framing colonialism as governmentality, Bhabha speaks to the potential contribution of Foucault's post-structuralism toward the post-colonial effort in its emphasis on the *how* of colonial power – how it constitutes. Post-colonialism takes my research from a post-structural analysis of a broad, theoretical shift to "micro-level transformations in the daily lives of contemporary actors" (Seidman and Alexander, 2001).

While post-structuralism opens our analysis to a new set of questions, it also poses a methodological challenge. How do we conduct research from a non-essentialist and non-positivist perspective? Foucault's genealogical method offers a way out of this dilemma, by linking theory to method. This genealogical approach involves deconstructing the conditions of possibility of dominant assumptions in a specific socio-political context (Howarth, 2002). The specific methods we choose are up to us. Post-structuralism's reluctance to be explicit about methodology challenges us to question our methodological approaches and how inextricably tied they are to our theoretical approaches, the issues we explore, and our analysis. Post-colonialism echoes this challenge and disrupts the traditional hierarchy of voices in social science research, bringing not only new questions to sociological exploration but also new ways of exploring those questions.

IV Self-determination: Challenging Notions of Citizenship

Nunavut is a post-colonial endeavour. It is the result of a collective mobilization which has shaped, and continues to shape, new subjects. Nunavut owes its status as a territory to a struggle across Inuit communities for *self-determination*[4] as well as acquiescence on the part of the federal government and Canada. Both the struggle and the acquiescence are about the ways in which people locate themselves within a collective and within a broader nation-state. In invoking notions of 'self,' self-government and self-determination become processes of situating and forming the subject. They are expressions of citizenship; of relationships within and between communities and of individual and collective rights and responsibilities. Self-determination and Nunavut are political expressions of a people's vision of themselves as part of Inuit, regional, and national collectivities – of their citizenship within Nunavut and Canada.

While sometimes used interchangeably, self-government, self-determination and sovereignty are not synonymous, nor do they refer to any single notion held by Aboriginal groups or others (Monture-Angus, 1999). Nevertheless, they are all collective expressions of identity, rights, and responsibilities. "Self-government" is often understood to be the realization of the inalienable rights of individuals to determine and pursue their own options and to give political expression to their perceived nationhood

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[4] I use the term self-determination, rather than self-government or sovereignty, because it is the term I have heard most often with respect to the Inuit mobilization that led to Nunavut. It is also the term that arises most often in documents such as the *Bathurst Mandate* which set the founding principles for the territory.

(Cohen, 1996, p. 270). It is, however, only a "limited form of governance" within a broader political power (Asch, 2002, p. 66; Monture-Angus, 1999, p. 29; see also Sunseri, 2000, p. 144). Sovereignty movements, on the other hand, aim to own the nation, privileging national boundaries. These movements assume that power or authority can be permanently transferred from individuals to an abstraction of the collective called "government" (Monture-Angus, 1999, p. 30). Jorge Valadez (2001) suggests that self-determination for ethnocultural groups should be understood as variously conceived, and as an "an integrated, overarching principle, or cluster of rights and resources, which links a number of important human rights with certain social and political institutional patterns" (p. 150). Self-determination is, thus, not simply about ownership or about the limited ability to govern by means of particular institutions. It is about rights *and* responsibilities, capturing a wealth of understandings that communities and peoples associate with their struggles as communities and peoples (Monture-Angus, 1999; Valadez, 2001). Hence, self-government is the political bodies that institutionalize self-determination so that people may govern (Jonsson, 1997, p. 69; Monture-Angus, 1999)

Prior to the First World War, the concept of the "self" in international discourse on self-determination was most often related to the right of "nations" to establish nation states (Jonsson, 1999). In the post-war era, the "self" in self-determination has come to refer to peoples within a territory bounded by a nation-state who identify themselves as having common interests (Jonsson, 1999; Tyler, 1993). Nunavut, as a territory within Canada, is not a nation, nor do many Inuit refer to themselves as constituting a nation as

many other Aboriginal communities do. At the same time, Inuit self-determination is rooted in a sense of identity that could be defined as nation. Benedict Anderson (1981) defines nation as an "imagined political community" – imagined as both inherently limited and sovereign." The Inuit have conceived of their connectedness as *limited* by some sense of spatial, political and cultural boundaries. It is imagined as a community in that Inuit are so vastly dispersed but define themselves as collective, as "the people." While the Nunavut land claim provides actual ownership over a space and the public government represents a population's whose majority is Inuit, Nunavut is not about sovereignty distinct from Canada. Moreover, Nunavut comprises both Inuit and non-Inuit who together constitute territorial governance within the territory. But it is Inuit, rather than Nunavummiut or northerners, who have shaped a collective struggle for self-determination and the creation of Nunavut.

Self-determination struggles are articulations of citizenship. Citizenship is often thought of in terms of who is or can become a member of a political community, or as the rights that come with being recognized as a member – the "substance of citizenship" (Brodie, 2002, p. 50). Ethnocultural groups within culturally pluralistic states, such as Canada, that seek autonomous self-determination undermine the assumption that all members of the polity are equally obligated to recognize the political authority of the state because of their consent to its political institutions (Valadez, 2001, p. 9). Settler societies such as Australia and Canada challenge our assumptions about citizenship. Notions such as 'Aboriginal,' 'immigrant,' and 'settler' citizenship become political constructs and cultural artifacts with discursive meaning and material implications

(Pearson, 2002, p. 1000). Aboriginal resistance and flexibility play constitutive roles in the formation of rule and government in movements of self-determination so that "self" and government hybridize (O'Malley, 1996).

Citizenship can be conceived as discursive, constituted through processes of meaning-making and constituting political practice (Menzies, Adomoski, and Chunn, 2002, p. 20). From this perspective, the identifier – "Aboriginal" can be more appropriately viewed as resulting from the "relation between state-organized colonizers and non-state peoples" (Pearson 2002, p. 1001). Brodie (2002) suggests that we examine citizenship as a set of practices linked to the broader study of governance. She frames her work within Foucault's analysis of governmentality where government is a way of thinking about our conduct and regulating that conduct. While "government" refers to the "Government of Nunavut" or the federal government, "governance" refers to a web of political rationalities. While governance has become an important issue in social science and policy research, there remains a lack of consensus as to what "governance" means and a great deal of ambiguity exists around the relationship of governance to development, institutional reforms, and public policy processes and outcomes (Olowu, 2002; Pierre and Peters, 2000). Governance, Brodie (2002) suggests, is "the historically shifting and politically negotiated (and enforced) relationships among the three principal domains of a liberal-democratic polity – the state, civil society and the economy – as well as the ways in which citizens and groups articulate their interests, exercise their rights and obligations, and mediate their differences" (p. 54). Policy, planning, and delivery are discursive expressions of those relationships and the political rationalities that shape

them. To explore health policy, then, we need to consider it to be a product of problematizations rather than a reaction to objective problems (Osborne, 1997, p. 174). Governance includes the entire range of activities of citizens, elected representatives, and public professionals as they create and implement public policy in communities (Box, 1998, p. 2). From this perspective, Beck's (1994) "subpolitics" – comprising individual, social and collective agents[5] outside the political or corporatist system – is no longer distinguishable from politics; they do not compete from a clearly separate location.

As a largely Inuit territory, Nunavut is meant to bring Inuit into local and territorial decision-making processes. Inextricably linked to the principle of democratic participation is the sharing of government decision-making (ie., among citizens, experts and elected officials) (Abelson, 2001, p. 777). Citizen engagement can be seen as a policy instrument where citizens, through their democratic participation and interactions with experts and elected officials, contribute to governance. A growing desire to engage citizens more meaningfully in public policy decisions has challenged researchers and policy makers (Abelson and Eyles, 2002). For instance, the recently completed Commission on the Future of Health Care in Canada ("The Romanow Commission") engaged citizens through website forums, public hearings, and citizen dialogues (Commission, 2002). There is growing recognition that meaningful citizen engagement is about good process: responsive agencies/decision makers, motivated participants, high

[5] This group includes professional and occupational groups, the technical intelligentsia in plants, research institutions and management, skilled workers, citizens' intitiatives, the public sphere and so on (Beck, 1994, p. 22).

quality deliberation, and a degree of participant control/power sharing (Beierle and Cayford, 2002). Valadez (2001) suggests that "deliberative democracy" is a requirement of multicultural democratic society (p. 5). This deliberative democracy is based on reasoned public deliberation as a means by which citizens can arrive at policy decisions that are collectively binding and generally justifiable (Valadez, p. 5). But strategies to involve the citizens in decision-making processes tend to ignore socio-economic, institutional, or political contexts within which decisions are being made (Abelson, 2001). Abelson (2001) identifies three kinds of contextual factors that influence public participation: pre-disposing influences (the structural and social context of the population), enabling influences (institutional factors), and precipitating influences or catalysts (interests and interest groups).

In Nunavut, the potential for engagement is bounded, in part, by territorial-national, North-South, Inuit-non-Inuit relations. In crafting Nunavut, Inuit have not attempted to leave Canada but are framing self-determination within the context of coexistence. Many see such coexistence as necessary to the achievement of self-determination. This coexistence suggests some element of common belonging and allegiance to a single polity by Aboriginal and non-Aboriginal peoples if it is to flourish (Cairns, 2001, p. 28). Framing Nunavut this way means that Inuit "must contend with the claims and interests of a much larger non-Aboriginal public beyond (and present as a minority within) their borders," responding to criteria of political legitimacy that transcend their Aboriginality and cultural distinctiveness (Scott, 2001, p. 11). Meanwhile Indigenous claims to land and rights undermine, threaten, or complicate relationships that

our settler-society has established with land and nationalism (Moran, 2002; Mackey, 1999). Multiculturalism and indigenous rights put the 'body politic' of the nation at risk (Mackey, 1999, p. 110). Nunavummiut persistence and determination force Canadians and their governments to review many assumptions and habits of public policy, and expands the national outlook (Jull, 2000, p. 16).

Some may argue that Foucault's analysis of governmentality cannot contribute to a reformulation of how health care can be governed or regulated, rendering it of little use in examinations of health policy (Osborne, 1997). But Foucault's questioning of the relationship between those who are governed and those who govern is crucial to understanding health governance. Foucault's work provides a starting point for exploring "the strategies, techniques and procedures through which different authorities seek to enact programs of government" (Rose, 1996, p. 41). Rather than the simple application of policy, Foucault's work draws our attention to the constitution of authority, relations between the state and space of government, and styles of government (Osborne, 1997).

Many criticize Foucault (and post-structuralists more generally) for rendering social and collective struggle meaningless. Some argue that the post-structuralist celebrates fragmentation at the expense of agency, the accountability of political agents, and movements for change. They call for resituating the production of identities in the systematic investigation of power relations, paying heed to discursive hegemonies but not at the expense of rigorous, empirically grounded analysis and an insistence on concrete social change (Amit-Talai and Knowles, 1996, p. 14). But Foucault's post-structuralism does not reject the notion of agency nor does it make identity-questions or empirically-

based research impossible or irrelevant. Rather, his approach brings a different set of questions to sociological exploration. Foucault's approach privileges a notion of the self establishing a relation with the self, rather than the self as embedded in and formed through types of social interaction (Bell, 1996, p. 93). Foucault sees public space as a discursive space. This facilitates a new notion of power, not as something that is held and wielded, but as discursively created and, as a result, being everywhere and in anytime (Bell, 1996). Struggles for self-determination are better framed in terms of Foucault's and Hannah Arendt's[6] notions of freedom as action, as resting on a subject who is engaged in the present, rather than will or sovereignty (Bell, 1996, p. 91).

Foucault has been cast as a pessimist, because he suggests that attempts to escape strategies of power are themselves entangled in power/knowledge networks (Bell, 1996, p. 83). That being said, Foucault's point is to show us that we are "freer than we think we are"; that a "zero sum conception of power is one that has limited our political visions, directing them away from the possibilities in the present and on to the hope of some future radical change" (Bell, 1996, p. 83). Once we recognize that our aims or intents are products of power relations, these aims become "contingent and arbitrary."

Applying an analysis of governmentality to the case of health care in Nunavut raises several questions: What shapes the struggles for health care and self-determination in Nunavut? How do Inuit and non-Inuit come to think about who they are in Nunavut and what are the consequences of this for health, health care, and self-determination?

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[6] Bell (1996) explains that Arendt criticizes Rousseau's suggestions that individual willpower will bring freedom, as simply replacing one willpower for another.

Before non-Inuit people can explore or understand issues that Inuit face, we (non-Inuit) must examine how our perceptions of these people are already structured (Buege, 1994). Challenging preconceived notions that strengthen colonialist subjugation is central to this project. As a non-Inuit I cannot set out to depict, describe, or define Inuit life or Inuit notions of health or self-determination. Nor can I ever really understand the issues that Inuit face, their experiences, and their own understandings. But I can engage in dialogue with people and call into question my own assumptions. I can explore the rationalizations behind current and past governance structures. I can listen to how people describe their struggles for change and visions for the future. In the following chapters, I explore what such struggles and visions tell us about dominant assumptions and practices in Canada and how these can be challenged and reframed. Post-structuralism facilitates this exploration but, despite its challenge to dominant discourse, indigenous approaches and voices remain significantly absent (Smith, 1999, p.167). This absence is also apparent in post-colonialism but because of its specific epistemological concern with colonial and post-colonial relations, post-colonialism offers the possibility of generating approaches from diverse value systems and worldviews.

V A Theory-in-Progress

My theoretical approach is "theory-in-progress"[7]: it remains flexible and open to multiple perspectives and potential change. In exploring health, health care, and self-

[7] I borrow this term from Karen Warren who describes her philosophy as a "theory-in-progress", informed by feminism, science, development, technology, and local and indigenous knowledges (Buege, 1994, p. 101).

determination in the new territory of Nunavut, my approach is post-structuralist in the sense that it aims to deconstruct discourses around health, the Canadian North, and Inuit struggles for self-determination. Foucault's post-structuralism and his analysis of governmentality direct me to an exploration of the relationship between subjectivities and health governance. Post-colonialism subverts and problematizes master-narratives.

In the following chapters I explore the intersection of health governance and new territory building by looking at the discourse of health and strategies of citizen engagement in health governance. In the next chapter, I explain how this theoretical framework guides my methodology. I outline my choice of specific research and analytic methods and how these aim to expose the potential for multiple shifting meanings of various texts.

CHAPTER THREE

Methodology

To explore the intersection between Nunavut's unique status as a largely Inuit territory and health governance, I have employed a qualitative methodology informed by both post-structuralism and post-colonialism. My intent has not been to describe or define life in Nunavut or Nunavummiut notions of health or self-determination. Rather, I have examined practices of meaning-making related to health, health governance and self-determination in the context of new territory building. In exploring discontinuities and shifts in meaning-making, I have considered how these practices are part of relations of power. Within this exploration, my intent has been to draw on methods that prioritize voices of participants while at the same time acknowledging that my own interpretations will act continually on the research endeavour. Like other interpretive approaches, a post-structuralist approach prioritizes lived experience but foregrounds researcher and textual reflexivity so that the researcher's interpretation is treated as just that - an interpretation (Denzin, 1998; Fontana, 1994). Similarly, post-colonialism foregrounds marginalized voices while drawing attention to the processes that marginalize those voices.

In the following sections I explain how the specific methods of my qualitative approach aim to deconstruct dominant assumptions by foregrounding multiple interpretations. I begin with a discussion of the ethical and political considerations that have ultimately guided this study. I then explain my approach to fieldwork and to

various texts including interviews and various public documents. I conclude with an explanation of my analytic approach.

I The Ethics and Politics of The Project:

Any research process requires, as a first step, confronting the ethics and politics of the project (Denzin, 1998). Confronting the ethics and politics of this particular study has not simply been a first step but has held significant constancy throughout this project. Aboriginal peoples around the world are calling attention to the ways in which they have been over-researched and exploited by "experts" aiming to prove, discover, and prescribe solutions (Smith, 1999; NAHO, 2002; Royal Commission, 1996a; Battiste, 2000). In so doing, they suggest that research is political. As researchers, non-Aboriginal or Aboriginal, we have to consider where we are located within the politics of research. My research process, therefore, began with an exploration of the histories of Aboriginal communities in Canada as well as research traditions that have been used on Aboriginal communities.

The process of achieving ethics approval put additional emphasis on the need to consider ethical and political aspects of this project. In addition to the McMaster University Ethics Approval process, I was required to apply for approval and licensing at the territorial level. Any research project that takes place in Nunavut, regardless of the discipline, must be licensed by the Nunavut Research Institute. This licensing process ensured that the study met the ethical guidelines set out by northern communities and

decision-makers. Moreover, it ensured the communication of my research intents to community leaders and sought permission to conduct this research in their communities.

Ethical and political considerations make continual demands on me as a researcher and on this project. One of my greatest challenges has been reconciling my non-Inuit, Southern researcher status with a keen interest in working on a project that could be meaningful to me, *as well as* project participants and related communities. There exists a great divide between South and North, non-Inuit and Inuit, non-Aboriginal researchers and Aboriginal communities due to the colonialist history of Canada and the social sciences. In its concern with defining "legitimate" knowledge, research has been part of the colonization process (Smith, 1999, p. 173). Smith (1999) suggests that in any cross-cultural context, researchers need to ask: Who defined the research problem? For whom is this study worthy and relevant and who says so? What knowledge will the community gain from this study? What knowledge will the researcher gain from this study? What are some likely positive outcomes from this study? What are some possible negative outcomes? How can the negative outcomes be eliminated? To whom is the researcher accountable?

These questions have been ever-present throughout my research process. The questions I attend to are certainly mine. The academic institution, limited time, and funding restrict the graduate student in various ways, encouraging, and supporting self-defined and self-lead research projects. But I believe the project may be relevant for a number of communities because of the recent creation of Nunavut and what it means for Inuit, the North, and Canada. Furthermore, the project reflects my interest in challenging

dominant discourses that I as a Southern, non-Aboriginal Canadian of European descent play a part in supporting. This research has also challenged my own assumptions and my position as a non-Aboriginal researcher. I remain continually aware that the interviews, group discussions, and the other texts I have read have all been filtered through me and my own biography. For this reason I have chosen flexible, qualitative methodological tools which allow for multiple voices and open the research process to a range of issues and questions raised by participants.

The process of collecting "data", leaving the community, and claiming ownership over "knowledge" perpetuates the colonization of Aboriginal peoples (Denis 1997). As a non-Aboriginal researcher, I am particularly concerned about how my research marginalizes Aboriginal voices. Claude Denis (1997) argues that it is reductionist and simplistic to suggest that non-Aboriginal people have no option but to be silent. The challenge for the non-Aboriginal person should be to find ways of doing research that is about "us and them", that is in a spirit of dialogue (Denis, p. 45). In the spirit of dialogue I have attempted to open up the research process to a diversity of voices and I have engaged in ongoing consultation with project participants. I also had the opportunity to present preliminary ideas to open community meetings in Rankin Inlet and Iqaluit in the fall of 2002. Upon completion, I will provide participants with a final summary report and I will submit final copies to the Nunavut Research Institute, the Government of Nunavut's Department of Health and Social Services, and Nunavut Tunngavik Inc.

PAGE 47 & SHE'S STILL JUSTIFYING THE UNDERSTANDING

II Fieldwork:

I use the term fieldwork to refer both to my entire qualitative research experience, encompassing several methodological tools and processes, as well as a specific method of engaging with particular geographical, social and political spaces. In early ethnography (1900s to WWII), fieldwork conformed to the positivist scientist paradigm, aiming to define and develop laws and generalizations and offering "valid, reliable, and objective interpretations in their writings" (Denzin and Lincoln, 1998, p. 13; see also Gupta and Ferguson, 1997). Later[8], the Chicago School's narrated life history approach led to the production of texts that gave the researcher-as-author the power to represent others' stories. The 1970s and 1980s brought a broad range of methods and perspectives and Clifford Geertz's 'interpretations of interpretations'. This ushered in the crisis of representation which problematized writing, challenged objectivism, researcher complicity with colonialism, and ethnographies as monuments to a culture (Clough, 1992; Denzin and Lincoln, 1998, p. 20). As a Western travel practice, fieldwork had been grounded by a historical vision, what Gayatri Spivak calls a "worlding", in which Indigenous authorities were reduced to native informants (Clifford, 1997, p. 207; Spivak, 1999). Today, linguistic, interpretive, and rhetorical turns have brought a double crisis of representation and legitimation. This double crisis suggests that lived experience cannot be captured but is created in the social text. It calls attention to interpretive quality of

[8] Denzin and Lincoln (1998) refer to the period between WWII and the 1970s as the Modernist period or the "golden age" of rigorous qualitative research. This period was marked by social realism, naturalism, attempts to formalize qualitative methods, rigorous qualitative studies of important social processes (p. 15).

writing! Secondly, it makes the traditional criteria for evaluating and interpreting qualitative research problematic; requiring that we rethink such terms as validity, generalizability, and reliability (Denzin and Lincoln, 1998, p. 21-22).

Practicing decolonized anthropology or sociology in a "deterritorialized world" means doing away with the distancing and exoticization of the research "field", and foregrounding the ways in which we are historically and socially linked with the areas we study (Gordon in Gupta and Ferguson, 1997, p. 38). This requires that we decentre "the field" as the privileged site of knowledge, and recover it as a "methodology for the construction of what Donna Haraway (1988) has called 'situated knowledges'" (Gupta and Ferguson, p. 38). By decentering "the field" Gupta and Ferguson suggest that we might facilitate a move away from "the field" as outside, to a mode of study that attends to the interlocking of multiple social-political sites and locations. Rather than develop or contribute to knowledge of "another society," fieldwork can be a way of appreciating the complexities of peoples and places. Such an approach would not only decentre the field but also the researcher as expert.

While the "field", in this study, might be thought of as Nunavut, I believe it is better understood as Nunavut and Nunavut communities within the context of a struggle for self-determination, relations between other territories, provinces and Canada, North America and the rest of the world, and as part of the Circumpolar North as a political and geographic region. More specifically, the field throughout this project refers to my experience of or relationship with social, political, and geographical spaces rather than a particular location with clear boundaries and characteristics.

My fieldwork took the form of several trips to three Nunavut communities (Iqaluit, Igloolik, and Rankin Inlet) from March 2001 to March 2002. Breaking up fieldwork in this way not only decentred the primacy of immersion, it also provided the opportunity to reflect on my experience, how my own assumptions influenced fieldwork processes, and changes that I could make for the next trip to better facilitate a forum of open communication. This approach to the field involved confrontations with constructions of North and South in both Northern and Southern spaces.

My choice to break the fieldwork into trips to three communities was also precipitated by the high cost of living in Nunavut. Due to the high cost of housing and food throughout the territory, living in a community would have required working in a community. Because communities are so small, such work, regardless of where it was, would have likely created further distance between me and the people who participated in this project. For example, if I worked for the Government of Nunavut this project may have been regarded by some as a GN project. Undoubtedly there would have been perceived ownership or bias. On the other hand, by living in a community I would have learned a lot more about life in Nunavut as a southern person and would have become acquainted with far more people, processes, and much more with the politics of a particular municipality. This was not an option. But my approach allowed for the kind of flexibility that Gupta and Ferguson suggest fieldwork can have. Furthermore, it transformed my notion of the field from a particular community to a range of community and North-South experiences. It contributed to a project that is much more about North-South relations than about any attempt at defining the North or Inuit.

My fieldwork included becoming acquainted with Nunavut, the Government of Nunavut and the DHSS, NTI and other Inuit representative organizations, northern media, health centres, and Inuktitut. I attended public meetings and events, visited health care centres, and spent time in and around communities. Experience in the field complemented and consisted of interviews, workshops and exploration of various other texts. This experience took place in a range of communities including Nunavut, Iqaluit, Igloolik, Rankin Inlet, and Canada.

Community Profiles: [9]

Nunavut:

In 1999, Nunavut (Appendix A) added a third Northern territory to Canada's geography. Geographically, Nunavut is one fifth of Canada's land mass (1.9 million square kilometres), 60% of what was the Northwest Territories and includes most of the Canadian Arctic Islands. Eighty-five percent of Nunavut's population is Inuit and 56% of the territory's population is under 25 years of age. This predominantly young, Aboriginal population is scattered over one fifth of Canada's land mass (Lanken and Vincent, 1999, p. 39). It has an economy based primarily on fishing, hunting, trapping, oil, gas, arts, crafts, and tourism. When I embarked on this project, I was struck by how physically huge Nunavut is and how unbelievably stunning. I was also shocked at how little I knew of the North in general. The North was largely a place that resided on the map and in my imagination. While my awareness was somewhat lacking, I was

[9] Population figures and percentages in these community profiles are based on Statistics Canada 2001 Census Population and Dwelling Counts (Statistics Canada, 2001).

convinced that the creation of Nunavut was a huge event that had touched all Canadians. As a result, I was and am continually surprised by Southern Canadians who ask where Nunavut is and/or what it is – even *three or four years* after its official creation. So many Canadians still seem oblivious to the creation of Nunavut and its significance geographically, politically, and socially.

Long before Nunavut became a Canadian territory it has been an Inuit place. The Inuit have always referred to the Central and Eastern Arctic as Nunavut which means "our land" in Inuktitut. Inuit means "the people" and Inuk, the singular form of Inuit, means "the person." Nunavut's non-Inuit population consists largely of Canadians of European ancestry, both Anglophones and Francophones.

Nunavut comprises three distinct regions (Qikiqtaani, Kivalliq, and Kitikmeot), twenty-eight communities and has a population of 26,745. Its three regional distinctions are partly a result of administrative divisions of the Government of the Northwest Territory and the federal government, as well as historical linkages between Inuit communities and hunting and fishing practices. Iqaluit is the largest community and capital of Nunavut and the Qikiqtaani (or Baffin) region. This region has the largest population (14,372) and is the most Eastern of the three. It encompasses Baffin Island as well as some of the Islands to the north west – approximately half of Nunavut's land mass (twice the size of the two other regions). Kivalliq (known also as Keewatin) region has a population of 7,557 while Kitikmeot has a population of 4,816. The Kivalliq region encompasses the region north of Manitoba, east of the North West Territories, south of the Kitikmeot region, and west of the Hudson Bay. Kitikmeot borders the Kivalliq region

to the South as well as a small piece of the Northwest Territories. It has the smallest population and has no direct air travel with communities outside of Nunavut.

Iqaluit:

Fieldwork, interviews and document collection took place primarily in Iqaluit because of its relatively large population, its status as the territory's capital, and because it is home to the seat of territorial government and offices of many Inuit non-governmental organizations (NGOs). My research-stays in Iqaluit were further facilitated by the presence of the Nunavut Research Institute lab, library, and researcher support as well as the accommodations I had arranged.

Iqaluit is just south of the Arctic Circle at 64 degrees north and is about 2,000 km from Ottawa. At summer solstice the community experiences twenty-four hours of sunlight and in December only six hours. The -30 degrees of my first day in Iqaluit stood in stark contrast to the blossoming springtime in Southern Ontario. Iqaluit experiences twenty four hours of daylight in June and six hours a day in December. Throughout the project, I had the opportunity to experience both the subtle and severe seasonal changes in Nunavut.

Iqaluit means "place of fish" in Inuktitut. Prior to the establishment of Nunavut, Iqaluit was also known as Frobisher Bay. It is located on the southeast of Baffin Island and is the largest community in Qikiqtaani with a population of 5,236 in 2001. It encompasses 52 square kilometers, spread out along the shore of Koojoose Inlet. Iqaluit comprises both the area that is referred to as Iqaluit and the area called the Apex which is set apart from Iqaluit by several kilometers and is in some ways a distinct community.

Iqaluit has grown around what had been the American Airforce Base and the Hudson Bay Company. The main part of town sits next to the airport and what was the base. The Apex is the area where the Hudson Bay Company post was and is set apart from Iqaluit by a few kilometers but is considered part of the city. The distance between these two parts of Iqaluit is a marker of its colonial history.

When I first arrived in Iqaluit I was struck by how large it was. I had expected a smaller community resembling the northern outposts of colonial tales. I arrived to a busy airport and busy noon-hour traffic. Iqaluit, incorporated as a city in April, 2001, has experienced a population increase of 24% since1996. Eighty-five percent of Iqaluit's population is Inuit. This is a significant change from 1957 when only 489 of the 1200 people in Iqaluit were Inuit. By 1996, 61% of the 4220 were Inuit. It is the seat of the territorial government and is very much a government town with large territorial legislature and federal buildings. It has the only hospital in the territory while the other communities have health centres or nursing stations. Iqaluit also has a public health office, the Nunatta Campus of Nunavut Arctic College and its student residence, the Nunavut Research Institute head office and research centre, a busy airport, a museum, a public library, galleries, several banks, a Northmart department and grocery store, a co-op grocery store which also houses a significant northern book section, a QuickMart, several hotels, movie theatre, bed and breakfasts, and restaurants. It has an Elders Hostel, a women's shelter, a high school, middle school, elementary school and Catholic, Anglican, and Pentecostal churches as well as a Ba'Hai centre. It is the transportation hub of the Baffin Region and much of Nunavut and until last year it connected Canada to

Greenland with direct flights. It is a growing community with a great deal of new construction – both residential and commercial. Nunavummiut make a point of distinguishing between Iqaluit as a busy government town or city and other Nunavut communities as "the communities."

Rankin Inlet:

> Ask someone from Nunavut for their first impression of Rankin Inlet, and they may tell you about the wind (Onalik, 1998, p. 203).

I first arrived in Rankin Inlet (Kangiqllinik in Inuktitut – meaning deep bay or inlet) as summer ended and autumn began. Rankin Inlet is on the Northwest shore of the Hudson Bay and experiences severe winter storms and autumn begins and ends quickly. The land surrounding Rankin Inlet is much more accessible than that of the hilly region surrounding Iqaluit. As a result, many people in Rankin Inlet have temporary tents or more permanent camps out on the land where they spend much of the summer fishing, hunting and berry picking. In winter, Rankin Inlet experiences some "ferocious Kivalliq winds" and "blizzards wreak havoc with flight schedules" (Onalik, 1998, p. 207).

The hamlet of Rankin Inlet, at 63 degrees north, is the second largest community in Nunavut and is the largest community in the Kivalliq region. Eight-five percent of Rankin Inlet's population is Inuit and it has a 20 square kilometer land mass. Its population of 2,117 has increased 5.8% since 1996. The settlement of Rankin Inlet formed largely due to the establishment of a nickel mine in the 1960s. Many Inuit families moved to the area so that men could go to work in the mine. A "rehabilitation centre" was also established in Rankin Inlet and ran from 1960 to 1963 (Grygier, 1997, p. 148). This centre was closed in 1963 when the federal government decided to phase out

the settlement of Rankin Inlet because the nickel mine was due to shut down (Grygier, p.148). Despite the mine closure, and several other development "experiments", the settlement persisted (Onalik, 1998). Rankin Inlet is now home to Kivalliq campus of the Nunavut Arctic College, the Northern grocery store, a Co-op grocery store, the Adult Learning Centre, a high school, middle and elementary schools. It has an art gallery and a pottery that hosts many training programs and provides workshop space for local potters. In addition to its health centre it has a birthing centre, the only publicly-funded, midwifery-based birthing centre in any of the territories. This was the primary reason I chose Rankin Inlet as one of the three study communities. It has a history of whaling and mining and when the mine closed many miners participated in the newly established pottery, which continues today. It is also described as a government town and is the transportation hub for the Kivalliq region.

Igloolik:

> Igloolik is on kind of a u-shaped island with the community inside the inlet (Rhoda Kaujak Katsak in Wachowich, 1999, p. 155).

By late November, the hamlet of Igloolik experiences only a few hours of daylight during which the sun stays very close to horizon. The ocean is frozen for hundreds of miles and its snowy surface records the snowmobile tracks of the many winter fishing and hunting trips that have already taken place.

Igloolik (or Iglulik, "place of houses"), the geographic centre of Nunavut, is about 200 miles north of the Arctic Circle at 69 degrees north and has a population of 1,286, 95% of whom are Inuit. It has a land mass of 102.87 square kilometers encompassing the entire island just North of the Melville Peninsula. What is considered the hamlet of

Igoolik is on the south east tip of the island and is a fifteen minute flight from Hall Beach to the Southwest. It is in the Baffin Region but borders the Kivalliq and Kitikmeot regions as well. It is often referred to as the "cultural capital" of Nunavut because of the role that Igloolik community members have played in preserving the Inuktitut language, supporting Inuit art, and because it is home to film making collectives, including Isuma Productions Inc. whose co-founders Zaccharius Kunuk and Norman Cohn created the film *Attarnajuat: The Fast Runner*. It has a health centre, a community radio station, a local televised news program, a hotel, a Northern grocery store and a Co-op, a Headstart program, a local office of the Inuit Broadcasting Corporation, as well as the Nunavut Research Institute's Igloolik lab and research centre. It boasts great fishing and has "long been blessed with abundant natural resources central to Inuit culture and identity" (MacDonald, 1998, p. 248). For this reason, Igloolik has a long history as an Inuit meeting place.

Northern and Aboriginal Canada:

Canada (Appendix B) is often referred to as a Northern country and both Canadians and non-Canadians invoke the Arctic and the North when representing Canada. However, Northern Canada (north of the 60th parallel) is, in many ways, quite distinct from Southern Canada. This region north of the 60th parallel includes the three territories as well as Nunavik (the Ungava Peninsula) in northern Québec (a largely Inuit region). It is part of the Circumpolar North which comprises Canada, Greenland, Northern Russia, Finland, Norway, Sweden, Alaska, Iceland, the Arctic Ocean as well as the far north Atlantic and Pacific Oceans.

The Canadian North has a much higher concentration of Aboriginal residents (including Dene, Inuit, and Innu as well as others) than most of Canada but is sparsely populated. In 1996 only 20% of Yukon's population was Aboriginal but 62% of the Northwest Territories' population was Inuit, including the Inuit of Nunavut. In 1996, 5% of Canada's Aboriginal population was Inuit and 6% of the Aboriginal population lived in the North. Inuktitut represents 3.4% of Aboriginal languages, making it the second largest Aboriginal language group in Canada. In 1996, two thirds of Canada's Inuit population (approximately 27,000 people) reported Inuktitut as their mother tongue. Knowledge of an Aboriginal language was most widespread in Indian reserves and settlements (56%) and the lowest in urban areas, both in census and metropolitan areas (11%) and other urban areas (18%). The Aboriginal population in Canada is approximately ten years younger than the general population. In 1998 more than half of the Inuit population under age fifteen (9,000 children) spoke Inuktitut at home. In Canada, although the fertility rate among the Aboriginal population is declining, this population continues to grow more rapidly than the total population.

III Many Voices

Apart from the many informal connections I have made through field experience, my primary methods of engaging in dialogue were through forty-one in-depth, semi-structured interviews and three issue-based collective discussion sessions. I also immersed myself in hundreds of transcripts from interviews conducted for the Igloolik Elders Project. Since 1986, the Inullariit Elders Society of Igloolik has collaborated with

the Igloolik Research Centre to gather oral history from its Elders. Transcripts of these interviews (in both Inuktitut and English) are held in the archives of the Inullariit Society, Igloolik Research Centre, Igloolik, NWT and at the Northwest Territories Archives, Prince of Wales Northern Heritage Centre, Yellowknife, NWT.

During my stays in the three communities, many participants were pleased to talk with me about their experiences, understandings, and histories simply because of the newness of Nunavut's creation. Some were interested in sharing their experiences with me because they felt I might represent an opportunity to have their voices and concerns heard. The fact that I was not from Nunavut and not connected to any Northern organization seemed to ease many people's minds. It seemed to provide extra assurance of confidentiality. My lack of experience in the North restricted my access to people while the small nature of communities facilitated the process of getting to know people and organizations. Several non-Inuit people that I approached regarding the study expressed some apprehension about me, my intents, and their potential participation and some asked if I had a license prior to any discussion. Prior to interviews and collective discussions, I provided participants with consent forms (Appendices C and D) in both English and Inuktitut. I also provided them with a copy of my research license (Appendix E). While I would like to introduce you to every participant with a brief biographical sketch, it is unlikely that I could do so without compromising the anonymity of participants. Due to the small size of communities and the small numbers of people who occupy particular positions, such biographical sketches would compromise anonymity.

Interviews:

I conducted forty-one (41) in-depth, semi-structured interviews over the course of one year in Iqaluit (26), Rankin Inlet (10) and Igloolik (5). Interview participants ranged in age from twenty to sixty years of age and worked for the Government of Nunavut, non-governmental Inuit organizations, municipalities, local businesses, and/or their families. They included teachers, health care providers, including nurses and Community Health Representatives, social workers, students, territorial decision-makers, territorial planners and managers, artists, other health practitioners, and homemakers. Eleven interview participants were men and thirty were women; twenty three were Inuit and eighteen were non-Inuit; eight were thirty years of age or younger. All of the Inuit participants were raised and lived either all of their lives or most of their lives in Nunavut. Of the non-Inuit participants one was born and raised in Nunavut, twelve have lived in Nunavut for more than ten years and seven of these have lived in the North for more than twenty years.

Participants were identified through purposive sampling. As I spent time in communities and met with people I was able to connect with others. In some cases interviewees contacted me after hearing about me and my project from another interviewee. As such, my sample is not necessarily representative of any group. Some interview participants were identified and invited to participate based on their participation in policy-making, planning, and health care delivery. Other participants

were self-selected as others passed along information about the project along with my contact information.

Ten interviews were tape-recorded while thirty-one were not. In several cases participants asked not to be recorded. Each participant chose the location of their interview. In some cases the setting was not suitable for tape recording due to the background noise or because the recorder would have drawn unwanted attention. Several interview participants asked to conduct their interviews in coffee shops or restaurants. These settings were too noisy to tape record. For some I did not tape record because I felt the recording device would be an added barrier between myself and the participants. Interviews were only audio-taped if the participant consented to taping. In cases where I did not tape record, I took detailed notes which I later transcribed as I did for all interviews.

All interviews were transcribed and, where possible, participants received a copy of the transcribed interview. In some cases it was not possible to locate the participant because they had left the position they had had at the time of the interview and moved out of the community. Most participants received transcripts and were asked to review the transcript and forward any changes or additions to me. Several people sent further comments and three edited primarily for correct spelling of place and people names which have been subsequently deleted for confidentiality purposes. Confidentiality was assured and outlined on the consent form that participants received prior to interviews. In transcribing interviews, and in the written analysis, I have maintained confidentiality by deleting place names, workplace identifiers, and other names or events that may be

related back to the individual interviewee. In the following chapters I refer to participants simply as participants and when it contributes to the discussion I add the gender, general work identifier, or whether they are Inuit or non-Inuit.

To provide some structure for the interview I used an interview guide (Appendix F) but each interview took the form of a conversation. The guide was used to spark discussion. In interviews participants discussed health experiences, health care use, understandings of health, health care, Nunavut, and Inuit self-determination, territorial and health care governance. All interviewees were very proficient in English so translators were not necessary. Participants were invited to use Inuktitut when they wished to and asked to provide a translation, and in some cases participants wrote down specific phrases and words in Inuktitut so that I could go back to them later.

Issue-Based Collective Discussion:

In addition to interviews with individuals, I facilitated three informal and unstructured group discussions with groups of three people, one in each of the study communities (Iqaluit, Rankin Inlet, Igloolik). Collective discussion participants were self-selected. In each case, one participant suggested a group discussion to address a particular issue that they felt was relevant to my project and invited the other participants. They ranged in age from thirty to sixty-five and all were Inuit. Collective discussions were not tape-recorded. In two of the three groups participants were women and in the third all men. These collective discussions were exploratory and my role as the facilitator was moderately nondirective. One group addressed issues related to employment in the health and social services sector in Nunavut. Another addressed birthing practices and

access to health services. The third group focused on the notions of self-government and self-determination and the future for Inuit of Nunavut. In all cases, the groups suggested the issue on which they wanted to focus. Rather than bringing a series of questions for each group, the groups' interests framed the discussions, decentring my position as *the* researcher and enabling me to spend more time listening.

In providing for collective discussion these meetings added another dimension to the project. Collective discussion has the advantages of being data rich, flexible, stimulating to respondents, recall aiding, and cumulative and elaborative, over and above individual responses (Fontana and Frey, 1998, p. 55). Such discussion enabled participants to discuss ideas of health, health care services, and self-determination with each other and to explore areas that may not arise when discussing these areas with me, an outsider. Furthermore, it facilitated greater use of Inuktitut as participants could translate for each other and check with each other on certain things in Inuktitut before sharing them with me. Group interviews are not new in sociology and usually take the form of a focus group where the interviewer's role is directive and the aim is to have certain questions answered (Fontana and Frey, 1998). Taking our research process beyond the interview or traditional notions of the focus group provide a richness that is often missed in other approaches. Collective work may also enable participants to gain something from the experience. These discussions added a further dimension to participant experiences by framing discussion around an issue of their choice.

Igloolik Elders Project:

Since 1986, the Inullariit Elders Society of Igloolik, in collaboration with the Igloolik Research Centre[10], has carried out a community-based oral history project known as the Igloolik Elders Project. The purpose of the project is to record and preserve some of the vast amounts of traditional knowledge and cultural perspectives held by the elders of the community. In addition to its goals of language retention, record creation, and gathering family histories, this oral history project identified the goal of recording a body of accessible Inuit traditional knowledge to inform the larger world (MacDonald, 2001). The community felt "that researchers, in general, and biologists in particular, tended to be dismissive of Inuit knowledge" (MacDonald, 2001). In these interviews Elders discussed contact history (including the introduction of Christianity), personal and family histories, social change, dispute resolution and social control, child rearing, traditional medicine and childbirth, spirituality and shamanism, hunting techniques, animal behaviour, skin preparation, tool making, legends and myths, astronomy, local geography and more.

The great body of transcripts from these interviews provided me with the opportunity to read the perspectives and experiences of individuals who do not speak any English but were able to tell their stories in their own language. They were interviewed by other members of their community, making questions and discussion much more meaningful to participants than my questions may have been. Interviews were largely translated by the same two people ensuring consistency (MacDonald, 2001). Because these interviews have all been stored electronically as well as on paper, I was able to

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[10] A branch of the Nunavut Research Institute.

search and explore interviews and then organize findings according to themes. Once organized thematically I was able to examine data in relation to my own interviews and collective discussions as well as various written and visual texts. Material quoted from the Elders' interviews is identified by the Elder's name, the year of the interview, and an interview prefixed by the letters "IE." For an example see page 76.

IV Written and visual text

> A broad range of texts presents different forms of knowledge from varying social and political locations that can make more complex our understanding of various places, people and predicaments (Gupta and Ferguson, 1997, p. 37).

In addition to spoken word, written and visual texts are important parts of my exploration. As outlined below, I have explored articles in print media, government documents (public), public documents from non-governmental organizations, films, and other visual art.

A. News Media

Throughout this project, newspapers and magazines have been important sources of information on events and concerns at a community and territorial level. They have helped me put faces to names, concerns to broader issues and so on. Everything from job postings to breaking news on the resignation of a local NGO leader helped me to better understand issues raised in interviews, collective discussions and other settings. I examined three years (1999-2002) of the two Nunavut newspapers: *The Nunatsiaq News* and *News North*. I also examine articles and editorials in Southern newspapers during

this time (including the *Globe & Mail*, the *National Post*, and *The Ottawa Citizen*) that address Nunavut, Inuit and Canadian Aboriginal issues.

Because of the isolated nature of Nunavut communities, regional newspapers and local radio are central in linking communities and people. *Nunatsiaq News* is an English-Inuktitut weekly newspaper that has served Nunavut and Nunavik since 1973. It is owned and operated by Nortext Publishing which partners with the local Iqaluit, Inuit-owned Ayaya Marketing and Communications. *News/North*, established in 1945, is also a weekly published by Northern News Services. In 1998 it went to a split-run format – Nunavut and the Northwest Territories. *News/North Nunavut* is printed primarily in English with some advertising and editorial in Inuktitut. Northern News Services also publishes *Kivalliq News* weekly in both Inuktitut (syllabics) and English. Both Northern News Services and *Nunatsiaq News* have websites with most of their printed material on-line and extensive archives. In addition to regional newspapers, most communities have local radio stations and CBC-North provides broad northern coverage. Everyone I spoke with agreed that both the CBC and community radio were the most important communication tools in the North. CBC Radio began broadcasting a portion of its programming in Inuktitut in 1960 and now has two stations in Nunavut – in Iqaluit and Rankin Inlet. When visiting people in their homes I found either the radio or television was turned on to local and/or Aboriginal programming. Many communities have local television channels that provide local news and events coverage. Many people also spoke of the Aboriginal People's Television Network (APTN) as an important linking agent

among aboriginal communities across Canada. Local television stations are run by local Inuit and programming is largely in Inuktitut.

While Inuit are featured in Nunatsiaq News as "special to Nunatsiaq News", under "Commentaries" or "Letters to the Editor", they are not often seen as authors of news articles. Rachel Qitsualik has been regularly featured in *Nunatsiaq News* with her column "Nunani" in which she writes about Inuit history, tradition and traditional knowledge. CBC-North Radio has seven Inuktitut shows (some of which are also in English) covering a broad range of topics and broadcasts regional news in both Inuktitut and English. CBC-North Television has two northern news shows: "Igalaaq" (in Inuktitut) and "North Beat" (in English). Inuit and Inuktitut programming dominates local community radio stations such as Igloolik Community Radio and Community Radio Station Clyde River. Nunavut also has an important filmmaking industry with Igloolik Isuma Productions based in Igloolik.

B. Government Public Documents

Government documents highlight the ways in which health, health care and self-determination are problematized at an official territorial level. I examined Government of Nunavut Legislative Assembly Hansards from 1999 to 2002. Within the Government of Nunavut's Legislative Assembly discussion of health and health care arise in two forums: Members' Statements and Oral Questions. In addition, the Legislative Assembly has a Standing Committee on Health and Social Services. I also looked at other Health and Social Services planning and policy documents, Sustainable Development planning and policy documents, and other government documents pertaining to the creation and

building of Nunavut and the provision of health and social services. I also looked at health promotion tools implemented by Health and Social Services including a new smoking cessation promotion strategy introduced in Spring 2001, as well as two short television pieces promoting traditional foods and encouraging smoking cessation.

C. Agency documents

There are several non-governmental organizations (NGOs) that represent Inuit in Nunavut and Canada. The Nunavut Tunngavik Inc (NTI) represents the Inuit of Nunavut at a territorial level and is responsible for the maintenance of the land claims agreement. The NTI has three regional agencies that represent Inuit in these regions. These include the Qikiqtaani Inuit Association, the Kivalliq Inuit Association and the Kitikmeot Inuit Association. These three NGOs monitor institutions of public government to ensure that they are fulfilling their obligations and responsibilities under the NLCA. They work on issues related to health, gender, hunting and fishing, education and training. Up until June, 2002 the Nunavut Social Development Council represented the Inuit with respect to health, social services, and cultural issues and the Government of Nunavut was directed to consult with the NSDC on these issues. Their work is now the responsibility of NTI. Nationally, Pauktuutit Inuit Women's Association and the Inuit Tapirisat of Canada represent Inuit. I explored documents from these NGOs that address building Nunavut as a territory, Inuit self-determination, and health. These include workshop reports, research reports, annual reports, and policy documents.

D. Art, film, storytelling

People contribute to and challenge discourse in many ways. Art, film, and storytelling are three primary ways that Inuit have been attempting to express and share their stories and experiences. These mediums have also been used by non-Inuit in attempting to capture Inuit stories and experiences. I looked at several films including Zacharias Kunuk's (2002) *Atanarjuat, The Fast Runner* and *Nunavut (our land)*, a thirteen episode series (Kunuk, 1995). In 1992, Madeline Ivalu of Arnait Video Productions in Igloolik produced *Women/Health/Body*, a documentary consisting of interviews with thirteen Inuit women. I explored a transcript from this film (Ivalu, 1992). The Inuit have always used various forms of visual expression to tell stories, including carving, tapestry, storytelling, and drawing. With the introduction of new mediums, tools, and techniques Inuit have also become well-known for weaving, ceramics, and tapestries. I explored an exhibit of Inuit woven tapestries at the Canadian Museum of Civilization, the permanent and temporary exhibits at the Iqaluit Museum, Inuit art galleries in Nunavut, Ottawa, Toronto and Vancouver and Canadiana shops (aimed at tourists) in Ottawa, Toronto and Vancouver as well as my encounters with various forms of artwork in Igloolik, Iqaluit and Rankin Inlet.

All of these have aided in further contextualizing and understanding issues that I have confronted through fieldwork and in interviews and group discussions. In exploring these various texts I have attended to the context within which the various texts have meaning and question my own position as the interpreter of the text.

V Interpretation, Analysis and Writing

I have combined these methods to decentre and deconstruct discourses around health, health care, Nunavut, and Inuit self-determination. To decentre, I have interpreted texts in relation to other texts and, in so doing, avoid privileging one (Lemert, 1994). To deconstruct texts I consider how they present particular arguments and how texts relate to one another.

Discourse analysis has been my primary analytic tool in exploring transcripts, field notes, and various other texts. As defined in the previous chapter, discourse is meaning-making and it is the rules and practices that govern what is said. Discourse analysis is thus an exploration of the processes of making meaning or "discursive practices" as relations of power. Discourse analysis is a deconstructive reading of a text, a technique of uncovering multiple and shifting meanings. Foucault's "genealogical method" is deconstructive in that it is an exploration of how certain events contribute to the ways in which we think about who we are. Discourse analysis is not about finding or discovering a truth. It is about interpreting and exploring the assumptions upon which claims are made.

In exploring health governance in Nunavut I have looked at strategies people employ in participating in discourses with attention to relations of power. I have considered how people engage in meaning-making processes and how such engagement is both restricted and facilitated; and I have explored how discourse is challenged and possibly transformed. To deconstruct texts and explore discursive practices I have posed a series of questions when reading each text:

- How does the speaker, writer, artist characterize or represent her/his experience or perspective? What discursive strategies are employed?
- In speaking/writing/creating what is the speaker, writer, artist doing? What meaning-making practices is that person engaging in?
- Where is the text located? How is it part of a broader discourse?
- How does the text centre or locate a particular experience(s)?
- What dominant meanings are expressed in the text?
- What dominant meanings are resisted or challenged by this text?
- What assumptions do I bring to my reading of this text?

These questions are based on Denzin's (1998) suggestion that every social text is a story that can be analyzed in terms of how lived experience is represented in the text, in terms of the relationship between the text and the author, and the reader and the text.

I have asked these questions several times throughout the course of this project. I first considered these questions when reading field notes, reflecting on interviews, and reading transcripts. Interviews, meetings, and time spent in communities were guided by these interpretive processes. Throughout the research and analytical stages of this study, I have maintained contact with many participants and they continue to offer helpful insight and direction along the way.

Due to the volume of texts I had to explore, I required a powerful tool for storing and organizing texts and analysis. As such, I have used NVivo (computer-assisted qualitative analysis software) to store and manage transcripts, documents, and notes.

While it was not possible to store some texts (actual films for example) in NVivo, I have been able to store my notes and make linkages between texts using this program.

I began this project with an interest in how health governance would unfold within this a new territory that has strong ties to both Canada and the Inuit struggle for self-determination. But I did not start out with any hypotheses. Through my engagement in the research and analytic processes, an inextricable link emerged between subjectivity and conceptions of health in shaping health governance. In the following chapters I address this link in several ways. I begin, in the following chapter, with a look at a century of relations between North and South and Inuit and non-Inuit.

CHAPTER FOUR

Constituting a People

> I was not the first to see the shiny object on the horizon on Frobisher Bay that day in 1957, but my questions were answered before reaching the shores of Iqaluit. The shiny objects, part of the Distant Early Warning (DEW) Line radar system, were *naalagutiit* – listening devices from faraway places. A new word was added to my vocabulary. (Hanson, 1998, p. 90).

The discourse of health and health care in Nunavut is part of a history of health and health care in the North and a history of relations between North and South and Inuit and non-Inuit[11]. In this chapter, I examine these relations within the Central and Eastern Arctic – a region now referred to as the Territory of Nunavut – over the past one hundred years. My intent is not to present you with a continuity of events. Instead, I explore events as they relate to the constitution of subjectivities and places, of Inuit, non-Inuit, the Arctic, Canada, and Nunavut. My approach is genealogical in the Foucauldian sense. I explore how certain events contribute to the ways in which Inuit and non-Inuit have constituted themselves and particular places. I am not simply concerned with the ways that European settlers imposed new ways of living and being on the Inuit. I am interested in how Inuit and non-Inuit have shaped each other and Canada.

Over these one hundred years, Inuit knowledge and practice has intersected with European trade and exploration, religious missions, the RCMP, Canada and its

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[11] For other readings of the history of North-South relations in the Eastern Arctic see Alia (1994), Tester and Kulchyski (1994), Duffy (1988), Marcus (1995), Wachowich (1999), Petrone (1988), Crowe (1991), and Pisteolak and Eber (1975), and Oosten and Laugrand (1999).

expressions of national sovereignty, the growth of northern media, the growing dominance of the medical profession, and the southern push for public health care. In the following pages, I look at four specific moments in North-South and Inuit-non-Inuit relations, beginning with the first half of the twentieth century. During this period, the South became increasingly aware of the North and the North of the South. After the Second World War, the Canadian state opted for a more direct administrative role over the region and Aboriginal peoples of the North. Through the 1970s and 1980s, the federal government devolved administrative power over certain areas of public policy to the North. Aboriginal Peoples across the North and throughout Canada began to mobilize and participate in a growing movement for Aboriginal self-government. This gave rise to the crafting and eventual establishment of Nunavut as a separate territory.

My interpretation of these moments is informed by both Inuit and non-Inuit voices. The marginalization of Aboriginal oral history traditions in the writing of Canadian and Northern history has led to an unbalanced history of Canada and Aboriginal peoples (Royal Commission, 1996b). My reading of North-South relations over these one hundred years is informed by both oral and written history-telling. In the following pages, I put written history as recorded by others alongside the oral history-telling that participants shared with me, as well as other oral history-telling that is now documented in many places.

I Regimes of Truth Collide

With its acquisition of Rupert's Land and the North-Western Territory[12] following Confederation the Canadian government "considered itself to be both the rightful and the de facto ruler of the North" (Grygier, 1997, p. 40). An imperial proclamation of 1763 had recognized Aboriginal treaty rights[13], and hence their identity as separate nations, but they were not invited to the table at Confederation in 1867 (Ignatieff, 2000, p. 59). In 1876, the Government of Canada established the Indian Act which stated who was and was not "Indian." While the Inuit were not included in the notion of "Indian" at this time, the Indian Act set the stage for Aboriginal and non-Aboriginal relations. The Indian Act excused Aboriginal peoples "from certain obligations of citizenship, such as paying taxes, while denying them the right to represent themselves, to organize as a free people, and to control the lands and resources they depended on for their livelihood" (Ignatieff, p. 59).

From the late seventeenth century[14], the Far North saw the South through European explorers, traders, and missionaries. The first half of the twentieth century was a time of increased southern exposure to the North and northern exposure to the South. Groups with no direct contact with southerners came to depend on items such as iron, tea,

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12 Rupert's Land included the hydrographic basin of the Hudson Bay (what is now Manitoba, most of Saskatchewan, part of southern Alberta and northern Quebec and Ontario). The North-Western Territory consisted of the areas to the north and west of Rupert's Land. In 1870 these were renamed the Northwest Territories when Canada purchased the territories from the HBC (National Library of Canada).

13 By 1876, Aboriginal people living in Eastern Canada, Quebec, British Columbia, the Yukon and Northwest Territories had not entered into relations with the Canadian state through treaties.

tobacco, and firearms (Brody, 1987, p. 189). An Elder explains how the presence of one European or southern agent gave way to another:

> Soon after, a trading post was established at Mittimatalik, soon a converted Christian came to our camp, that was Qalluttiaq, Umik and Anguiliannuk with their family. From these people we were taught and converted to Christianity. This happened before I took a woman for a wife as I was still too young. (Noah Piugaattuk, 1991, IE-170)

Early Inuit and non-Inuit contact intensified through the early twentieth century as Roman Catholic and Anglican missionaries joined the Hudson's Bay Company (HBC) traders, explorers, and, eventually, the RCMP as well as both Canadian and American defense personnel during World War II in "settling" the North. Many of these agents brought with them the same proprietary sense that the Canadian government expressed when it took "ownership" over the Far North in the nineteenth century. In 1904, Mounted policeman Major J.D. Moodie gathered 25 Inuit on the shores of the Hudson Bay and told them about the "big chief" across the water (i.e., King Edward VII) "who was in charge of things and had their welfare at heart as long as they did 'what was right and good'" (Francis, 1997, p. 165).

In southern Canada, the state involved itself in health care and medical practices as early as 1832 with the appointment of a Sanitary Commission and a Board of Health (Clarke, 1996, p. 251). These came about as a result of growing concern over the arrival in Canada of immigrants with cholera. Later, the government became involved in public health efforts and the establishment of hospitals and asylums across the country. During

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[14] As early as 1497, the quest for the Northwest Passage brought Europeans to the Arctic (Brody, 1987, p. 15).

this time, the Far North was largely a place of myth for the South and its national government. Missionaries, traders, and the RCMP were often the sole providers of Western medicines in many areas of Nunavut and the Arctic as late as the mid-1900s. The government remained far removed from the "hospital business," encouraging mining companies and missions to provide health care (Tester and Kulchyski, 1994). The Order of Grey Nuns established the first nursing station in the Northwest Territories in 1867, at Fort Providence, in the Western Arctic (Hankins, 2000). By the 1920s missionaries, traders, and police were well established in the North (Brody, 1975, p. 18-19; Alia, 1994, p. 25). Across the Eastern Arctic, the emerging connection between southern religion, trade, settlement living, and the practice of southern medicine led to changing beliefs about illness and its causes. Ruthie Piungittuq, an Igloolik Elder, reflects on the anxiety that new conflicting beliefs and practices contributed to:

> I am certain that some would have continued to practice their old ways in fear of breaching a taboo. I have heard of someone that was filled with anxiety when they were being introduced to Christianity, he thought that they would be powerless without their old belief. (Ruthie Piungittuq, 1991, IE-199)

South of the sixtieth parallel, biomedicine and the medical profession were shaping notions and approaches to health and health care. In 1912, the Canada Medical Act standardized medical licensing procedures across Southern Canada. By 1918, sixty thousand Canadians had died in the First World War and between thirty and fifty thousand died that year as a result of a global flu epidemic (Clarke, 1996, p. 254). In response, organized labour recommended a system of universal medical insurance. This became part of Mackenzie King's 1919 Liberal Party platform but was not implemented until years later.

In the early twentieth century, the fur trade brought increased Southern and European attention to the North. It took on a mythic quality; a place far-removed from the daily lives of Canadians but central in their perception of what made Canada unique. Robert Flaherty's 1922 film, *Nanook of the North*, told the story of Nanook, a fictional character, who lived and hunted happily in the Arctic. At the time, this film was viewed as documentary rather than fiction; as an "ethnographic account of Inuit life" (Margaret Mead cited in Marcus, 1995, 13; Ginsburg, 2002)[15]. Such "accounts" contributed to the national and international image of Canada as a rugged, northern country sparsely populated by "cheerful, strong, brave and resourceful people" (Francis, 1997, p. 164; Marcus 1995). While the "Indian" was stereotyped as "cunning, warlike and [standing] in our way", the "Eskimo" was stereotyped as one who "smiles from the sidelines" (Brody, 1987, p. 19). The perceived lack of resistance on the part of Inuit and their more recent experience with colonialism contributed to a Canadian policy of neglect toward the Inuit. In contrast, Canadian policy took an assertively assimilationist approach toward Aboriginal peoples in southern Canada during the early part of the twentieth century (Cairns, 2001, p. 49).

Flaherty's 1922 film release coincided with the release of *The Friendly Arctic* in 1921 and *The Northward Course of Empire* 1922 by Viljhalmur Stefansson, a Manitoba-born anthropologist. In the latter, Stefansson "made a case for the huge economic

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[15] In "Nanook of the North", Flaherty dresses his leading man in white fur pants which were, some suggest, uncharacteristic of Inuit from that region. In his film, "Atanarjuat, The Fast Runner", Zacharius Kunuk seems to comment on this misrepresentation by including a strange visitor wearing the same pants that Flaherty uses in his film.

potential of the Arctic" declaring that "there is no northern boundary beyond which productive enterprise cannot go" (Stefansson, 1922, p. 19 in Francis, 1997, p. 161). These works marked the beginning of a broader national and international awareness of Canada's North and a growing debate and tension over responsibility for the North.

In 1922, the Canadian Department of the Interior centralized all of the federal government's northern functions into the Northwest Territories (at Fort Smith) and Yukon Branch (at Dawson) (Grygier, 1997, p. 43). Eskimo Affairs, in Ottawa, was charged with providing basic health care, supervising Medical Health Officers, education, sanitation, arts and crafts, support for mission schools and hospitals, and the study of Inuit needs and habits. Because Eskimo Affairs had only a maximum of six staff members to carry out this lofty set of tasks, it continued to delegate fieldwork to the Mounties, the HBC, missionaries, or the occasional medical officer (Grygier, 1997, p. 43). Through these agents, the federal government established a policy of providing "relief" (monetary support) to Inuit "in distress" (Tester and Kuchyski, 1994, p. 20). At this time, the Department of the Interior also appointed the first resident physician to the Inuit, Dr. Leslie Livingstone, who sailed on the Eastern Arctic Patrol from 1922 to 1926 and moved to Pangnirtung in 1927 (Grygier, 1997, p. 44). Through its reliance on the Eastern Arctic Patrol in administering the North, the Canadian government entrenched the notion that southern expertise needed to be literally shipped in to the North. Later, Inuit would find themselves also being shipped out for medical care.

Throughout the first half of the Century, the federal government was still not directly involved in the provision of hospital services in the Arctic as it considered itself

to be under no statutory obligation to do so (Duffy, 1988, p. 52). By this time, there were approximately eleven hospitals in the Northwest Territories (only two of which were in the Eastern Arctic), nine owned and operated by missions and two by mining companies (Duffy, 1988, p. 52). National leaders such as Arthur Meighen were calling for a hands-off approach, suggesting that "nursing our Indians has hurt them" and that the best policy would be to leave them alone (Duffy, 1988, p. 45). His suggestion reflected a growing concern about the dependency-producing regime of the reserve system in the South and a desire to avoid this kind of dependency in the North (Tester and Kulchyski, 1994, p. 19). In keeping with its "hands-off approach," the Canadian government relied on the Eastern Arctic Patrol to watch over the North and provide occasional expertise. Through its tacit approval of trade-based economy, missions, and RCMP-enforced social control, the government encouraged the elimination of the migratory and land-based lifestyle of the Inuit. The Canadian government was perhaps hoping that Inuit would simply assimilate on their own.

Throughout his career, Dr. Livingstone advocated for the establishment of nursing stations that would offer out-patient services to Northern communities. He was critical of the religious rivalry that changed the nomadic ecology and the disease epidemiology of Inuit peoples; but government policy continued as it had, relying on missions and mining companies to establish and run nursing stations and small hospitals (O'Neil, 1986). Eventually, Dr. Livingstone was given the authority to develop his Northern Health Service at the Department of the Interior (which became the Department of Mines and Resources in 1931), while the Department of Indian Affairs was developing a parallel

Indian Health Service for southern Canada (Grygier, 1997, p. 47). This was a time of medical pluralism in Aboriginal communities across the country (Kelm, 1998, p. 153). Aboriginal peoples were facing varying and often competing notions and approaches to health. Meanwhile, as increasing numbers of southerners traveled to the North, southern awareness and concern about the North and northern health problems grew. Problems and their solutions were framed in southern terms – in terms of biomedicine and the medical profession. Aboriginal forms of medicine were dismissed as quackery or superstition, limiting cross-cultural dialogue and ensuring the assertion of European allopathic medical expertise (Kelm, p. 153). Dr. Otto Schaefer, another well-known physician who practiced in the Far North, "freely admitted that he came to the North with a 'haughty disregard' for any kind of folk medicine. Later, instead of ridiculing traditional beliefs and practices, he tried to understand them. In many cases, he gained a real appreciation" (Hankins, 2000, p. 87).

Before the 1950s, most Canadian Inuit lived on the land, in hunting camps or settlements, moving as large family groups, rarely coming into contact with European settlers in the South. By the 1940s, these large family groups began to settle around trading posts as the trade-based economy took its hold and dependency on the fur trade grew. One Inuk participant explains: "My family lived 120 miles down the Bay. My father decided to come to Iqaluit for the wage economy. We had been living on the land before that." Another Inuk reflects on the settling of Inuit families:

> They wanted everybody in one community. So they can do the census, give them welfare cheques, take the kids and ship them off to residential school. And they [the Inuit] don't speak the language so they're more dependent on government. It's scary. (Participant)

In exchange for participation in the wage economy, Inuit were counted, surveyed, and moved.

While Inuit were experiencing abrupt changes in lifestyle and living conditions, southern media reported on survey work done by National Health and Welfare personnel suggesting that "Eskimos" were found to be healthy and less stressed than "Canada's civilized population". This type of coverage perpetuated socially constructed myths held by southern Canadians that the Inuit were "happy, 'furry' people, living blissful and innocent lives in a land of perpetual ice and snow" (Tester and Kulchyski, 1994, p. 47). A headline in the *Financial Post* on April 3, 1943, stated: "War Unlocks Our Last Frontier – Canada's Northern Opportunity" (Alia, 1994, p. 33). That same year, the National Film Board produced "Look to the North" (narrated by Lorne Greene) which stressed the opportunities of postwar development (Alia, p. 33). In 1944 a group of Canadian and American military, government, and scientific specialists formed the Arctic Institute of North America (AINA) to research and disseminate information about the North. Its establishment marked a new height of nationalist and scientific interest in the North.

It was not until World War II had ended that northern administration did anything officially about health care or medical facilities (Duffy, 1988). In the 1950s, Prime Minister Louis St. Laurent reflected on the first half of the century stating that the government had administered the North "in an almost continuing absence of mind" (Canada, 1953c, p. 696 cited in Marcus, 1995, p. 43). While the federal government's current legislative responsibilities for Indians and Inuit derive from section 91(24) of the

Constitution Act, 1867, it was only in 1939 that federal jurisdiction for Indian peoples was interpreted by the courts to apply to the Inuit and it was even later that Inuit became commonplace in federal policy. Inuit are now recognized as one of Canada's Aboriginal Peoples under section 35(2) of the *Constitution Act, 1982* (Sawchuk, 1998, p. 15).

By the end of the 1940s, the Inuit were increasingly seen by the South as a problem. This view was fuelled by increasing incidence of infectious diseases and growing dependence on the state. Inuit became the object of medical and governmental scrutiny. They were a problem that needed to be addressed. Until the 1947 proclamation of the National Citizenship Act, native-born Canadians were first and foremost subjects of the British Empire, and their paramount allegiance was to the King and Queen (Menzies, Adomoski, and Chunn, 2002, p. 20). Through the Indian Act an Aboriginal person in Canada could maintain a limited kind of citizenship within the confines of the reserve system or he/she could abandon their Indigenous identities as the price for acquiring Canadian citizenship (Denis, 2002, p. 113; Pearson, 2002; Ignatieff, 2000). In exchange for their Aboriginality, Aboriginal peoples could become full citizens of the nation. In this way, colonialism is about the way in which power is exercised. It is about the power to define, to make invisible, and to determine who belongs and excludes.

II. Administering the North

In the early half of the twentieth century, the federal government had administered services in the North through other agents such as missionaries, RCMP, and Hudson's Bay Company (HBC) traders. As the HBC increasingly attempted to "pass the

social costs of its activities on to the state," the Canadian state took on a greater administrative role in the lives of Inuit (Tester and Kulchyski, 1994, p. 20). Indian Health Services (IHS) eventually took control over Inuit health care, away from the Department of Mines and Resources, and in 1945, responsibility for health care was transferred to the new Department of National Health and Welfare. In southern Canada, a system of universal medical insurance was proposed again in 1945 by the Dominion-Provincial Conference on Reconstruction (Clarke, 1996, p. 256). At this time, provincial officials had jurisdiction over the health of non-Aboriginals, while Aboriginal health was the jurisdiction of the Department of Indian Affairs.

By the 1950s the Northern trade system had become a welfare system, white fox fur prices dropped, HBC store prices increased, and the Inuit of the Eastern Arctic became the "Eskimo Problem" (Marcus, 1995; Tester and Kulchyski, 1994). The federal government responded to growing dependence, malnutrition, and illness, by providing in-kind family allowances to Inuit families for use at the local HBC store to receive such things as milk powder, Pablum infant formula, and oatmeal.[16] The Department of Health and Welfare focused on teaching Aboriginal peoples across Canada the use of milk, distributing powdered milk with wire whippers (Tester and Kulchyski, 1994).

In sharing stories of her life in *Saqiyuq* (Wachowich, 1999) Apphia Agalakti Awa remembers the introduction of in-kind family allowances:

> We had no supplies that time and nothing to eat, so my husband brought a carving to the mission. While he was there he was told by the priest that the RCMP had

[16] Some Inuit, who were children during this time and through the 1950s and 1960s, have shared stories with me about how they despised Pablum and how large bags of oatmeal were often used as emergency food for dogs or to patch sled runners.

> told the Roman Catholic mission to give Inuit money for our children.... How joyful that was! We had been given money, and we had so much food! I felt like we would never be hungry again.... There were other people, though, who had not children of their own, so they didn't get any money. (Awa in Wachowich, 1999, p. 77).

During this time of plenty and hardship in the North, Canada was experiencing an economic boom and a new international focus which prompted federal revisions of Inuit administrative policies. These brought images of northern hardships into sharper focus. The Second World War and the subsequent Cold War heightened national concerns around boundaries and security and the North became crucial in planning and protecting the nation. During the Cold War, the Distant Early Warning (DEW) line, with a string of airports, was constructed on the Arctic coast which attracted many Inuit to work and trade opportunities (Schaefer, 1993, p. 1).

By 1952, Inuit were deeply entrenched in the international ideas of what Canada was as a nation. Simonie Michael, a well known Iqaluit Elder and former MLA, recently reflected on his voyage 50 years ago to attend the Coronation of Her Majesty, Queen Elizabeth II. His journey was in response to a letter from the Government of Canada that instructed the RCMP to select an Inuk from Frobisher Bay to attend the historic event. "I knew about the relationship between the Hudson Bay Company and the Queen and what it meant for the Inuit at the time to be proud to be a part of this important event" (Nunavut, 2002d). His awareness of this relationship suggests that while Inuit were becoming increasingly important to international and national visions of Canada, the

HBC, trade, and Britain's imperialism[17] were becoming increasingly entrenched in Inuit ideas of what Canada was and how they fit into this Canada.

Increasing global attention toward the North brought a growing recognition that the Inuit had suffered as a result of European colonialism. In 1953, Inuit "affairs" were brought under the Department of Northern Affairs and Natural Resources with an Arctic Division concerned only with Inuit (Crowe, 1991, p. 202). Inuit were now permitted, for the first time, to vote federally, but the Northwest Territories Council did not meet in the Eastern Arctic until 1957. Canadian citizenship and the terms of that citizenship were imposed upon Inuit while the means to practice that citizenship remained out of reach.

The mid-1900s brought reports of "alarming rates" of tuberculosis (TB) and other illnesses and there was a growing sentiment among government decision-makers that the federal government "must exercise a 'protective' responsibility towards the Inuit" (Tester and Kulchyski, 1994, p. 36). To do so, it staffed semi-icebreakers such as the *Nascopie* and the *C.D.Howe* with physicians (and, occasionally, other specialists such as dentists) and equipped them with x-ray machines, darkrooms for chest x-rays, and beds for patients (Grygier, 1997; Duffy, 1988; Hankins, 2000). The *Nascopie* was a Hudson's Bay Company Ship which made its last trip in 1947 and the *C.D.Howe* made its first trip in 1950. In addition to providing medical services, these ships facilitated medical research. The North became a laboratory for the study of Aboriginal peoples in the context of exposure to the South and southern illnesses. Ships such as the *C.D. Howe*

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[17] Empires were the historically dominant form of political organization, in which the political sovereignty of several peoples was controlled from a central government (Kaplan, 1999, p. 39).

provided an opportunity for physicians to conduct tests and gather information on Inuit health and illness. Northern physicians, such as Otto Schaefer, made significant contributions to medical literature paving the way for systemic studies of the Inuit (Hankins, 2000, p. 129; see also Schaefer, 1993).

During the 1958 federal election campaign, John Diefenbaker took up Stefansson's earlier optimism about the future of the North. He promised to build "roads to resources" in order to make the North the new frontier of economic development (Francis, 1997, p. 161). That same year the federal government passed the Hospital Insurance and Diagnostic Services Act and by 1966 federal legislation for state medical insurance was passed. While southern Canadians were developing ways of ensuring equal access to health services, northern health care was characterized by dislocation. Many Inuit boarded ships such as the *C.D. Howe* and the *Nascopie* for examinations and TB tests and were held on board to go south to a sanatorium. Some never returned. Hankins (2000) writes that "most patients came willingly to the ship, but some needed to be bribed: they would get tea and biscuits only after seeing the doctor" (p. 60). In *Inuit women artists: Voices from Cape Dorset*, Pitaloosie Saila, an artist from Cape Dorset on Baffin Island, explains the fear she experienced when she was a patient of a southern hospital for a lengthy period of time:

> I never once saw another Inuk patient there; it was like I was imprisoned there. . . At that time I did not understand English either, so I couldn't ask if there were other Inuit there. (Saila in Leroux, Jackson, and Freeman, 1994, p. 164)

Oopik Pitsiulak, also an artist from Cape Dorset, explains her experience of separation from her primary caregivers – her aunt and uncle:

> There was a medical ship named *C.D. Howe*. My uncle and my aunt were put on that ship to go down South, and I came down here to Cape Dorset in 1955. That was Nellie and George Pitsiulak; they had T.B. and they went on the *C.D. Howe*. Because my aunt and my uncle were taken away, I came to be with my parents here in Cape Dorset. I cried very much when my aunt and my uncle left. . . You would never know when those people who were taken away were going to come back. (Pitsiulak in Leroux, Jackson and Freeman, 1994, p. 191)

As more and more people were sent to southern hospitals for treatment or returned to settle in rehabilitation centres, TB worked to further separate Inuit from each other. Strategies to address TB not only disrupted individual and family lives, they changed the shape of communities. In the mid 1950s, 5 to 10% of Canadian Inuit were evacuated for active TB treatment, many of whom spent one or several years in southern sanatoria (Schaefer, 1993, p. 29). Rehabilitation centres, established in several communities to deal with the growing numbers of people returning from TB treatment, contributed to the development of new settlements. In 1957, a rehabilitation centre was established in Iqaluit (or Frobisher Bay as non-Inuit referred to it then) with accommodation for 24 single people and six families. By 1961 it consisted of 35 buildings which were used as residences for rehabilitants and their families, transit centres for adults and children, workshops, warehouses, a kitchen, and a dining hall (Grygier, 1997, p. 146).

While this brought Inuit and non-Inuit together in the same settlement, they were kept quite separate. This separation further entrenched the perceived distance between Inuit and non-Inuit experience and expertise. Margaret Hayden,[18] a teacher who had moved from South Australia to Iqaluit in 1958 to open a new school, describes how she

saw Iqaluit as comprising several communities. The first was an air force base[19] with several hundred airmen and RCMP at the end of the base road. Another was Rehabilitation Village[20] which "had been built for rehabilitating the Eskimo families whose members had been sent to hospital in the South for treatment for TB for up to six years" (Hayden). Because the TB rate was considered to be as high as 80% in some communities, whole families were brought to live in this new village. She describes "white people and Eskimo" as having "no social activities in common"; because "alcohol was not allowed to be given to Eskimo people," they were excluded from all white functions. The way in which TB was addressed in the Arctic further separated north from south, Inuit from non-Inuit, Canadian from Aboriginal. Such rehabilitation projects exemplified the paternalistic and arbitrary manner in which southern administrators addressed health and health care in the North. In response to TB, as well as starvation and a "failure of caribou" in the Keewatin barrens, another rehabilitation centre was established in Rankin Inlet and ran from 1960 to 1963 (Grygier, 1997, p. 148). In 1963, the federal government decided to phase out the settlement of Rankin Inlet due to the closure of the nickel mine. As a result, the rehabilitation project closed. Such decisions speak to the perceived power of the South to establish and dismantle communities as it saw fit. The settlement of Rankin Inlet persisted.

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[18] Hayden's description of her time in Iqaluit is part of the permanent collection at the Nunatta Sunakkutaangit museum in Iqaluit.

[19] This area is now home to the Iqaluit airport, around which the main centre of town has developed.

[20] This is now referred to as the Apex (see Chapter Three).

Attempts to "manage" TB in the Eastern Arctic spurred on administrators' efforts to develop a system of identifying Inuit. This eventually led to the distribution of discs – round discs with identification numbers[21] – to each Inuk as a means of identification.[22] During the TB epidemics, when many Inuit were brought to southern hospitals, the discs were meant to simplify identification and to ensure that patients were returned to the right settlement and family. In *Saqiyuq: Stories from the lives of three Inuit women* Apphia Agalakti Awa explains the introduction of the disc system:

> In the old days, though, before we had two names, we were given numbers. If a person died in the hospital down South, before they buried that person, the government would put the E-5 number on the coffin.... Today when people go down South to look for their relatives' graves, they use the E-5 number to locate the grave. (Apphia Agalakti Awa in Wachowich, 1999, p. 129).

Complaints about the disc system were a regular part of Territorial Council discussion for several years. The use of discs ended with the introduction of an operation called "Project Surname"[23] in 1969 where a family name[24] was determined for each individual (Alia, 1994). Through its use, the disc system further entrenched the individualizing effect of southern medicine and health care.

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[21] These discs simply had the individual's "e-number" which referred to the "E"-district or "Eskimo Registration Districts" in the eastern Arctic where they were apparently living (Marcus, 1995, p. 32).

[22] Alia (1994) explains that discs were proposed in 1935 and again in 1936 as a way to resolve a problem in Pangnirtung where the hospital, HBC, mission, RCMP and government "had five different ways of spelling and pronouncing names". Some reports suggest that the discs were in place in time for the 1941 census, others suggest a few years later (p. 30).

[23] Christian missionaries had begun the practice of renaming decades before by christening children with Biblical names (Alia, 1994, p. 25).

[24] In most cases Inuit were "allowed" to choose their family's surname. Many chose the first name of their father while others chose names more arbitrarily.

The 1950s marked a shift in the image of the Inuit in the Canadian public's imagination. The Canadian public was now confronted with images of Inuit deprivation and hardship in Farley Mowat's *People of the Deer*, and Richard Harrington's *Face of the Arctic*, both published in 1952. Both of these described the desperate state of an Inuit community. Both the *Toronto Globe and Mail* and the *Wall Street Journal* ran articles that characterized Inuit as "losing interest in hunting and fishing" and preferring "hand-outs" (Marcus, 1995). Later that year, a conference on Eskimo Affairs developed "solutions for northern problems" including a relocation policy (Marcus, p. 31). This relocation proposal unfolded through the 1950s and 1960s as Inuit were relocated from "over-populated districts" to "depleted districts." For example, some Inuit were relocated from the "overpopulated" Port Harrison district to the unoccupied High Arctic in 1953-55 (Marcus, p. 35). Relocation served to populate the far reaches of the nation, while solving the "Inuit problem" by providing groups of Inuit with a new and supposedly better place to live.

This was a time of expansion of the federal government's administrative role over Inuit education. Growing numbers of Inuit children were sent to day schools and residential schools. First Nations communities in southern Canada had had the residential school system imposed on them as early as the turn of the century; and by the end of World War II federal and provincial governments were increasing the number of day schools for northern Aboriginal children. Day schools were often built near trading posts and missions so that children who lived in nearby camps stayed with relatives or in small hostels while some families moved from the camps to be near school as well as the

nursing station, store, and church (Crowe, 1991, p. 197). In *Saqiyaq*, Apphia Agalakti Awa remembers that "in the 1960s it seemed as if all our children were leaving us to go to school. They had to, that was the law of the teachers, that every student had to go to school" (in Wachowich, 1999, p. 107).

A participant reflects on a story of her partner's residential school beginnings and highlights some of the effects of residential schooling on families:

> His family was living in igloo, sod huts, skin tents, living on the land when he was young. Living on the sea ice, being able to hunt, being in control of their own lives. He was one of the first kids to go to a residential school. Families came in but parents had no say. His mom was beside herself. All her kids were taken away to residential school in grade school. He was six. The fall-out from that has been enormous. (Participant)

These schools were meant to provide Inuit with skills needed to live life in Canada and to train people for migration south (Crowe, 1991). Health education was part of the residential school curriculum where children were taught proper "Euro-Canadian" health, hygiene, and domestic skills (Kelm, 1998, p. 63).

While it was commonly recognized that trade-based economy, settlement life, and the impacts of these on Inuit lives led to many illnesses, federal energies remained strictly focused on medicines, evacuations, and increased medical personnel in the north. After considerable debate over whether or not to fly Inuit out for medical care, the Northwest Territories Council decided to "prevent disease, if possible, and educate the people to help themselves" by sending in physicians and establishing health centres (Duffy, 1988). These health centres were staffed with nurses and occasionally visited by physicians. (Evacuating patients to southern hospitals continues to be central to the provision of health services across Nunavut.) In 1954, Northern Health Services was established to

provide health care in the Yukon and Northwest Territories and by the end of 1956, 1000 Inuit (10% of the total Canadian Inuit population) were receiving hospital treatment in southern Canada (Lehtineimi and Mundee, 1988, p. 341; Duffy, 1988, p. 71). In 1962, the Medical Services Branch (MSB) was formed by merging Indian Health and Northern Health Services with other independent federal field services. The MSB divided Canada into several major regions and established a system of north to south corridors linking three levels of care: a network of nursing stations, small "zone" hospitals and major hospitals in the southern cities of Montreal, Toronto, Winnipeg, Edmonton and Vancouver (Weller, 1990, p. 124). In 1964, the Northern Medical Research Unit was established for the MSB with Dr. Otto Schaefer as the Director until his retirement in 1985 (Schaefer, 1993, p. 15).

With the increase of permanent land-based medical services, the medical patrol of the *C.D. Howe* was finally discontinued in 1969. Land-based services were supplemented by air survey teams as well as some regular commercial flights which made medical evacuations easier (Grygier, 1997, p. 137). Nellie Tookalak, an Inuk midwife from Northern Quebec, explains how evacuation of Inuit women for childbirth was introduced in the 1960s:

> There wasn't any research program to see if the evacuation policy was a reasonable idea for our people. We were not consulted regarding what help our people needed, or what would help us progress in our own way. (Tookalak, 2000)

While the federal government claimed to be primarily interested in supporting "native self-reliance," the goals of both Indian and Inuit policy were the same: assimilation through a long, intense program of assistance (Tester and Kulchyski, 1994, p. 37;

Marcus, 1995, p. 187). The Inuit were a people to be dealt with, to be taken care of. Decisions were made without consultation and programs and plans were imposed upon them.

Increasingly and in various ways, Inuit became a people to be observed and studied by non-Inuit. In *Saqiyuq* Rhoda Kaujak Katsak tells of a great deal of medical and social science research in her community in the 1970's:

> In Igloolik there was lots of research going on about the "Eskimo." There was study after study about us. I don't even remember all of them. It was like they couldn't get enough.... A lot of time we didn't really understand what was going on. We just did whatever they told us to do. People in the community, Inuit, would complain to each other during those years. They would say stuff like, "Oh, here they come again to study us." (Katsak in Wachowich, 1999, p. 176).

Southern attempts to bring health care and health research to the North contributed to the individualizing and dislocating of Inuit as each Inuk was examined, treated, and sometimes taken away, without regard for broader community needs. From a system where social relationships and health were understood in a fundamentally integrated manner; the colonization of mind, body, and community in the Canadian north resulted in a situation where people became alienated from their own well-being (O'Neil, 1986, p. 122). Inuit knowledge and expertise were not accorded any value. The Inuit were defined as a people who needed to be protected, evacuated, cured, relocated, and settled. And they were a valuable tool for populating northern regions in the struggle to maintain national sovereignty over the vast space of the Arctic Canadian landscape.

III. The Shifting Ground of Authority:

In 1960 the United Nations General Assembly unanimously agreed to *Resolution 1514, Declaration on the Granting of Independence to Colonial Countries and Peoples*, which states that "all peoples have the right to self-determination" (Cairns, 2001, p. 41). This reflected a global challenge to colonialist imperialism and the mobilization of indigenous peoples around the world. From the 1960s onward, many stakeholders began to shape health and health care governance in the North, including Inuit non-governmental organizations. Aboriginal peoples formed organizations to represent the interests of their people in the courts and legislatures in Canada (O'Neil and Postl, 1994, p. 72).

In 1969 Trudeau's federal government released its statement on "Indian Policy" – the 1969 White Paper. This policy statement dismissed "Aboriginal claims" and argued for assimilation, suggesting that the system of separate treatment and administration for "Indians" held them back (Cairns, 2001, p. 51). Massive Aboriginal opposition to this, expressed in The Red Paper, referred to The White Paper as a policy that "will harm our people" and eventually led to its defeat (Cairns, p. 67). The Red Paper included a document called "Citizens Plus" which proposed a model of Aboriginal citizenship within Canada that would recognize Aboriginal peoples as unique, having both rights of Canadian citizenship plus rights rooted in their Aboriginality. In 1973, the Nisga'a's claim to Aboriginal title in the Nass Valley of British Columbia gave Aboriginal land claims credibility as the federal government admitted Aboriginal title existed (Cairns, p. 171). While the Nisga'a did not win their case, six of the seven Supreme Court judges

agreed that Aboriginal title had existed, and three judges asserted it had not been extinguished.

Despite the imposition of policy and planning on the North and the complete disregard for Inuit input, the Inuit experienced political development, educational improvement, and increased local autonomy through the 1960s. "By the late 1960s it became clear that if there was to be real change in the lives of Inuit, we had to become involved in the political process" (ITK). Bringing Inuit students together at residential high schools in Churchill, Manitoba and Yellowknife, NWT facilitated mobilization as Inuit men and women from different regions started discussing the types of problems they were facing. In 1971 a national Inuit non-governmental organization, the Inuit Tapirisat of Canada (now called Inuit Tapiriit Kanatami [ITK]) formed which, in 1976, was instrumental in presenting *The Nunavut Proposal* to Ottawa. This marked the beginning of a long process of negotiation for an Inuit land claim agreement and a territory. Inuit mobilized to reclaim Nunavut based on several factors: their constitution of a culturally homogenous majority in central and eastern NWT; the absence of any treaty with the federal government to clarify Inuit rights; and how far-removed the seat of the NWT's administrative and political power in Yellowknife was geographically from the Eastern and Central Arctic (Légaré, 1997). The geographic basis of Nunavut Territory was established through a 1973 ITC study of Inuit land use and occupancy to demonstrate the extent of Inuit aboriginal title in the Arctic.[25] The ITC began to

[25] The results, published in 1976 in the three volumes, are a historical record unique in Canada and perhaps the world (Crowe, 1991, p. 224).

negotiate land claims with the federal government, claiming that political development could not be discussed outside the context of land claims (Duffy, 1988, p. 257). At the same time, the Advisory Committee on the Development of the GNWT proposed the development of local government to encourage economic, social and political development (Duffy, p. 229).

The 1970s and 1980s were a time of increasing Inuit and circumpolar mobilization. The Inuit Circumpolar Conference was founded in 1977 to unite Inuit from across the circumpolar north (Alaska, Canada, Greenland, and Chukotka in Russia) as Aboriginal peoples across the circumpolar north were setting precedents for the eventual Nunavut land claims agreement. The Alaska Native Claims Settlement of 1971 awarded land and financial compensation to Alaskan Aboriginal peoples, and the 1975 James Bay land claim established a basis for various institutions of Cree and Inuit self-government, such as school boards and health and social service agencies. With the institution of home rule in Greenland in 1979, the Danish government turned over the control of domestic affairs to the almost entirely Inuit government of Greenland, and the 1984 Inuvialuit settlement gave western Arctic Inuit a portion of their traditional lands, including shares of oil and gas royalties (Lanken and Vincent, 1999, p. 46). The Makivik Corporation was created in 1978 by the Inuit of Nunavik to protect the integrity of the James Bay and Northern Quebec Agreement, and to address political, social, and economic development of the Nunavik region. Pauktuutit Inuit Women's Association formed in 1984 to represent Inuit women in Canada. Inuit began to see the South, government, and biomedical expertise as agents to be negotiated with and challenged.

In 1982, with Section 35 of the *Constitution Act*, the Canadian state acknowledged for the first time that "aboriginal people" and "aboriginal rights" exist (Asch, 1984, p. 1). Section 35 expressed no consensus regarding the meaning of aboriginal rights but stated that this meaning would emerge through further dialogue. The March 1983 First Ministers' Conference clarified the federal position on Aboriginal people by acknowledging contemporary aboriginal societies to be "autonomous cultures that have the rights to an ongoing existence within Canada, and that one specific attribute of that existence is the constitutional recognition of some kind of self-government" (Asch, 1984, p. 55). Aboriginal rights were thus framed as including political and property rights (p. 56). In 1985, Parliament passed Bill C-31, "An Act to Amend the Indian Act". Bill C-31 was an attempt to: eliminate discriminatory provisions of the Indian Act, to restore status and membership rights, and to increase control of bands over their own affairs.

Amidst Aboriginal mobilization, health services in northern Canada continued to be colonial in character, increasing local dependence on the non-Aboriginal professional nurses and doctors who worked for the federal government (O'Neil, 1990, p. 157). By the early 1970s every Inuit community had a nursing station. Inuit who had previously worked as lay dispensers of medication in missions, trading posts, or RCMP stations, were no longer needed and there was no attempt to upgrade their positions within the new health care system (O'Neil, 1986). These new nursing stations offered positions for interpreters and other support staff, but by the mid-1980s these positions were no longer considered desirable employment opportunities (O'Neil, 1986). In 1969 a training

program for "Native health auxiliaries" was developed and later extended to the North through the development of the Community Health Representative (CHR) program. The CHR program was initiated by the federal government through the Department of National Health and Welfare in the 1960s (Paul, Toulouse, and Roberts, 1988, p. 66). CHRs assisted Inuit in attaining health benefits, linking communities to health centres. These positions provided for participation in front-line, waged health care positions. But Inuit were increasingly attracted to other sectors such as education, housing, and municipal services under Territorial rather than Federal responsibility. Positions within the health sector were increasingly viewed as unaccommodating to a land-based lifestyle and Inuit paraprofessional involvement in health care services declined (O'Neil, 1986, p. 124).

The Mulroney government of the 1980s adopted a policy of devolution for the North that shifted federal northern affairs programs and budgets to territorial administrations. Devolution was favoured more in Western than in the Central and Eastern NWT, and more by the non-Aboriginal population than First Nations, Metis, or Inuit (Weller, 1990). Inuit saw the devolution of the Mulroney years as consolidating an unsatisfactory political system and making Nunavut less likely. Devolution may not have brought more aboriginally-responsive institutions but it did further the Eastern Arctic Inuit effort to settle land claims and define the new territory called "Nunavut."

Some viewed devolution as advantageous because in bringing control back to communities, it would allow for a shift from the curative, high-technology approach favoured by the federal government to a more preventive, low-technology approach

(Weller, 1990, p. 127). Weller (1990) explains that devolution was viewed as potentially disadvantageous because it could establish a system that would be too small to be effective, making it easier for a dominant professional group such as physicians or administrators to control it (p. 128). As such it would be difficult to reorient it from curative to preventive. Moreover, devolution did not involve any official agreement between levels of government, nor did its planning involve aboriginal groups. Greater local control and influence depended on how active communities were around health care.

Responsibility for health care services was transferred to the Northwest Territories in 1988. But as the transfer of responsibility only targeted services that were usually insured by the provinces, the Northern and Inuit Health Branch (NIHB) and some other national programs, were excluded (Commission, 2002, p. 223). Many health programs continued to be administered by the federal government. Throughout the 1980s and 1990s the GNWT administered health care through Regional Health Boards. Each region of the territory had its own health board which was responsible for the planning, management and delivery of health services. These were meant to devolve authority to regions while community-level citizen participation was to be encouraged through community health committees or other participatory structures (Northwest Territories Health, 1990, p. 27).

National awareness and dialogue about Aboriginal participation in governance culminated with the release of the *Royal Commission on Aboriginal Peoples* in 1996. The final report emphasized how Aboriginal peoples were linking federal health

programs to statutory or treaty obligations (Commission, 2002, p. 212). The RCAP led to Health Canada commitments to diabetes and tuberculosis initiatives as well as the development of the Aboriginal Healing Foundation in partnership with the Department of Indian Affairs. More importantly, the RCAP marked growing Aboriginal interest and engagement in health research, planning, provision, and governance across the country. Aboriginal peoples were mobilizing across the nation around self-government and self-determination. Through the 1980s and 1990s, the Inuit made great strides toward their collective vision of self-determination.

IV A New Territory and Territorial Citizenship Take Shape

> Well, basically it's the same but it's our land. It's not NWT's land anymore. It's our land. (Participant)

In 1993, the Inuit, represented by Tunngavik Federation of Nunavut (now the Nunavut Tunngavik Incorporated – NTI), the Department of Indian Affairs and Northern Development (DIAND) and the Government of the Northwest Territories signed the largest Aboriginal land claim agreement in Canadian history[26] - the Nunavut Land Claims Agreement (NLCA). The NLCA established the Nunavut Territory through an extension

[26] In September of 1992 Inuit and federal negotiators reached a final land claim agreement – the Nunavut Land Claims Agreement, and 84.7 per cent of voters in Nunavut ratified the agreement in November of that year. Tunngavik Federation of Nunavut and representatives of the federal and territorial governments signed a land claims agreement-in-principle in 1990 which supported the division of the Northwest Territories. The NLCA gives the Inuit ownership of 350,000 square kilometres of land with a share of resource royalties, hunting rights, a greater role in managing land and protecting the environment, as well as $1.148 billion in compensation (Lanken and Vincent, 1999, p. 39).

called the Nunavut Act, Bill C-132, under the Statutes of Canada Act. As such Nunavut was framed as both a land claim and a political agreement. Inuit negotiators long recognized that in addition to a land claim agreement, they needed political control of the central and eastern Arctic. On April 1, 1999, the federal statute (Bill C-132), passed by Parliament in 1993, officially installed the Nunavut Territory government (Légaré, 1997, p. 404).

When Canadian Parliament passed both the NLCA and the Nunavut Act in 1993, the Nunavut Implementation Committee (NIC) was established to oversee territorial implementation and NTI was set up as a private corporation to ensure that the promises made in the NLCA are carried out. NTI represents the interests of over 21,000 Inuit, for whom the land claim agreement was settled ("Beneficiaries"). Inuit or beneficiary authority resides officially in Nunavut Tunngavik Incorporated (NTI). Because the land claim is specifically for Inuit and the territorial government is a public government, there is often confusion about how Inuit are to be involved in the governing of the territory. In a 1999 interview for *Inuktitut*, Paul Quassa, then president of NTI, stated:

> When this was being explained many people understood it as only one thing; but it really is two, one process following another. Forming the government followed the land claims, as is clear in the land claim agreement. You cannot separate the two. Talking about it, it becomes one and the same. Eighty-five percent of the population represented in Nunavut is Inuit, which is the basis for the land claim. Within the government, Inuit will be the majority. The two are linked together. . . No matter who is running the government, Inuit will have to be involved, through the land claims agreement. (Kunnuk, 1999, p. 10-11)

The territory of Nunavut is a 1.994 million-square-kilometer severance from the Northwest Territories (NWT) with the same territorial powers and responsibilities as the NWT and Yukon. Unlike the NWT and the Yukon, the Inuit majority makes it a "*de*

facto model of self-government" (Lanken and Vincent, 1999). While only 48% of the population of the NWT is Aboriginal (Dene, Inuit, Metis and others), 85% of Nunavut's population is Inuit. John Amagoalik, chairman of the Nunavut Implementation Commission, describes Nunavut as a "distinct society" and states that the Nunavut government will have "the responsibility of protecting and preserving that distinct society" (Lanken and Vincent, p. 46). The Nunavut Act and the NLCA ensure that Inuit and the territorial and federal governments are guaranteed representation in institutions of public government responsible for issues that are left to the federal government alone in Canada's other territories -- such as the Nunavut Water Board and Nunavut Wildlife Management Board, which make decisions affecting Crown (federal) lands and offshore areas. Provisions in the NLCA are meant to increase the local wage economy and thus reduce dependency on federal government transfers.

While a province exists in its own right as a creation of the *Constitution Acts, 1867–1982*, a territory is created through federal law. As a result, Crown lands in the territories are retained by the federal government in the Crown in right of Canada. In contrast, provinces own provincial lands in the Crown in right of the province. In a territory, federal Parliament may engage in provincial-type affairs, such as school curriculum. And territorial governments are not included in the Constitutional amending formula so they do not have a say in decisions to change something in the Canadian Constitution. While territories may not have as much power as provinces do, the situation with Nunavut is a little different. Nunavut changes the practical meaning of s. 35(2) [Section 35 of the Constitution] by giving its Inuit citizens a unique degree of

leverage to chart their own course (Cairns, 2002, p. 76). Nunavut has responsibilities for delivering health care services that are comparable to the provinces. Program criteria, eligibility, and rates are set by the federal government and the government must have written approval from the Minister of Health for contracts in excess of $50,000. In Nunavut and the Northwest Territories, access to health services is available to all residents regardless of their membership in one or another ethnic community. Paradoxically, the only rules that exclude people from access to services are those established by the federal government for the NIHB program for First Nations and Inuit (Commission, 2002, p. 223).

Prior to the establishment of Nunavut in 1999, the Nunavut Implementation Commission developed recommendations for the delivery of services, the first election process, a training program, the administration of the new government. It also recommended a decentralized model to "bring government closer to the people" (Winter, 1999, p. 19). The Government of Nunavut (GN) is a representative public service and endeavours to improve its representation of Inuit land claims beneficiaries through the hiring of Inuit at all levels. It distinguishes itself from the Northwest Territories and Yukon Territory through its incorporation of "Inuit values and beliefs into a contemporary system of government" and through its use of Inuktitut as its working language.

Nunavut's Department of Health and Social Services (DHSS) administers these health and social services throughout the territory. While it is headquartered in Iqaluit, it has regional offices in Pangnirtung, Rankin Inlet and Cambridge Bay. The Baffin

Regional Hospital in Iqaluit is Nunavut's only hospital and several communities have public health offices. Every community has a nursing station or health centre with at least one Nurse and one CHR. Originally, this position was established to assist local people in accessing health benefits. There is now at least one CHR per community and these CHRs work under the direction of either a health promotion coordinator (depending on the size of the community) or directly under the Nurse-in-Charge. CHRs conduct health promotion activities and link communities with health centres. In addition, often because of lack of staff in health centres, CHRs will act as support staff. Many communities also have at least one social worker. Seven of Nunavut's twenty eight communities are operating with only 63% or fewer of their Health and Social Services positions filled. Only four communities have filled all positions (Nunavut, 2001a). There are currently eight physicians in Nunavut, but at least 80 patients are flown south every week.

In 2000, the Medical Services Branch was renamed the First Nations and Inuit Health Branch. Despite new territorial autonomy and Nunavut's status as a de facto model of self-government, the Federal Government continues to play a major role in the provision of health services to Nunavut communities. In addition to federal programs, Aboriginal peoples most often rely on medical care available in their home province or territory. The current funding situation is confusing and unsatisfactory because not all Aboriginal peoples have equal access to programs and services offered by the federal government and funding is scattered among federal, provincial and territorial governments, and Aboriginal organizations (Commission, 2002, p. 217). Nunavummiut

embark on the building of a new territory within a very complex web of local, territorial, and national relations.

V. Conclusion

Despite their dominant position in how we conceive of Canada as a nation, Inuit and the Arctic have been excluded from, and marginalized in, national, regional and local governance. This exclusion is rooted in how European colonialism, British imperialism, and the establishment of Canada as a nation have shaped North-South and Inuit and non-Inuit relations. The South attempted to impose its notions of place, citizenship, nationhood, Aboriginality, religion, education, and health on the other. At the same time, Inuit resisted, embraced, and reframed southern/western religion, trade, settlement living, southern/western medicine, as well as new beliefs about medicine and illness.

With the growing numbers of non-Inuit in the North and the resulting expansion of surveillance capabilities, Canadians became increasingly aware of the Inuit. This awareness developed through a particular lens, informed by the assumption that European colonialism brought much needed progress to the hinterlands. Canadians saw a primitive people, a people that were suffering due to their lack of skill at living like Canadians. They needed help. Inuit were introduced to Canadians through trade relationships, the RCMP, missions, medical surveillance and evacuation. At the same time, non-Inuit were seen by Inuit as bringing wage economy, food, supplies, illness, separation, and loss of ways of living. These experiences led to a deep cleavage between Inuit and non-Inuit – positioned as two vastly different peoples with different stakes in the new nation.

Nevertheless, Canadians needed the Inuit; Canadian sovereignty needed "strong", "resilient" Inuit to people the North.

Efforts to bring Inuit into a Canadian way of living catalyzed Inuit mobilization. As Inuit became increasingly aware of Canadian nation building, they also learned more about each other and the struggles of other Aboriginal peoples. During this time, the Canadian government was recognizing its administrative limits in the Far North and began to devolve administrative authority. This may have strengthened Inuit efforts at shaping their own territory and citizenship within the nation. Inuit linked with a broader discourse of Aboriginal self-determination as well as many non-Inuit who sought change and challenged colonialist visions of the North. Through decades of negotiation with the federal government, they crafted a new territory -- with the intent of engaging Inuit in local and national governance. This new territory is an expression of a new sense of political empowerment. In naming this territory Nunavut, "our land", Inuit have identified this space as both a geographic and political space situated in a long history of Inuit lives. But this new geographic and political territory does not mean independence from the nation. Inuit have created a territory that is to be as much a part of Canada as it is about Inuit self-determination.

As I suggested in Chapter One, health governance represents a particularly salient way of exploring Aboriginal participation in governance and the related struggle for self-determination. The creation of Nunavut as a largely Inuit territory suggests that Inuit will realize increased control over policy, planning, and service provision. In Chapter Five, I examine the discursive field of health and health care in Nuanvut and consider how

health is implicated in the ways that Nunavummiut have come to see themselves as Nunavammiut, as part of a new, largely Inuit territory, as part of a nation, and as part of a movement toward self-determination.

CHAPTER FIVE

The Discursive Field of Health

Notions of "health" and "health care" figure prominently in our imaginings of Canada as a nation and of ourselves as its citizens. These notions are constituted by and constitutive of political rationalities that ultimately frame health governance. Health also surfaces as a key element in the defining of Nunavut as a new territory. The *Bathurst Mandate*, which establishes priorities for new territory, states that "the health of Nunavut" depends on the health of its physical, social, economic and cultural communities (Nunavut, 1999a). In this chapter, I explore ways of talking and doing health in Nunavut and how these link up with broader ways of talking and doing health in Canada. This is not simply a study of a conversation. It is a study of discursive formation. As I explained in Chapter Two, this does not mean that I am looking for unity in the ways health is talked about. While there are similarities in how people talk about health, I am not endeavouring to discover what health is to anyone. Instead, I pay attention to the differences as well as the similarities in how health is explained and the strategies used to talk about or do health. I consider how these come to shape a discursive field of health and highlight relations of power. It is through these relations that Nunavummiut come to see themselves as part of a new, largely Inuit territory, as part of a nation, and as part of a movement toward self-determination.

No single notion of health prevails in Nunavut. There are, instead, various strategies employed by a broad range of stakeholders to talk about health. While the

federal government and biomedicine may have dominated Inuit and northern health care in the middle of the twentieth century, many voices, including media, government (local, territorial, national), non-governmental organizations, the public and researchers join in planning and providing health care in Nunavut, the north, and Aboriginal communities. In so doing, they employ techniques or strategies that constitute health and health care in Nunavut. In this chapter, I explore these techniques and how they contribute to and challenge regimes of truth around health and health care in remote, Inuit communities. I then consider how these are implicated in the constitution of Nunavummiut subjectivities. In Chapter Six, I examine how discourses of health and their resulting subjectivities frame health governance in Nunavut.

In the following pages, I explore the ways that various stakeholders or agencies contribute to or challenge dominant conversations about health. I look first at three techniques that stakeholders employ to engage in a dominant discourse of health in Nunavut:

- Establishing southern parameters
- Problematizing Nunavummiut health in terms of risk and grievance
- Marginalizing northern knowledge and expertise

These three techniques frame health and health care in southern terms but expose many tensions. The health talk in Nunavut is not simply about health in southern terms nor is it simply about dependence on the South. Participants also use strategies that attempt to subvert or challenge the dominant conversation about health. In this chapter I look at three of these:

- Shifting the discussion away from 'health' and 'health care'
- Shaping local governance through Inuit expertise and experience
- Talking in terms of self-reliance and self-determination

These three techniques of resistance are rooted in the language and experience of the North and of Inuit. Together, these six techniques are employed by Nunavut as they engage in a territorial as well as a national discourse on health and health care. Finally, I conclude by considering how these techniques become "technologies of the self" that contribute to multiple subjectivities. I consider how Nunavummiut think of themselves as inserted in webs of discourses.

1 Techniques of Governmentality

Certain assumptions about health pervade health and health care conversations in Nunavut. These assumptions are part of a discourse of Nunavut as a new and northern territory *within* Canada. They reflect dominant ideas about Canadian health care for remote, Aboriginal communities within Canada. They frame Nunavut and Nunavummiut as lacking but deserving the kind of health care that Canadians see as their inherent right as citizens. They suggest that the success of Nunavut as a Canadian territory is dependent on the health of its citizens and on the efforts that these citizens make to be healthy. The first technique is that of framing the discussion within "southern" parameters. This sets the foundation for the second technique of problematizing Nunavut lives as health problems. Nunavut lives are constructed as risky and in need. These techniques contribute to and rely on a third technique: the marginalization of northern

knowledge and expertise. I refer to these three techniques as governmental because they contribute to a way of talking about and dealing with health in which Nunavummiut discipline and care for themselves. They are attempts at bringing them into a way of living as "healthy" Canadians.

In the following section I explore these techniques as they are variously employed and consider how they contribute to the framing of Nunavut health and health care discourse within Canadian health and health care discourse.

A. Establishing Southern Parameters

Health and health care for many Inuit and non-Inuit Nunavummiut are English terms that refer to a southern/western idea, an idea that arrived in the North with the first European settlers and traders, and evolved with changes in southern health care. Over time, in Canada, the word health[27] has come to refer to a particular state of being – of the

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[27] The English word 'health' is believed to have evolved from the old English '*hoelth*' and '*hal*'. The old English term '*hal*' evolved into health, whole and holy suggesting that the three concepts were in some way related. The Oxford Concise English Dictionary (Thompson, 1995) defines health as: *n.* 1 the state of being well in body or mind. 2 a person's mental or physical condition *(has poor health).* 3 soundness, esp. financial or moral *(the health of the nation).* 4 a toast drunk in someone's honour. [Old English *hœlth*, from Germanic]. Similarly, the French word *santé* was used to refer to the state of the soul - *l'âme* - as early as the 1200's. Until the 1600's it was most commonly used in toasts or wishes (*boire á la santé de quelqu'un*). In the 1600's, the term "*officier de santé*" was used to refer to physicians, apothecaries, surgeons who served the King. By the 1800s the term was used to refer to a state of the collective - *santé publique* - and a bodily state of harmony (Santé). I emphasize both the English and French words here because of the dual participation of England and France in the colonization of Canada and its Aboriginal peoples. While Britain may have become the dominant force in the forming of Canadian government, Inuit were colonized by both French and English traders, missionaries, explorers, scientists and researchers across the North.

physical, mental and other states of the individual – that certain strategies and services can help us attain. Health care has come to refer to the collection of services available to Canadians, both publicly and privately, in their pursuit of health.

When asked what health means to them, several Inuit interview participants refer to hospitals, nurses, physicians and Western medicines. They suggest that health and health care are *Qallunaat* or *Kadluna* terms.[28] Many participants explain that there is no equivalent Inuktitut word, while others choose words that refer specifically to hospitals, nurses, doctors and other related medical services, as well as illness and injury prevention. One participant suggests that the Inuktitut words *anairtanik* and *aaniaqangituq* best capture what she has come to understand as health because of her exposure to Southern notions of health and health care. She explains that these terms refer to an absence of illness. Another explains "we adapted the term *aanniajukkuvik* - it's a place where they look after services that prevent illnesses that's the translation of 'Department of Health and Social Services.'" Participants use these words[29] and others such as *akaumiqattianiq*, and *aanniatat'inuq* to explain how the southern or western understanding of health is best translated into Inuktitut.

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[28] These are terms that Inuit and some non-Inuit use to refer to non-Aboriginal people. This word is sometimes spelled as *Qabloonat*.

[29] These words are spelled as participants spelled them. I asked participants to write the Inuktitut words for me. Most explained that spellings of words can differ not just regionally but from person to person.

Table 5.1 Inuktitut words for health as identified by participants:

Anaurtanik	State of well-being, absence of illness
Aaniaqangittuq	Absence of illness
Aanniajukkuvik	Health services, hospital
Akaumiqattianiq	Well-being
Aannaqtailiniq, Aanniaqtailimaniq	Preventing Illness

There is little similarity across participants in the Inuktitut words they use to explain what they understand health to be.[30] Table 5.2 lists several other Inuktitut words with similar meanings.

Table 5.2 Other Inuktitut words with similar meanings:

anniarvik (Kivalliq, North Baffin) ᐊᓂᐊᕐᕕᒃ (ILD[31]), *aanniahiurvik* (Kivalliq) (Schneider 1985)	Hospital
Aanniarpuq (West Hudson), *aannaqtuq* (Kivalliq, Baffin), *qanimaguarpuq* (West Hudson) (Schneider 1985)	To be ill, in pain
Aanniarainkpuq (Baffin) (ILD)	Sickly
Qannajuk qanimajuq ᖃᓄᔪᒃ ᖃᓂᒪᔪᖅ (North Baffin) (ILD)	He is ill
Aanniasurti luuktuq (North Baffin) ᐊᓂᐅᓕᖅ; *iluaqhaiji* (Kivalliq) ᐃᓗᐊᖅᓴᐃᓐ (ILD)	physician, doctor of medicine
najanngutuq ᓇᓗᓇᒃᑐᐊᖅ (Kivalliq); *iluaqsaiji* (North Baffin) ᓇᓗᓇᒃᑐᐊᖅ (ILD)	Nurse
inuulisaut (North Baffin) ᐃᓄᒃᓕᓴᐅᑦ; *i'uaqsaut* (Kivalliq) ᐃᓗᐊᖅᓴᐅᑦ (ILD)	Medicine, remedy
ikajuqti ᐃᑲᔪᖅᑎ, *irnisuksiji* ᐃᖏᓵᒃᓱᑦ (ILD)	Midwife

[30] Most participants emphasize that Inuktitut is very much a spoken language, one that adapts to specific contexts and differs across regions and communities. Inuktitut is the language spoken in much of the Eastern Arctic including the Baffin and Kivalliq regions of Nunavut, as well as Nunavik, Quebec, Inuit communities of Labrador and some communities of the Kitikmeot region of Nunavut.

[31] The *Inuktitut Living Dictionary*, a new online dictionary, managed and maintained by the GN's Department of Culture, Language and Youth, includes Dorais's *1000 Inuit Words* and *Inuit Language of Igloolik* as well as the *NAC Human Services Glossary* and the GNWT's *Inuktitut-English Terminology List*.

The preceding table is not meant to be an exhaustive list. I include it here to provide some sense of how health-related terms are operationalized in Inuktitut. Differences between English and Inuktitut highlight the differences across ways of understanding or "regimes of truth". These Inuktitut words refer to illness and practitioners. None refer to a state of health. When speaking of the pre-colonialist past, Inuit speak very little of health as a state, a goal to be achieved, or of approaches to achieving such a state. They speak of medicines and organized ways of addressing life events and certain circumstances but they do not refer to any organized way of addressing a particular state such as "health". While shamans addressed problems that we might now refer to as health problems, and midwives provided what we might call health care, their scope of practice was rooted in a different set of beliefs. The *Inuktitut Living Dictionary* contains no Inuktitut words for health. In the Index of his *Inuktitut-English Dictionary*, Schneider identifies the word *ilusiq* to be an equivalent for the word "health" but actually defines *ilusiq* as the "state of health, habits or behaviours" of a particular person. The *Inuit Living Dictionary* translates *ilusiq* as congenital – meaning to be born with. Schneider (1985) also suggests that *suqraittuq* means healthy, in good shape, one who has not changed. Both *ilusiq* and *suqraittuq* are words used in regions of Northern Quebec.

Many of the Elders interviewed in the Igloolik Elders Project speak about illness and injury, their causes and remedies as well as childbirth, dying, and other life events. But very few refer to a state of health. Understandings of sickness causality say much

about the way in which European colonialism has impacted on Inuit epistemologies. When asked what causes illness an Elder explains:

> I don't know everything, but I'll tell you what I know. Those people who have problems would be sick. It wasn't a real sickness, it was from their mind. . Maybe because they kept too many secrets to themselves, not telling anyone about their problems. That's how they could have gotten sick. (Therese Qillaq Ijjangiaq, 1995, IE-343)

This Elder distinguishes between "real sickness" and sickness "from their mind." Like many others, this Elder seems to distinguish between the kinds of sicknesses that medical doctors and nurses now deal with, such as tuberculosis, and the kinds of sicknesses she attributes to the "mind." This distinction reflects a difference between two ways of thinking about sickness causation: (1) a contemporary understanding, significantly informed by colonialist introductions of health, health care, Western medicine, religion, settlement, and new infectious diseases; and (2) a pre-colonialist understanding of sickness causality that continues to inform health understandings today.

When speaking about illness, many Elders suggest that to prevent illness, or even death, one needs to talk about wrongdoings or bad thoughts. Christianity brought a new way of referring to this practice – "confession" – along with a new framework for this practice – the authoritative figure of the priest who receives the confession. The word "confession" appears frequently in Elders' interviews. One Elder explains the change in belief:

> Yes, we must confess what is now known as sins and this was being practiced even before the introduction of Christianity. We are being prepared for days to come for our soul. The belief of shamanism is the same. If someone dies without confessing his wrong doing due to illness after the shaman made attempts to get him to confess his wrong doing, *takatumee* (the one below) will make his soul

> suffer to eternity. That was the way it was interpreted. (George Agiaq Kappianaq, 1993, IE-274)

While many Inuit can talk about traditional Inuit practices and remedies, many contemporary Inuit have had little to no experience with such things. Paradoxically, until recently, many Inuit had little contact with nurses, physicians, or other health practitioners. The transition to settlement living was abrupt. Inuit and non-Inuit now tend to link causes of illnesses to the sudden and significant changes to family and community living, to hunting and fishing practices, to childbirth, to spiritual practice, and to governance.

Colonialism brought new illness experiences, new concepts, and new words. It brought infectious diseases such as tuberculosis and it brought a centralized approach to addressing a broad spectrum of life-course events including childbirth, death and dying, injury and illness. This approach included evacuations to the south, the establishment of nursing stations, health centres, and hospitals, and the use of ships such as the *C.D. Howe* in monitoring and managing Inuit lives. As a result, health and health care are considered by many to be *Qallunaat*; they are southern, biomedically-based ways of looking at life, life events, illness, sickness, treatment and recovery. An Inuk participant who refers to health as a "government word," explains that its introduction has brought new ways of looking at individual bodies: "it used to be – we all woke up, got dressed, went outside, went hunting. . . You don't know what you're doing – but you're exercising, eating well. . . They wouldn't look at a person as unhealthy – a fat person or a skinny person" (Participant). In response to new ways of thinking about and addressing life events and circumstances, Inuit have developed new or modified existing Inuktitut

words. Participants suggest that the Inuktitut words they attribute to southern health and health care have developed with the need to have words to refer to hospitals, nurses, doctors and other aspects of southern health care. An interview participant explains Inuit exposure to the term "health":

> When Inuit were exposed to the term health, when the government established their department sometimes it was difficult to translate some words. And health was one area where it was difficult. I think more confusing than difficult. Inuit, I'd say, were exposed to these services first in a hospital area. They received these services through a centre, like a hospital centre. So the hospital, for Inuit, is a place to go when you are sick. So the term health – Inuit have adapted the term to mean a place you go when you are sick. When health has nothing to do with sickness, health is being well. (Participant)

In the above quote, this participant suggests that "health is being well." Many Inuit and non-Inuit participants use words such as "holistic" and "well-being" to highlight the differences between what they perceive to be a southern, biomedical understanding of health and their own, in many cases northern or Inuit, understanding of health. They feel that these words encompass a broader range of issues than what they perceive to be a narrow biomedical focus. And many suggest that this broader approach is particularly important in decolonizing the North. In using such words, though, there lies the risk of pitting southern/dominant notions against Aboriginal understandings of health while continuing to frame both within the language of one.

Health is perhaps the easiest way to communicate particular notions of well-being to non-Inuktitut speakers. It enables discussion between Aboriginal and non-Aboriginal leaders. Josée Lavoie (2001), in an exploration of self-determination in health care in Nunavik, found that Aboriginal leaders use the language of health to formulate what might otherwise appear as dissent from, and rejection of, medical services, or simply as a

quest for greater power and control (p. 334). But framing discussion of problems within a discourse of health can limit the terms of engagement. It can also "recolonize" Inuit knowledge as it is "reconstructed through the biomedical model" (Lavoie, 2001, p. 335). In framing problems as health problems we medicalize, bringing issues and concerns under the authority of medicine. O'Neil (1986) suggests that once Medical Services got communicable diseases such as tuberculosis "under control" in the 1970s, problems associated with the stress of social change began to appear in their annual reports as the leading causes of morbidity and mortality (p. 125). This marked the onset of the medicalization of social problems which further legitimates one kind of expertise over another.

When Aboriginal people in Canada talk about healing practices that their ancestors used, they include a wide range of activities, from physical cures using herbal medicines and other remedies, to the promotion of psychological and spiritual well-being using ceremony, counselling and the accumulated wisdom of the Elders (Royal Commission, 1996, Appendix A). These are often framed as being "of the past", "primitive" and unsophisticated. This view ignores fundamental philosophical differences between the two systems, including the essential dimension of spirituality in Aboriginal healing and its much more comprehensive goal of restoring balance to individuals and communities (Royal Commission, Appendix A).

Pitting western and aboriginal approaches at opposite ends of a spectrum masks underlying assumptions and glosses over the complexity of both traditions (Brady, Kunitz and Nash, 1997, p. 273). While we may broaden the definition of health we are

ultimately using the language of health. Our definitions of health come from deeply held assumptions about progress and perfectibility and the role that science can and should play in the direction of human affairs (Brady et al, p. 272). Health is a goal and health care is about the strategies to meet this goal. Framing problems within the guise of health further legitimates a particular kind of expertise – one that will help us identify and resolve our problems. In the following section I consider how the dominance of health discourse contributes to particular ways of problematizing Nunavummiut lives.

B. Problematizing Nunavummiut Lives

Defining aspects of the "everyday life world" in terms of "health" involves at least two "problem logics" or ways of thinking about things as health problems. These problematizations contribute to the way in which solutions are framed (Eide and Knight, 1999, p. 529). In the first logic problems are talked about in terms of risk. Nunavummiut lives are framed as risky. In this way individuals are made aware of potential problems and health becomes a problem that needs to be solved at an individual level. In the second, problems are politicized as Nunavummiut link problems to particular sources and attempt to resolve them by appealing to those they believe have contributed to the problem and who can alleviate it. They launch grievances. While the goal of risk-based problematization is to change one's own actions, the goal of grievance-based problematization is to change someone else's (p. 531). This gives rise to tensions as efforts to change individual behaviours are met with efforts to place responsibility on various levels of government. The effect of this risk and grievance problematizing is

governmental in that it internalizes and individualizes the disciplining gaze while increasing dependence on certain institutions and accepted forms of expertise.

In this section I examine how dominant assumptions about health as southern expertise and experience, contributes to and is rooted in the problematization of Nunavummiut health in terms of risk and grievance. I then consider how the relationship between these two problem logics explains some of the tensions that arise in dilemmas around and struggles over health and health care.

1. Nunavummiut lives are risky

A predominant message within the health and health care conversation in Canada is that northern Canadian, Aboriginal communities are among the sickest in the world and the North is a risky place to live. Nunavummiut and Inuit lives, in particular, are constructed as risky and as needing help to avoid the risks inherent in their northern and aboriginal existence. An Inuk highlights some of the perceived health risks of living in the north:

> Everyone has cancer. People are dropping like flies. I was away for a year and a half and I came back and people have died. Is it the water? Is it the food? Big issues are young people having STD, getting pregnant, adults having cancer and not knowing where this is coming from. (Participant)

Risk thinking is key in how we think about our selves; it is about regarding our identities and selves (and communities) as unfinished, ongoing projects; the individual-as-enterprise (Eide and Knight, 1999; Petersen, 1997). Ulrich Beck argues that modernity is characterized by the construction of risk, by the "largely defensive attempt to avoid new problems" (Elliott, 2002, p. 295). In constructing risk, we assume that we

are initially unaware of how our current way of life gives rise to potential problems (Erde and Knight, p. 531). Defining health as a problem through this notion of risk, depends on potential for self-reflexivity, on our capacity and desire to look back on ourselves and evaluate potentially risky behaviours.

Northern media, researchers, government and others are active in naming problems. News media are particularly powerful in their ability to articulate and disseminate messages about minorities, usually framing aboriginal peoples as having and creating problems (Fleras and Kunz, 2001). From 1999 to 2002 both the *Nunatsiaq News* and *News/North* ran stories, editorials, and letters-to-the-editor on the poor health of Nunavummiut and the risks of northern living. Articles described the "low health status of Nunavummiut," poor nutrition, alcohol-abuse, suicide, tobacco use and stop-smoking campaigns, Diabetes, STDs, as well as injuries related to northern living and environmental contaminants.

Often, media, research, and government work symbiotically in constructing an image of Nunavummiut life as risky. A newspaper article on the Government of Nunavut's "Report on Comparable Health Indicators for Nunavut and Canada" released in the fall of 2002, was titled "Nunavummiut get sick more often, die younger: Want to live and prosper? Don't live in Nunavut" (Bell, 2002). Nunavut's report was part of the Government of Canada's "National Health Indicators Report", the first time that all provinces and territories gathered information on the same set of health indicators. Nunavut's report indicates that Nunavummiut experience lower life expectancy, lower birth weights, and high infant mortality rates (Nunavut, 2002e). But it suggests that

shorter lives are often due to unintentional injuries and suicide – neither of which supports the claim that Nunavummiut are "sicker". Rather than suggesting that Nunavummiut get sick more often, it would perhaps be more accurate to say that Nunavummiut are "less satisfied," less involved in decision-making, and experience less access to care.

Comparison is a key strategy in the construction of Nunavummiut lives as risky. Northern, Aboriginal communities are not just sick, they are *sicker than* other communities. This exacerbates concerns about illness causality. For example, in conversation with Inuit women many immediately indicate that they are fearful of getting breast cancer. They ask questions about their risks, assuming I might know. Such fear exists despite the fact that the rates of breast cancer have been identified as being significantly lower for Nunavummiut women than for other Canadian women (Nunavut, 2002c). A lack of clarity and information contributes to fear and potential modifications to behaviours and practices.

Media and research inform assumptions of risk that pervade decision-making. When Nunavut and Inuit Nunavummiut are mentioned in southern Canadian media they are usually referred to as sick and drastically underserved. In 1998, *Nunatsiaq News* called tobacco "the killer who lives at home" (Wilkin, 1998). Growing concern about smoking led to the Department of Health and Social Services' anti-tobacco strategy. This was based largely on a series of very graphic posters exhibiting damage to lungs and other body parts. When asked about the practice of evacuating women for childbirth, one decision-maker participant explains: "We're not prepared to allow mothers and babies to

die. It's not acceptable any more". The framing of lives as risky leads to the development of solutions that address risk. Anti-tobacco posters attempt to change behaviour while evacuation for childbirth removes pregnant women from "risky" birth environments. Risk-based problematization provides us with information on how to manage ourselves rather than how to manage others (Erde and Knight, 1999, p. 531).

In addition to being sites of claims-making, media have become important health promotion tools. In November 2002, the *Nunatsiaq News* began running a sex education column by Dr. Madelme Cole of the Baffin Regional Hospital. In her column, Dr. Cole provides information on STD and pregnancy prevention as well as other sex and reproductive health issues. In a public information spot on APTN, an Elder Aboriginal woman stands in a grocery store aisle commenting on the poor quality of store-bought food compared to country or traditional food. In another, a parent steps outside of the house, away from his children, to have a cigarette. This promotionalism is individualizing in that it is directed at individual strategies for dealing with the risks of Nunavut living. And it is totalizing as it brings Nunavummiut together as a collective of at-risk lives, living in a risky place.

From 1999 onward, the DHSS has attempted to shift its focus from treatment and crisis intervention to prevention of illness and health promotion (Nunavut, 2001c). Health promotion in Nunavut is primarily conducted by CHRs as well as the few public health nurses and health promotion coordinators. Currently, each community has at least one CHR and these CHRs work under the direction of either a health promotion coordinator or directly under the Nurse-in-Charge. In their health promotion work, the

CHR will often do community information shows on local radio around a particular theme. These themes usually reflect the national health promotion programming. For example, CHRs might be directed to focus on STDs one week and another week it might be smoking. CHRs translate southern health promotion expertise to the community. They become the helper in the helping relationship that risk-based problematization demands. But in framing health in terms of risk, their work involves translating southern models of health into community accessible form.

In defining what it is to be healthy and supervising the path to health, health promotion is productive and governmental (Coveney, 1998, p. 462). Health promotion engages us in ways of working on our selves, and our lives. This is particularly evident in the nutrition education aspects of health promotion work. Problems with weight gain, obesity, tooth decay, and other nutrition related health issues have been linked to the growing dependency on "junk food" available in co-ops and other grocery stores in communities. As a result, the past three years have seen increasing attention to northern nutritional behaviour. Promotion strategies emphasize the benefits of country food over other foods and encourage a balanced diet comprising the four food groups. At the heart of these efforts is the development of a "Nunavut Food Guide" (Nunavut, 2002e). Like the "Canada Food Guide" it divides foods into four types: "For Strong Muscles" – meat, fish, birds, eggs and beans, "For Strong Bones & Teeth" – milk, yogurt, cheese, and bones, "For Good Eyes, Skin and Less Infection" – berries, fruit, and vegetables, and "For Energy" – bannock, bread, cereal, rice and pasta. The Guide incorporates images of

the North by laying the four groups out over an *ulu*[32] and including images of caribou, whale, bones, and Arctic blueberries.

The incorporation of Inuit nutritional practice is in sharp contrast to health promotion efforts of the mid-1900s when National Health and Welfare crusaded on the benefits of milk among a people who had never consumed milk. The new food guide clearly incorporates Inuit knowledge and nutritional practice. At the same time, however, it focuses efforts on changing individual behaviours. Risk-based problematization constructs a problem at the level of the individual, regarding our identities and selves as unfinished ongoing projects – the individual-as-enterprise (Eide and Knight, 1999; Petersen, 1997). Risk becomes a key element in how we are able to order reality so that we can better manage it (Petersen, 1997, p. 190).

While a health promotion tool such as the Nunavut Food Guide might remind people what is nutritious, it does not address access issues. Health promotion tools do not address the long-term viability of specific approaches to nutrition such as traditional Inuit dependence on country-food or the Southern/Western dependence on store-bought food. As community populations grow and restrictions on hunting and fishing expand, how will access to country food change? Participants strongly connect access to country food with their ability to make good eating choices and their capacity for good health. Their access to country food has a lot to do with their relationship with the land and the community they live in. For example, participants in Iqaluit state that it is harder to find

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[32] An *ulu* is an Inuit knife used primarily for cutting meat and cleaning skins. The ulu has become an Inuit symbol attributed primarily to women.

country food. Some remark at the fact that you have to pay for it. They suggest that this presents a barrier to their capacity to contribute to family health. There is a common perception across the territory that country food is healthful while Southern, grocery-store food is not. Several participants suggest that "low self-esteem" and colonialism have contributed to the tendency to buy store food and junk food. In this way, they shift the discussion away from the maintenance of individual behaviour and politicize problems.

2. *Launching grievances*

In a recent study of Australians' perceptions of risk, Deborah Lupton and John Tulloch (2002) find that participants individualize risk, representing themselves as rationally making decisions about the risks they choose to take. However, they also find that when discussing those risks to which they believe Australians in general are exposed, the participants no longer individualize risk, but politicize risk, emphasizing the production of social inequity via deliberate government strategy or neglect (Lupton and Tulloch, p. 331). Not only do they take a reflexive approach to risk, as Beck suggests, but they also base their responses on notions of "Australianness" (Lupton and Tulloch, p. 332). Eide and Knight (1999) refer to this collective, political level of problematization as grievance-based politicization. Grievances are "a form of complaint," placing blame on the actions or inactions of others (Eide and Knight, 1999, p. 529-530). For example, one participant states: "One thing I'm most angry about is sugar, candy. If they ask the Northern where they make the most money it's on pop, candy and cigarettes." This

participant accuses the Northern (the HBC chain of grocery/department stores in the North) of making money off the poor health of Nunavummiut.

Most participants frame health problems in terms of a lack of access to health services and information. One Inuk participant explains his family's experience of trying to access care for his mother:

> My mother has ... cancer. For a long time, she kept complaining about pain and the nurse would say "it's nothing serious, it will go away", over and over. Finally, my mother couldn't take the pain anymore so the family chartered a plane from [the community] to here for her to see another nurse. It so happened that there was a doctor in town so the doctor spent the whole day with her. By evening he sent her down to Winnipeg because he knew there was something seriously wrong. So he sent her down. It's a lack of concern on the part of certain nurses. And lack of availability of doctors up here. And lack of health care facilities. There are health care facilities but really no equipment up here. (Participant)

This participant lists a host of problems with health care services and highlights the difficulty his family faced in getting any kind of information on his mother's condition. In this way, grievances politicize problems by identifying a lack of something and aiming to change the actions of others (Eide and Knight, 1999, p. 531). They raise questions about the impacts of colonialism and how institutional structures inhibit or encourage possibilities for health. Grievances draw attention to a lack of resources and health services, and the difficulties encountered in traveling to the South for health care.

Health and health care problems are raised and addressed in several ways within Nunavut's Legislative Assembly. They discuss risks to Nunavummiut health and strategies to address these risks such as new health promotion programs and evacuation for childbirth. Other areas of discussion are clearly grievance-based as members politicize health by emphasizing a lack of resources and placing responsibility elsewhere

– primarily on the federal government. Concerns are raised around travel costs, wait times, quality of services, access to physicians and the construction of new health centres. Negotiation and struggle characterize the relationship between the GN and the federal government. This highlights "a politics of blame assignment and avoidance" encouraged by federal/provincial division of powers (Hutchison, Abelson, and Lavis, 2001, p. 118).

While talking about health in terms of risk addresses individual bodies and selves, talking about health in terms of grievance calls for the recognition of rights and the restoration of equity and justice (Eide and Knight, 1999, p. 530). Complaints about a lack of services, funding, or resources in Nunavut are often framed in terms of equality. In demanding equality among citizens of Nunavut, there is some erasure of difference between Inuit and non-Inuit northerners. Northern newspapers position themselves as *northern* newspapers and news coverage usually refers to Nunavummiut rather than Inuit or non-Inuit. When an article refers to the "low health status of Nunavummiut" it is suggesting that all residents experience this low status. This erases context as Inuit and non-Inuit have very different histories with health and illness. While non-Inuit residents have the same services available to them locally, many of them have connections in southern Canada that facilitate access to services there. Furthermore, when traveling to the South for medical care, non-Inuit residents are likely to be comfortable with the language than Inuit residents and may have family and/or friends in the southern community, whereas Inuit often will not. In its "Report on Comparable Health Indicators for Nunavut and Canada" (Nunavut, 2002c), the Government of Nunavut does not

distinguish between Inuit and non-Inuit. How Inuit and non-Inuit differ in terms of their experiences of care and illness is left unexplored.

Alongside the near erasure of differences between non-Inuit and Inuit Nunavummiut, there is also a discourse of difference. Differences among Inuit and non-Inuit are more often pointed out by Inuit than non-Inuit. One Inuk who has been prominent in the news media attention to health is Jose Kusugak, president of the ITK. Inuit non-governmental organizations and local radio often focus on Inuit rather than Nunavummiut, or they address Nunavummiut in Inuktitut. This discourse of difference is most often voiced in comparing North to South. For instance, Kusugak has argued that "Inuit health needs are starkly different than non-Inuit health needs". He suggests that the "debate in southern Canada regarding the health-care system appears to be a decidedly urban one" (Kusugak, 2002). He writes: "We are aware that even in large urban centres, speedy access is also difficult, and that urban Canadians, in sheer frustration, are going to the United States for quicker service. This is not an option for Inuit."

While distinguishing between Inuit and non-Inuit health concerns, Kusugak joins calls for equality across Canada. Roy Romanow suggests that Canadians consider equal and timely access to medically necessary health care services on the basis of need as a right of citizenship, not a privilege of status or wealth (Commission, 2002, p. xvi). The presumption of the right to equality is based on citizenship within the nation. And it gives rise to the assumption that as citizens of the same nation, we want, need, and value the same things. Assuming that people across Canada can make the same "right" decisions

once they are provided with the "proper" information presumes an identical distribution of resources and access to resources. Kusugak and others draw attention to the inequities in health resources. They reframe health problems so that blame is not located at the level of the individual but that of the state. At the same time, they contribute to notions of Nunavummiut lives as risky by pointing to lack of resources and access. Similarly, risk-based problematizing often leads to grievances. For instance, in addressing the risks to Nunavummiut health, territorial leaders suggest that federal monies are insufficient and demand more.

The relationship between these two problem logics explains some of the tensions that arise in discussions about health and health care. While the DHSS focuses its energies on health promotion and illness prevention, it finds itself struggling for more funding and resources from the federal government. Nunavummiut may suggest that community-based action is necessary to address problems that are framed as health problems, but in framing them as health problems they point to solutions that target individual behaviour. This supports an individualized, health promotion approach rooted in southern health expertise. As a result, Inuit and northern expertise is marginalized. In the following section, I consider this marginalization and how it is linked to techniques that frame health in southern terms and problematize Nunavummiut lives in terms of risk and grievance.

C. Marginalizing Northern Experience and Expertise:

In a story aired on "The National" on November 28, 2002, Rick Boguski reported on the long waits that residents of Clyde River, Nunavut, face in attempting to see a physician. The report suggested that a lack of providers in the North leads to significant health risk. This is a report to a southern audience – CBC has flown into this community with its camera to show the South what is happening in the far corners of the nation. The piece communicates that Canada's Northern population is the sickest in the country with the fewest resources and the highest TB and infant mortality rates in the western world. It attributes a lack of physicians to the risky nature of northern living. By emphasizing the lack of physicians rather than any other health strategy it strengthens a particular view of health expertise.

Grievances about a lack of resources are often framed within a discussion of "primary health care." The notion of "primary health care", however, is fraught with ambiguity and variability. In practice, Canadian primary care is physician-centred, organized predominantly around family physicians and general practitioners (GPs) working in solo and small-group practices (Hutchison, Abelson, and Lavis, 2001, p. 117). In a physician-centred model of primary care, decision-making is bounded by a particular kind of expertise. Consultation and collaboration with communities is rarely built into the process. By defining the "comprehensiveness" standard as coverage of only hospital and physician services, the Canada Health Act reinforces hospital- and physician-centred health care, limiting the potential for innovations in health care delivery based on

alternative settings and providers, even in situations where they might be more appropriate or efficient (Hutchison, et al. p. 118).

The dominance of the medical profession and the biomedical model in Canada limits what is considered to be a legitimate health service or knowledge. This dominance restricts the range of health services to those deemed legitimate by the medical profession and biomedical health services. The Clyde River story aired on "The National" also contributes to the notion that southern expertise is superior to northern and Inuit knowledge and expertise. It does so by leaving out any discussion of northern and Inuit defined strategies for solving northern and Inuit defined problems. In addition, the story of Clyde River contrasts the community's nurse, who states that they did all they could, with the suggestion that the autopsy was incomplete. In this way, the piece suggests that Northern workers are currently inadequate, that more Southern aide is required. The marginalization of northern expertise and experience is crucial to sustaining particular ways of talking about and dealing with health. In order to employ the preceding techniques, northern experience and expertise must be marginalized. At the same time, the employment of these techniques reinforces this marginalization.

In an interview, a CHR voices frustration in trying to work with the nurses in the nursing station:

> I'd like to see nurses ask for my help. For example, if a mother has a kid who isn't putting on weight, the nurse should ask me "this lady needs help, go talk to her." (Participant)

This CHR points out that nurses do not seek CHR expertise when addressing health problems. As a representative of the community in the health centre, the CHR could

potentially contribute to more culturally appropriate and community oriented health promotion work. Often, though, CHRs find that they spend most of their time on interpretive work and in providing administrative and other support to nursing staff. The simple inclusion of an Inuk-based position like the CHR does not legitimize Inuit expertise. In fact, CHRs often find themselves caught between their own vision of their roles and others' expectations of their work. At a 1986 National Conference of Aboriginal CHRs, CHRs listed their activities and roles as including the following community catalyst and change agent, community health education, health promotion, counseling and crisis intervention, service provision, liaison and coordination, interpretation, referral services, and administration (Paul, Toulouse, and Roberts, 1988, p. 67). They suggested that there was a great deal of conflict between the expectations placed upon them by the community and expectations of others such as government personnel who are not community members" (Paul, Toulouse, and Roberts, 1988, p. 67).

Another participant explains that Inuit non-governmental organizations are consulted very late in the process of program development:

> This is Health Canada's way of consulting. They bring us in way later – on the 30th draft. And in terms of personality they are all *Qallunaat* men and some Inuit men – as a young, Inuit woman I feel there are personal attacks rather than working on the initiative. They look at me as an individual rather than working with me. And the federal and territorial governments are coming to Inuit organizations later than they should. They developed home and community care and then give it to us and we read it rather than developing it through a collaborative effort. We get it at the end and have to adapt a lot of their programs which aren't really helpful for Nunavut. (Participant)

Several participants suggest that services are developed and Inuit are added later. While there is recognition across the territory that Inuit tradition, knowledge, and experience must underlie all forms of governance, there is a perception that one approach is better than another. Inuit expertise is seen as valid only in certain ways:

> You cannot do all of the things in the health business that need to be done without having the technical qualifications. You can do some. Some of the Aboriginal healing – that is perfectly valid. (Participant)

Most would agree that a great deal of health care work involves specialized technical expertise. In making this point, however, this participant reduces Inuit experience and expertise to "Aboriginal healing" and, thus, dismisses all other possibilities for the integration of Inuit experience and expertise into health care. Inuit expertise in health care is almost invisible and local level health profession training significantly lacking in Nunavut. Apart from a nursing program, which has seen few graduates to date, and a social work program there is no other local training. Since Nunavut's implementation, the GN has dealt with a serious under-representation of "beneficiaries" in the Nunavut public service by giving priority to beneficiaries who meet the qualifications over other applicants for all job competitions (Nunavut, 2001a; Nunavut, 2001b). But non-Inuit-Nunavummiut (non-beneficiaries) continue to hold the majority of decision-making positions in the territory.

The issue of midwifery and appropriate maternity care captures the delegitimizing of northern expertise as well as risk and grievance problematization. Take, for instance, a discussion on March 8, 2001, between the Minister of Health and Social Services, Ed Picco, and two MLAs on local childbirth and midwifery (Nunavut, 2001d). First Mr.

Nutarak explains "we were told that there was going to be midwifery introduced to the communities" and asks which communities have midwifery programs. At that time, and still today, Rankin Inlet is the only community with a midwifery program. Minister Picco suggests that the Rankin Inlet Birthing Centre has "moved forward, it has expanded its practice and indeed, we have employed and trained Inuit midwives in the community and it was a success." No Inuit midwives have ever been employed or trained at the Birthing Centre. It is possible that he is referring to the employment of Inuit Maternity Care Workers at the Centre, of which there was one in September, 2001[33]. When Mr. Nutarak suggests that communities would like to "practice midwifery at the community level," Minister Picco states that because birth mothers are getting younger and many smoke during pregnancies, there has been an increase in low birth weights. Unlike thirty years ago when "mothers seemed to be healthier, they had a different lifestyle," it is now unsafe to have babies in Arctic communities. Northern birthing is risky. He does add, though, that "almost a quarter of our total budget is spent on pregnancy and bringing women out of their communities, which is not acceptable. So we are trying to move in that direction where possible."

This discussion is followed by a question from another MLA, Mr. Iqaqrialu, who asks about midwifery training:

> I was taught about how traditional midwifery went on a long time ago, and I'm astonished about the skills known through *Inuit Qaujimajatuqangit*. Is it possible to set up some kind of a traditional midwifery course because they know so much, is it possible to set up those kinds of programs? (Nunavut, 2001d)

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[33] Maternity Care Workers work in a supportive capacity in the birthing centre in the same sort of capacity as a CHR works in a nursing station.

Mr. Iqaqrialu attempts to shift discussion away from the Rankin Inlet centre to the possibility of setting up courses through *Inuit Qaujimajatuqangit* and setting aside money to train "interested people about traditional midwifery." Minister Picco suggests that the Department is committed to training more women to be professional, registered midwives. Mr. Iqaqrialu then asks: "Are you talking about traditional midwifery or modern midwifery?" Minister Picco responds:

> I think we're talking about a mix of both. That's what we've been doing successfully in Rankin since 1993.... we would be interested to see if there is an opportunity to train other women in Nunavut who would like an opportunity to be trained as midwives. I see this as complementary Mr. Speaker, to our staff at the health centre that we have other trained people, other trained professionals on the ground who could help out in the case of a delivery. So I think it is a good suggestion. Thank you, Mr. Speaker. (Nunavut, 2001d)

In this last quote, Minister Picco frames Inuit professionals as potential "helpers". This discussion about community-based midwifery exposes some of the differences between perceptions of legitimate services as well as the disconnect between community desire and territorial policy. The inclusion of Inuit in health care through CHR or maternity care worker roles is often framed as putting health care in the hands of Inuit and incorporating Inuit "tradition" into health care. These positions locate Inuit in a specific way into the hierarchy of health care provision. These mechanisms reconstruct certain aspects of Inuit know-how through a southern, and often biomedical, model (Lavoie, 2001, p. 335). While most agree that these types of positions are crucial to health care and to self-determination in Nunavut, many suggest that this does not go far enough. They suggest instead that we need to frame problems and solutions differently

In the following section, I consider other techniques that Nunavummiut use to engage in and constitute discourses of health.

III Techniques of Resistance

With reference to British colonialism Stuart Hall (1991) describes the "English eye" as "strongly centred: knowing where it is, what it is, it places everything else," but it is "not so good at recognizing that it is itself actually looking" (p. 21). In the same way, the biomedical eye is strongly centred and, as the guiding force of the Canadian health care system, it marginalizes other approaches and understandings of health. Once individuals recognize that it is not the only "eye," however, it becomes apparent that there is no reason why it should be privileged over any other.

The discursive field of health and health care in Nunavut is not simply characterized by the dominance of one perspective or approach. It is characterized by many discourses and practices. This heterogeneity of discourses and practices shapes strategies and apparatuses of government (Barnett, 1999, p. 384). As I suggested in Section IA of this chapter, many Nunavummiut, and Inuit Nunavummiut in particular, articulate an awareness of the dominance of one approach. They identify it as an approach – one among many. This consciousness of multiple perspectives can perhaps be linked to several things: the recent history of colonization in the Arctic; the fact that many Inuit, even those in their 40s, can remember living on the land; Inuit linkages with other Aboriginal struggles for self-determination and self-government; and their connection with a global post-colonial shift that calls into question the dominance of one

way of understanding, living, and governing. In framing the dominant approach to health in Nunavut as one possibility, many Nunavummiut challenge its dominance. In this way, they highlight the instability of power relations. Moreover, while referring to "alternative" or "Aboriginal" approaches to health many dichotomize approaches, this naming of the "other" entrenches a consciousness of difference that may enable resistance to a privileged perspective.

Throughout the March 8, 2001 midwifery discussion in the Legislative Assembly, Mr. Nutarak and Mr. Iqaqrialu both struggle to shift the conversation away from risk and conventional notions of expertise. In this way, they highlight how fractured the discursive field of health and health care in Nunavut is. There are many voices that raise alternate perspectives, approaches, and possibilities for change. They challenge the assumption that health care expertise, knowledge, and experience belongs to the south.

This resistance is part of a construction of Nunavut as Inuit land, located in Inuit history, within a history of colonization and the development of Canada, as a nation. It is about Inuit-Nunavummiut wanting to be part of Canada while being recognized and respected as Inuit. It frames Nunavut and Nunavummiut as being the locus of a particular way of looking at and understanding the world which is historically situated. It is a discourse of rights and citizenship – as Nunavummiut, Inuit, and as Canadians. A discourse of resistance posits the success of Nunavut as an Inuit territory as dependent on the strength of its communities. In this section I consider three techniques of resistance that Nunavummiut employ when speaking about health and health care in Nunavut.

A. Shifting the discussion away from "health" and "health care"

B. Shaping local governance through Inuit expertise and experience

C. Talking in terms of self-reliance and self-determination

It is through these techniques that Nunavummiut most clearly articulate a connection between health governance and Inuit self-determination. This is not a discourse of blame, nor is it a discourse of risk. It is one of Inuit participation or engagement in the governing of their lives. It is a discourse in which Nunavut is considered "our land," rooted in Inuit history, part of Canada but not required to look like the rest of Canada.

A. *Shifting the Discussion Away From "Health" and "Health Care":*

When Nunavummiut employ this first technique of resistance they do more than attempt to broaden the notion of health, they change the terms of the discussion. They attempt to define problems and solutions from a uniquely northern Inuit perspective. As I mentioned earlier in this chapter, many participants suggest that health and health care are southern terms that refer to southern ideas. While some use these terms to engage in discussion and others broaden them, several participants, both Inuit and non-Inuit, divert the conversation to other issues by using terms that really are not about health at all.

The attempt to shift the conversation is most clearly demonstrated when asked how they would refer to health in Inuktitut. Several participants use *inuusiqattaarniq* (as written by one participant) to describe what health means to them. One participant suggests that this word refers to "living with yourself and others.... It means trying to have a better life." He explains: "It makes me think of health. It is important to have *inuusiqattiarniq*." Several similar Inuktitut words are listed in Table 5.3.

Table 5.3 *Similar words:*

Inuuqati[3,4] ᐃᓅᖃᑎ (ILD)	Neighbour, companion, friend
inuusiq[4] (North Baffin) ᐃᓅᓯᖅ; *inuuviq*[3] (Northern Quebec),	Life: To live, is living
inuusiqarnatuq (Northern Quebec) (ILD)	Which vivifies, enlivens
Inuusiqattiarasugunnarutiit (ILD) ᐃᓅᓯᖅᑲᑦᑎᐊᖅᓱᒍᓐᓇᕈᑎᑦ	Life skills

One participant makes a point of drawing on the entrenched dichotomy of health versus illness to explain her perception of health:

> People in the health care field have a different view. Health care is about not having a disease. For me, it is the ability of a person to live a life that's worthwhile. (Participant)

Across media and research (medical, clinical, social sciences, health policy) there is a tendency to posit Aboriginal notions of health against western notions of health suggesting the latter to be reductionist and physiology-centred and the former to be holistic and community-centred. Rather than dichotomizing two approaches, this participant subverts discussion about health versus illness by speaking about life. While acknowledging that health and health care are terms that give rise to talk around specific problems, most interview participants suggest that what is really at stake is the ways in which they live in community with others, and their local capacity to provide for their families and communities. They identify colonial relations as major contributing factors to the breakdown of this capacity. A participant explains how colonialism has contributed to a breakdown in the capacity for "confession" which has resulted in illness:

> If you keep too much inside of you it will come out one way or another. And usually it comes out in a very negative way. You've probably heard a lot about my elderly people - my mother and my grandmother - they all died of cancer. I think that's because they had so much hurt in them they never had any outlet to let it go and it eventually ate them. (Participant)

Participants suggest that addressing this "hurt" could have a "ripple effect" across the territory:

> [Health] would have a ripple effect for Nunavut as a whole. It's not diseases, sickness. It's healthy minds and healthy communities. We are, or the healthy community or healthy family is deteriorating. It's not only their fault but they are deteriorating because of outside forces. (Participant)

This framing of problems in terms of "outside forces" reflects the kind of grievance-based problem logic that I examined in the previous section. But in talking about health in terms of Nunavut and communities, this participant reframes the discussion as one about self-determination. Like many others, she emphasizes relationships and how those relationships are bound up in various histories including colonialism. In the following quote, a participant demonstrates a different way of framing the discussion. Rather than placing blame anywhere, she talks about what needs to happen between groups to facilitate change.

> There's a lot of hostility between Inuit and non-Inuit because of the control and the environment that we've had for many generations. So I think putting all of that, pulling down our defenses and saying "okay, I'm willing to put my emotional well-being on the line if you can help deal with this". I think that's really how I define health. (Participant)

Many participants direct attention away from physical and mental health problems to a discussion of individual and community self-reliance, community cohesiveness and participation, communication, resources, and self-confidence. This, I contend, is not about the medicalization of life. It is not about applying medical expertise to a broad

range of problems. It is about drawing attention to the effects of colonization and calling for the application of Inuit expertise. If we try to couch this discussion in "health" and "health care" terms we risk recolonizing Inuit knowledge and experience.

In looking at risk- and grievance-based problematization in Section IB of this chapter, I suggested that health and health care discussion in the territory's Legislative Assembly tends to focus on the risky lives of Nunavummiut and the lack of resources for Nunavut health care. Another area of discussion captures the kind of discussion that Mr. Nutarak and Mr. Iqaqrialu were trying to engage – one which attempts to shift dialogue to decidedly northern and Inuit perspectives. This discussion comprises members' questions about, as well as departmental attempts to address, Inuit representation, *Inuit Qaujimajatuqangit*, traditional practices, local training, standards, and legislation. A primary issue within this area of discussion has been maternity care and the question of incorporating traditional Inuit midwifery practices into a maternity care program. In such discussions the Legislative Assembly veers from making health a problem, to talk about the crafting of Nunavut on Nunavut terms.

B. Shaping Local Governance Through Inuit Expertise and Experience:

> Inuit have their own ideas on how to improve their health. *Inuuqatigiittarniq* – the healthy interconnection of mind, body, spirit and environment – is one of the lamps or qulliqs lighting the way for Inuit health reform. *Qaujimajatuqangit* – Inuit traditional knowledge – is another such qulliq (Qikiqtani Inuit Association in Commission, 2002, p. 221).

Across Nunavut, people are calling for recognition of traditional Inuit knowledge, expertise and experience as well as Inuit participation in planning, service provision, and

decision-making. The nature of IQ and its proposed role in territorial governance makes it a particularly salient point from which to examine the attempt to legitimate northern and Inuit expertise. The Bathurst Mandate identifies IQ as part of all aspects of territorial governance, thus, setting the new territory apart from other provinces and territories.

In simple terms, IQ is about traditional knowledge. The IQ Working Group[34] defines IQ as a philosophy or a way of living and thinking that encompasses a range of elements including: the long-practiced tradition of passing Inuit knowledge,[35] values, and teachings from the Elders down to the younger generations; a system of laws, values and consultations before making important decisions that affect the community; and an understanding of complex family relationships that is explained by Inuktitut kinship terminology. The Working Group also states:

> ...confirming the value of *Inuit Qaujimajatuqangit* will restore Inuit pride and increase individual self-esteem. By increasing young Inuit self-esteem, some of today's social problems such as substance and alcohol abuse and even suicide will be eliminated. (Nunavut, 2000, p. 15)

Carmen Levi, then Deputy Minister of the Department of Culture, Language, Elders and Youth adds that IQ "is contemporary, but also incorporates the practices of the elders" (McCluskey, 2001). Simon Awa, co-chair of the IQ taskforce, states "we want to marry Inuit Knowledge into modern, contemporary ways of governing" (McCluskey). To many

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[34] In September 1999, the Government of Nunavut hosted the Inuit Qaujimajatuqangit Workshop, where territorial government employees from all levels sought "counsel" from Elders on ways to preserve, promote and integrate IQ into all Government of Nunavut programs, services, and policies, in order to best meet the requirements of the majority of the population served by the new Government (Nunavut, 2000, p. 3).

people, the "traditional knowledge" aspect of IQ is often the only side that is seen. IQ is really about "healthy, sustainable communities regaining their rights to a say in the governance of their lives using principles and values they regard as integral to who and what they are" (Arnakak, 2001). IQ is not about static, traditional knowledge but a way of living that is flexible and adaptable. Bringing IQ into territorial governance means incorporating Inuit values and understandings, not simply particular traditional practices.

IQ is not easily translated into English. Its broad scope makes for an uneasy fit in government planning and practice that is rooted in territorial governance processes that are embedded in national governance processes. It is even more difficult to put into practice in health care, partly because health care is commonly perceived as non-Inuit. Many suggest that it cannot be accomplished simply through including Inuit Maternity Care Workers in the Rankin Inlet Birthing Centre. The mission of the Department of Health and Social Services is to promote, protect, and enhance the health and well-being of all Nunavummiut, incorporating IQ at all levels of service delivery and design. Some suggest that this is happening to a certain extent in other departments such as Education but that it is difficult to incorporate IQ into health and health care. When asked how IQ could be incorporated in health planning, most interview participants are stumped. It seems much easier to consider how IQ could be incorporated in education – for example, with the introduction of Elders as teachers in schools, in planning curriculum, and in training teachers. Several participants suggest that this is not so easy in health care

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[35] Inuit knowledge is said to include knowledge of wildlife, survival skills, traditional healing and counseling methods, and a system of dealing with fellow Inuit who need help that is based on trust and love (Nunavut, 2000, p. 14).

because health care is a southern concept. Others suggest that the incorporation of IQ in health care could be done through, for example, the inclusion of traditional midwifery practice in the planning and delivery of maternity care. One participant explains his perception of how the inclusion of IQ will happen:

> The government has taken steps to do this – have sort of an IQ section where they're sort of the overseers of the new system. So that they can take the solution that might be from British Columbia and that's going to be implemented here and then they can modify it with their own recipe. So they can make a modified version so it makes sense for the people here. (Participant)

This participant explains that IQ is a group of people in territorial government charged with ensuring that solutions are informed by Inuit approaches. But governing through IQ within a framework that is not based on IQ is not a simple task.

Despite the difficult fit between IQ and a Canadian framework for territorial and health governance, Nunavummiut remain strongly committed to the goal of making governance more relevant and meaningful to Inuit and Nunavut. The potential role of IQ in governance goes hand in hand with the priority placed on Inuktitut. Participants, both Inuit and non-Inuit, consider language to be crucial to Inuit participation in governance. One participant comments on the tenuous position of Inuktitut in the territory:

> People in Nunavut have a stronger connection with their roots, are maintaining their language. But younger people - most 20 year olds can barely function in Inuktituk. There are all sorts of outside influences. There needs to be a more concerted effort to restore language. People are forced to choose between English or Inuktitut streams. (Participant)

For many, Inuktitut encapsulates the way in which understandings and approaches can be "of a people". Inuktitut is not reduced to something of the past in the same way that IQ can often be. Inuit emphasis on the importance and centrality of Inuktitut, therefore,

provides a glimpse into efforts to build self-reliance in a framework of self-determination.

C. Talking About Self-Reliance and Self-Determination

In attempting to shift the health conversation to issues of community strength and building Nunavut as a largely Inuit territory, many participants speak of self-reliance, decision-making power, and local participation in decision-making. This third technique is one of framing the discussion in terms of self-reliance and self-determination. It is about reclaiming decision-making power as well as an interconnectedness of life, place, and community.

Resistance in childbirth is a particularly compelling example of local resistance to assumptions that certain life events are health problems that need to be addressed through southern expertise. Moreover, it points to the interconnectedness of self-reliance, access to decision-making and place. Several participants refer to experiences they have had in assisting other women in childbirth. They speak of women who have refused to fly to other communities to have their babies and women who have refused to inform the Health Centre they were pregnant because they did not want to be flown to another community. These acts of resistance are as powerful as words. Many explain that relocating childbirth in families and communities is about reconnecting the territory with communities, individuals, life-processes, and decision-making around these processes. Notions of self-determination and self-reliance are deeply connected to notions of place.

Both Inuit and non-Inuit suggest that the implementation of Nunavut both as a political and geographic space increased local capacity for self-determination. The establishment of Nunavut in and of itself has given rise to a new sense of empowerment among many Inuit.

> It has changed my life in some ways. It taught me to be more informed in terms of decisions that are made by our leaders and how it's going to affect us as a public. It made me realize that we have a place in this world as an Inuit group. I feel more strongly about my culture, the changes that have affected culture, the responsibility that we have to make it better for our children, our grandchildren, great, grand children. (Participant)

Many participants underline the importance of building self-reliance, individually, as a territory and as a people. This connecting of self-reliance, health, and territorial building is central in the *Bathurst Mandate*. It seems plausible that rather than "health" the Bathurst Mandate is actually referring to strength when it states: "the health of Nunavut depends on the health of each of its physical, social, economic and cultural communities, and the ability of those communities to serve Nunavummiut in the spirit of *Inuuqatigiittarniq*"[36] (Nunavut, 1999a).

In interviews many people talk about self-reliance and the importance of building self-reliance – not simply on an individual level but on a community and territorial level as well. Many see this work as the heart of the struggle for self-determination as individuals and as a people. The desired shift away from dependency to collective self-reliance underlies many health-related strategies developed by Inuit organizations. For example, Pauktuutit Inuit Women's Association developed *Guidelines for Inuit Communities Working on Reducing Tobacco Use* (1995). Rather than titling this

resource kit "Steps to Reduce Tobacco Use," Pauktuutit emphasizes the central role of the community in addressing the issue of tobacco use. Moreover, it states within the resource kit that local action has the greatest chance of building a healthy community (p iv). Pauktuutit has been a leader at provincial/territorial, federal, and international levels in bringing Inuit concerns and strategies around such issues as HIV/AIDS, midwifery, training and economic development, national and international protections for collective and intellectual property rights, and with indigenous peoples around the world (Morris, 2002, p. 16).

Rather than being the objects of health promotion and other health related services, participants state that Inuit need to be involved in every stage of planning and delivery. In October 1999, the GN's Standing Committee on Culture, Education and Health (Nunavut, 1999b) released its "Report on the 1999-2000 Six-Month Departmental Progress Updates." In this report, the Committee applauds the DHSS' overall goal of *Inuusikatiarniq* but states that it "is concerned that the approach envisioned seems to be one of hiring more professionals from the south, rather than one of community empowerment" (Nunavut 1999b, p. 13). It questions the wisdom of spending more on staff from the south given recruitment, retention and housing difficulties, rather than investing more in the community itself. It recommends community-based decision-making through a Community Health Committee with consistent staff support and a community wellness worker for each community.

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[6] The first part of this word, *Inuuqati*, means neighbour or companion.

One non-Inuk participant suggests that government departments need to work together to encourage Inuit participation:

> This government needs to realize that it has to be part of a bigger strategy. Not just an employment strategy but a developmental strategy that goes across every single department. At this point, all of the different departments are operating in isolation of each other – in silos. (Participant)

At the same time, participants are concerned about the kind of leadership they see in some Inuit non-governmental organizations:

> I think before Inuit self-determination is possible, not only Inuit but Northerners have to have a sense of well-being. We've had a lot of leaders in the past who have messed up big time. This isn't good for our own identity. They messed up big time because of alcoholism, drug-addiction. These are major problems. And they're our leaders. We should take some examples from them of what not to do. I think we have to become whole ourselves. I don't know if it's whole or more complete before Inuit self-determination will be possible. (Participant)

Further complicating this negative perception of leadership is the relationship between local, Inuit, territorial, and federal governments. Despite the presence of Inuit organizations and the supposed symbiotic relations of territorial government and Inuit representative organizations, there is a widely held perception that, in terms of health care, the federal government continues to have more control over Nunavut than any other body. This further marginalizes Inuit in their own views of how health care can be provided in their communities.

Attempts, at territorial and community levels, to address suicide highlight the distance between government and the public as well as the potential for community-driven strategies. In May, 2001, in response to growing concern about high suicide rates and mental health concerns, the GN's health and education departments unveiled a campaign promoting Inuit values. The campaign consisted of a set of posters and

advertisements bearing images conveying resilience, survival, strength, and perseverance. While the government has invested resources in suicide prevention through the development of this campaign and through community workshops emphasizing Inuit values, it does not position itself as capable of preventing suicide. In a June 2001 letter-to-the editor of Nunatsiaq News, an unidentified writer took issue with a suggestion that the response to suicide was in a return to tradition, rather than government. The unidentified author suggested that the Saami of Norway have seen a decrease in suicide rates due to a combination of "grassroots community action" and "active, but not overbearing, government" ("A role for government", 2001). The unidentified author wrote: "When residents of a community decide to act, government must be there too, to provide the things that only governments are capable of providing. This includes not only money and moral encouragement, but also the provision of skilled professionals, such as child psychiatrists and properly trained counsellors." This exchange highlights the discord between perceptions around government and local responsibility and the roles each should play in addressing issues such as suicide. One health care provider suggests that the difficulties underlying suicide are not being addressed through current strategies:

> In 1999 it was – "okay, it's Nunavut now" – after 1 or 2 generations of developing dependency on government institutions. Some communities are very skilled at living off the land so they have some choice around dependency. But in Rankin Inlet, where a lot of people don't have the skills, people don't have choices around dependency. Young people don't see themselves as agents. . . I saw a suicide poster – a health promotion poster – and someone had written on it "caught between two cultures." There are a lot of real difficulties, a lot of challenges and I don't know if they're being talked about. (Participant)

The vision of "caught between two cultures" superimposed over a health promotion poster says a lot about the disparities that pervade health governance in

Nunavut. Many suggest that the administrative, regulative role of government in their lives can complicate family or community autonomy. They suggest that suicide needs to be addressed by communities at a community level. At the end of August, 2002, Terrence Tootoo, the first Inuk to play professional hockey, killed himself after being charged with impaired driving. Nunavummiut responded in several ways, including letters to the editor of newspapers such as Nunatsiaq News, pleading with those who are considering suicide to reach out for help. Following Tootoo's death and in response to heightened concerns about suicide, Rankin Inlet community members gathered to discuss ways that they could address suicide in their community. Inuit and non-Inuit, health providers, religions leaders, and educators came together to brainstorm about ways to deal with suicide and approaches each one of them could take back to their work, families, and daily life.

Lock and Kaufert (1998) suggest that individual responses to their lived experiences "can be read at times as resistance, but simultaneously as commentaries on the workings of networks of power" (p. 12). In the same way, Nunavummiut's responses to their lived experiences can be seen as both resistance and reflection. Despite the complex field of multiple relations that Nunavummiut must make their way through on the way to self-determination, they persist. They continue to talk in terms of self-reliance and self-determination. Just as Inuit came together to establish Nunavut as a separate territory, Inuit may find the strength to craft out their own model of self-determination in Nunavut through their local, national, and international mobilization. Colonialism, and increased contact with the South and other parts of the world, has shortened the distance

between Inuit, as well as Inuit and other Aboriginal Peoples in Canada abroad. Inuit see themselves as part of communities of Aboriginal Peoples across Canada, the Circumpolar North, and around the world. Inuit of Nunavut do not see themselves as an isolated community. Some suggest that being "plugged into the world has enabled northern communities to break out of their isolation and to align themselves with the politics of indigenous peoples elsewhere" (Fleras and Kunz, 2001, p. 167). Aboriginal media such as the APTN facilitates connectedness to Aboriginal communities across Canada and politicizes aboriginal awareness. Perhaps more significantly, however, Nunavut entrenches an Inuit space within the nation, making room for the possibility of self-determination.

III Conclusion: "Subjects-in-progress"

As I explained in Chapter Two, I am not attempting to identify the true nature of Inuit identity. I am, however, interested in how identities and selves are problematized through struggles for self-determination and participation in health governance. These six techniques are part of a discursive field of health and health care in Nunavut which constitutes multiple subjectivities. These techniques are "technologies of the self" – ways of constituting selves within and through systems of power. There is not one single Nunavummiut subjectivity, not one way of understanding one's self or one's relationship with others, with governance, with the territory and with health care.

The health and health care conversation in Nunavut is partly constituted by dominant Canadian assumptions and values around health care as well as a history of

Inuit and non-Inuit relations, colonialism, biomedical dominance, Christian missions, and capitalist notions of progress. From this broad and complicated context comes a dominant discourse of health as having to do with hospitals, physicians, southern expertise and northern helplessness. This gives rise to a perception of Nunavummiut as being at risk and needing help. This is not the "ward of the state" that we saw in the first half of the twentieth century, but a people who need help to help themselves. But help themselves to what purpose? To be the same, have the same desires, and deal with the same problems in the same way as the rest of Canada? In helping them to help themselves, northern health services have remained "one of the most powerful symbols of the colonial relationship between northern peoples and the nation state, and the pervasiveness of this symbol in the intimacies of everyday life undermines further development in other institutional areas" (O'Neil, 1988, p. 47).

> We need to learn to be a family. We kind of lost that. Our whole being has changed. Now we rely on the health system here. We didn't use to rely on that. (Participant)

The relationship between the North and South has long been defined by dependency. But there lies a tension between a discourse which constructs Nunavummiut lives as risky and needing help, and a discourse of placing responsibility on the colonizers. This tension breaks open a space for resistance as Inuit-Nunavummiut find themselves slowly attaining access to decision-making and negotiating power. Inuit Nunavummiut do not see themselves as totally dependent on southern systems and models of care. They define themselves as people with rights. As Michael Ignatieff (2000) suggests, the rights revolution has brought voices that were never heard before into the conversation of the

country that "was firmly in the hands of a political and economic elite" (p. 26). In addition to defining themselves as people with rights, Inuit see themselves as people with expertise and experience.

Inuit are becoming more clearly visible as vehicles of power, not simply its points of application. Nunavut has managed to provide Inuit with some hold over collective identity and claims to territoriality. As such, it provides Inuit with a stronghold from which they may challenge and change embedded systems that have, in the past, repressed Inuit knowledge, experience and expertise.

Nevertheless, some participants suggest that trying to mix Southern and Inuit approaches only works to marginalize Inuit identity:

> At the end who are we? Who are we and how come we're speaking this language? It's here and we understand each other. Integrating these two cultures is not good. . . We lose identity. (Participant)

Inuit negotiate their perceptions of themselves as Inuit, as Inuit who have survived colonialism, as citizens and architects of a new, largely-Inuit territory, and as citizens of Canada. In this negotiation Nunavummiut struggle to shift the conversation to issues they feel are important. They work to find ways to direct governance through Inuit and northern expertise and experience. And they maintain the discourse of self-reliance and self-determination that gave rise to Nunavut in the first place.

While several participants raised concerns about the imposition of southern systems and approaches, most suggest that undoing the relationship between North and South, Inuit and non-Inuit is impossible. They suggest, rather, that they would like to transform the relationship from one of dependency to one of cooperation. Many Inuit are

married to non-Inuit and have raised families and communities together. Many non-Inuit have lived in the North for decades and some have been born and raised in the North. Rather than pitting Inuit against non-Inuit, many talk of building Nunavut on Nunavummiut terms. They speak to hybrid selves, selves that constitute a breadth of experience and history.

The Community Health Representative embodies the hybrid quality of Nunavummiut subjectivity and, in this embodiment, highlights some of the complexities involved in participating in and addressing health care in Nunavut. CHRs are at once representative of their Inuit communities and of the Department of Health and Social Services's health promotion programming. They have traditionally been advocates for fellow Inuit who need assistance or have questions while they must also advocate national strategies for health promotion. They speak in the language of their communities and in the language of national health promotion programming. They work in Inuktitut and English. They work within Health Centres or Public Health offices under the direction of a health promotion supervisor and/or a nurse but they see themselves as working for the community. They represent a body of Inuit experience and expertise but are caught in a system that places this experience and expertise at the bottom of a hierarchy. At the same time, unlike other health care providers they have access to their communities because of their proficiency in Inuktitut and their presence on radio, in schools, and in other public locales.

This kind of hybrid subjectivity is a "subject-in-process" that strives for self-determination, constantly reorganizing itself (Alarcón, 1996, p. 136-137). The multiple

subjectivities expressed and constituted through the various techniques explained here, contribute to "a new subjectivity, a political revision that denies any one ideology as the final answer, [but has] the capacity to recenter depending upon the kinds of oppression to be confronted" (Alarcon, 134). Gloria Anzaldua (1987) refers to this hybrid subjectivity as "a borderland subjectivity." She speaks of subjectivities on the borders and of her own experience in a borderland that includes Mexico and America. In living in the interface of multiple realities, people in the borderlands are "forced to become adept at switching" (Anzaldua, p. 37). This hybrid subjectivity subverts dualisms that pit tradition against modern or North versus South. While Nunavummiut do not live in a borderland, in the way we think of borders between nations or regions, they live in the interface of multiple realities and are forced to find some kind of ground from which to start to tell their stories.

If these techniques are part of webs of discourse within which Nunavummiut are inserted in multiple, shifting ways, how can change happen? In subverting the discourse of health and health care, Nunavummiut suggest that this access must be to decision-making at a much broader level than simply health care choice before real change can be seen at the level of health care. It is only by having access to power at decision-making levels that Inuit will have decolonized health services (Lavoie, 2001, p. 339). In the following chapter I examine how the ways in which Nunavummiut notions of health and subjectivity shape institutional factors that enable and disable Nunavummiut participation in health governance.

CHAPTER SIX

Enabling Citizen Engagement in Territorial Governance

> A sense of participation is hard to find - to have people seeing themselves as agents of a system that is conducive to self-determination. People in the health care system might be from the community but have been working this way for 10 years, 5 years. Everybody knows that there is stuff here that is not good. But how do people participate to make it different? (Participant)

In 1996, the Royal Commission on Aboriginal Peoples found that little attention had been directed to promoting real Aboriginal involvement in and control of health and social services in Canada (Royal Commission, 1996, p. 3.4). While some work had begun to develop partnerships between Aboriginal and non-Aboriginal organizations, the Royal Commission called for more fundamental reforms that would recognize and support Aboriginal self-determination. The creation of Nunavut as a territory marks an important moment in the history of Aboriginal governance in Canada. As a de facto model of Aboriginal self-government, Nunavut presents the opportunity for Inuit to craft territorial governance on their own terms. Gilles Paquet (2002) refers to the creation of Nunavut as a "shift toward distributive democracy;" a "devolution of the Canadian governance regime" that will give way to citizen engagement, consultation, intersectoral partnering and federal-provincial negotiated arrangements (p. 304).

In Chapter One, I suggested that the connection between our understandings of health and our collective identifications has implications for the ways in which people plan and experience health care. In the previous chapter, I explored how Nunavummiut talk and do health in various, often competing, contributing to the constitution of hybrid

subjectivities. In such a complex discursive field, how does Nunavummiut participation in health governance take shape? How is this participation perceived or framed? How is self-determination possible? If self-determination is about citizenship and we treat citizenship, as Brodie (2002) suggests, as a set of practices linked to governance than we must consider the relationship between the creation of Nunavut and the unfolding of citizen engagement in territorial governance. In this chapter I examine how the creation of Nunavut has contributed to citizen engagement and to visions of potential engagement in local and territorial health governance. I consider how the discursive field of health and health care complicates or facilitates Nunavummiut engagement in governance paying particular attention to relations of power. Finally, I look at how local engagement in health governance is implicated in the building of Nunavut as a manifestation of the Inuit struggle for self-determination.

As I explained in Chapter Two, I use the term "governance" rather than government to distinguish between government, as in the "Government of Nunavut," and governance as a field of discourse. It is a set of practices, or rules and rationalities that include policy, planning, and delivery. In this chapter I consider how the field of health governance in Nunavut engages (or disengages) citizens in decision-making processes. Because Nunavut is built on Inuit aspirations for self-determination, I look specifically at Inuit engagement. To do so I draw on Abelson's (2001) triad of contextual factors that influence public participation: pre-disposing (structural and social), enabling (institutional), and precipitating (interests and interest groups).

Pre-disposing influences include structural and contextual factors. Most participants suggest that colonial relations and the shift from settlement life to dependence on government frame possibilities for engagement. They act as pre-disposing influences.

> I think health care and social services care too are dependency producing so they tend to do damage, if you're not careful – the caregiver and the recipient. They do damage to your independence. And so it's very easy to become reliant on those kinds of capabilities of government systems to look after you. (Participant)

Other pre-disposing influences include Inuit mobilization to establish Nunavut as a territory, Inuit experiences with health care, linkages between Inuit and non-Inuit, to name a few.

Precipitating influences are catalysts: they are factors that bring about participation and can include the role that interests and interest groups take in shaping the participatory process (Abelson, 2001). Participation in governance is precipitated by Inuit mobilization around and interest in crafting their own territory:

> When you look at the region's history – we're very young in terms of having contact with another culture. There weren't as many health problems in the 1940s. When you look at the overall picture the health and social services problems – it's not going to get better for awhile. People are very resilient and adaptable so hopefully we can pass this on to our children. It's very important that we prepare them as much as possible. (Participant)

Participation is also precipitated by growing concerns around health and social problems, media attention to these problems, and efforts by Inuit and Aboriginal organizations such as Pauktuutit, ITK, and NAHO to address health.

Enabling influences include institutional contexts that encourage or impede participation. Many participants see the establishment of Nunavut and its public government as enabling citizen engagement in governance:

> There is a general feeling of confidence, an identification that has been positive. There are people who aren't doing well and weren't before. Government hasn't evolved to the point where it can deal with people in very difficult situations. Beyond the superficial level people are doing very well with Nunavut government. It is a healthy, confident, happy Nunavut and has a special place in Canada. (Participant)

In this chapter, I focus on this third set of factors, the "enablers", in exploring a range of institutional contexts. I consider how participation in the field of governance in Nunavut is enabled (or disabled) through five enabling factors: the territorial government, the organizations established by the Nunavut Land Claims Agreement, the federal government, Nunavut regions and communities, and front-line health programs and delivery. I look at how these five institutional contexts represent a range of decision-making levels and capacities that enable and disable citizen engagement in health governance. And I examine how the establishment of Nunavut has shaped these institutional contexts. In section II of this chapter, I explore how these enabling influences connect with pre-disposing and precipitating influences in shaping the participatory process in two specific cases of health policy, planning, and delivery: early childhood and parenting education, health promotion, and midwifery.

I The Field of Governance

In this section, I consider how the establishment of Nunavut has shaped five institutional contexts for decision-making which both encourage and impede Nunavummiut participation:

- The new territorial government
- The Nunavut Land Claims Agreement
- The federal government
- Community-level groups
- Front-line health care provision

These institutional contexts represent various levels of decision-making. In exploring these contexts I consider what kind of participation is enabled and how meaningful citizen engagement is. How are participants engaged? Are they consultants, acting in an advisory capacity? Or are they directly participating in decision-making, resource allocation, and regulation?

A. The New Territorial Government

> It is important for us to remember that Nunavummiut, through the Nunavut Land Claims Agreement and the process of setting up this government, did not work to achieve a government that was simply located in Nunavut. We worked to create a government with its heart and soul in Nunavut. Where Inuit Employment is a reality. Where *Inuit Qaujimajatuqangit* is a living part of the way government operates. Where the Inuktitut language is the means of expression. (Commissioner Irniq in Nunavut, 2002f)

In framing Nunavut as a separate territory, the Nunavut Implementation Committee proposed a public government that would fit Nunavut's largely Inuit

population while representing all of Nunavut – both Inuit and non-Inuit. Unlike provinces which were created through the *Constitution Acts, 1867-1982*, territories are created by federal legislation. Although territories do not have the same jurisdictional authority as provinces do[37], Nunavut is a little different. The Nunavut Land Claims Agreement (NLCA) provides the Nunavut government with some decision-making authority in areas that are normally federal jurisdiction (Ames, 1998). For instance, through the NLCA and its majority Inuit population, Nunavut owns land and has responsibilities and authority over land use management (NLCA, 1993).

The Government of Nunavut (GN) operates under a non-partisan[38] system and on the basis of consensus politics. To reflect the spirit of Inuit decision-making practices, the legislative assembly makes decisions according to the consensus of the majority of its members rather than along political party lines. Its 19-member Legislative Assembly meets in English and Inuktitut (with simultaneous translation), rotating locations of its sessions throughout the territory. In 2001, the GN received the Institute of Public Administration of Canada Gold Award for Innovative Management. It attributed this award to five "major innovations": achieving a representative public service, decentralizing government services, incorporating IQ into government programs and services, introducing advanced information technology systems, and developing collaborative government (Nunavut, 2001a). The GN operationalizes this notion of

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[37] In addition to a territory's limited authority over lands and resources, the federal Parliament may enter into provincial-type affairs, such as school curriculum in territories. And territorial governments are not included in the Constitutional amending formula — they do not have a vote when a change is proposed but provinces do.

collaborative government as "citizen participation in governance" (Nunavut, 2001a, p. 3). The GN attempts to provide for this collaborative government through an emphasis on Inuktitut as one of the working languages of government, decentralization, IQ, and representative workforce. In this section, I consider the various ways in which it has attempted this collaborative government.

The first step that the GN has made to bring government to the people is to decentralize many departmental offices throughout the territory. This has entailed locating several operational branches of each department in communities outside the capital of Iqaluit. For example, the Operations and Practice Branch of the Department of Health and Social Services (DHSS) is located in Kugluktuk. The intent is to devolve substantial authority and resources to local communities, to facilitate local, Inuit employment and to strengthen Inuktitut as one of the official territorial languages (White, 2000, p. 132); to bring "Government and Nunavummiut closer" through decentralization (Nunavut, 2002b).

There is no question that decentralization has brought new employment opportunities to communities. Although branch positions may often be filled by non-Inuit, there have been significant spin-offs as a result of the influx of new community members. For example, when a branch relocates to a community such as Pangnirtung, people are transferred from Iqaluit and new people are sometimes hired from the south or elsewhere in the North. The new growth in community population increases the demand for new infrastructure and services such as taxis, day-care, banks, restaurants, and hotels.

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[38] Members of Nunavut's Legislative Assembly do not represent political parties.

Despite these employment opportunities and small business growth, it is not clear that Nunavummiut, and Inuit-Nunavummiut in particular, are experiencing increased opportunities to influence and participate in territorial government.

The belief that decentralization will bring government closer to Inuit is partly hinged on the assumption that because Nunavut is 85% Inuit, a majority of Inuit employees in government is unavoidable. Moreover, the GN is obligated under Article 23 of the NLCA to achieve a workforce that is representative of the population across all occupational categories. Yet, most participants, both Inuit and non-Inuit, suggest that while MLAs are predominantly Inuit and many government employees are Inuit, decision-making positions are largely held by non-Inuit, who are often new to the North. Non-Inuit continue to fill a majority of positions in the GN. As of December 2002, Inuit hold 33% (193 of 568) of filled positions in the DHSS (Nunavut, 2002a). This is a significant increase from 20% in 2001 (Nunavut, 2001a; Nunavut, 2001b) but the department has been significantly pared down. In 2001, DHSS was at 68% capacity with 630 filled and 204 vacant positions. The DHSS is currently at 82% capacity with 104 vacant positions. The GN is at 82% capacity compared with 77% capacity in 2001 and Inuit occupy less than 50% of all GN positions.

The Department of Human Resources attributes recruitment and retention problems of staff, in general, to lack of housing for new employees, competition from other employers, capacity related issues, return to home communities, issues related to cross-cultural working environment, limited opportunities for training and development

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Political parties do not run candidates for elected positions in the territory.

(Nunavut, 2002a, p. 4-4). These factors are not specific to Inuit or non-Inuit staff. There is little discussion about the factors that limit the whether or not local Inuit are hired.

Many participants suggest that a small group of "hirable" Inuit, those perceived as having the adequate training and experience for government jobs, move from government to non-governmental agencies depending on salary and benefits. Many leave positions because they perceive little potential for real engagement or advancement.

> It's difficult to be working with the government as you're growing as an individual. I didn't like how I was growing in there, my voice didn't count. I didn't have enough power to be able to have an impact. I felt like a small little voice in one big government.... You'd be lucky if there was enough flow to get it to the Minister. (Participant)

Others feel they are unable to advance because of the lack of training initiatives. Several participants suggest that while Inuit may be able to get jobs, the training available to them is minimal so they are often left fending for themselves.

> It's kind of scary if, just because you're Inuit, you're hired for a position you don't completely understand. If you're not qualified for the job who will they hire? One of the main priorities is to educate Inuit people. A lot of it is about building self-esteem and confidence in order to go anywhere. (Participant)

Several participants claim that even the local level training is often not recognized. In the following excerpt from a group discussion, three women discuss the obstacles they face in looking for work in Nunavut:

> C: A lot of Inuit people are reluctant to be in higher positions.
>
> A: We're always scaring ourselves. You get attacked either way.
>
> C: Inuit are second on the list so we don't even bother trying.
>
> A: A lot of social services – it seems like I've seen the same thing over and over. We keep looking for Inuit counselors. We've been looking.

S: Why do you think this is the case?

A: They say it's human resources or that someone had a higher education. There's no fairness.

B: Even though I have a degree and the diploma I can still lose out.

C: We're used to it What's the use of trying.

These participants express some apprehension about taking on positions. And they complain that northern experience and training are treated as inadequate or insufficient for available positions. They join many participants in suggesting that southerners are given priority for many positions because they have university degrees.

Many suggest that while Nunavut is an endeavour to do things differently, hiring processes are simply transplanted from the South. They emphasize, in particular, the criteria used for hiring, including education and previous job experience. These restrict Inuit from many positions because they often do not have comparable southern university education, nor do they have extensive work experience in southern communities or in fields that are new to their communities. Some suggest that southern hiring practices limit the potential for Inuit to be hired.

> It's a chain reaction. The GN hired a consulting group from the South to consult with the GN and to hire people. This consulting group went head-hunting and they head hunted the wrong people. The way they approached their process was to hire as they do in the South. This is alien to the way that Inuit work, or approach life. How to get a job, doing job interviews is so different from the way we do things.... Once these people get hired they have the choice of who will support them. A lot of times they hire people from the South. So it is a chain reaction. (Participant)

When the Eastern/Central Arctic split from the GNWT, planners were faced with the short-term problem of having to fill many new government positions. Some believed that

the new government would benefit from the experience and corporate memory of public service employees from the GNWT who would transfer to the new territory (White, 2000, p. 137). The initial hiring process for Nunavut government positions neglected the tradition of local self-government, filling key jobs directly from "Outside," "a fact which made many Inuit and their leaders suspicious of too big a Southern Canadian hand in their affairs" (Jull, 2000, p.16).

> So many *Qallunaat* in senior positions in the government is a huge part of the problem. They usually have their own agenda, their own mandate. A lot of times they are doing it for their resume and they don't fully understand the impact of their decisions. And it doesn't need to be so complicated. It can be simpler here. (Participant)

Another participant asks: "Who are these people that are coming up? I have no idea who my supervisor is, what is his background, his culture. And we have no access to that information."

Decentralization and an emphasis on Inuit and northern hiring are clearly not enough to "bring government closer to the people". To engage Inuit in territorial government, Inuit must see government as something of their own making. The NIC recognized this when it crafted the *Bathurst Mandate* (*Pinasuaqtavut: that which we've set out to do; our hopes and plans for Nunavut*) which establishes principles and priorities of territorial governance (Nunavut, 1999a). The *Bathurst Mandate* is one of the key markers of difference between government in Nunavut and other provincial and territorial governments. Informed by Inuit knowledge, tradition, and ways of governing, the *Bathurst Mandate* sets the founding principles and key priorities for the building of Nunavut as a territory and for the Government of Nunavut. While it addresses

conventional territorial or provincial concerns such as economic development, it also acknowledges Inuit social problems, their history with colonialism, and a need for change. The *Mandate* outlines four priority areas (Nunavut, 1999a):

1. Healthy Communities: *Inuuqatigiittiarniq* – "to serve Nunavummiut in the spirit of *Inuuqatigiittiarniq*: the healthy interconnection of mind, body, spirit and environment" (p. 3);
2. Simplicity and Unity: *Pijarnirnirqsat Katujjiqatiriittiarnirlu* – "makes the tasks more focused and more achievable; and invites participation" (p. 4);
3. Self-Reliance: *Namminiq Makitajunarniq* – "as individuals we are responsible for our own lives ... and our families and communities"; "as communities and as a government we are connected to and reliant on each other", and "as Nunavummiut we look to support ourselves and contribute to Canada" (p. 5);
4. Continuing Learning: *Ilippallianginnarniq* – "To achieve the dreams of Nunavut we all need to listen closely and learn well in order to acquire the skills we need to increase our independence and prosperity" (p. 6).

Through these priorities the *Bathurst Mandate* suggests that building the territory is directly linked to building self-reliance and incorporating Inuit values and knowledge. It links public governance to self-reliance and to healthy communities. The first priority area – *Inuuqatigiittiarniq* – calls for a shift away from the all-intrusive government programs that dominated from the 1950s onward (Jull, 2000, p. 14). It expresses a resistance to the history of forced dependency in Inuit communities. The *Bathurst Mandate* sets the conceptual framework for a government whose purpose it is to assist individuals, families and communities in building their own capacity for self-reliance. And it emphasizes the importance of facilitating participation in the building of Nunavut.

The *Bathurst Mandate* entrenches IQ as an important principle for territorial government. Under Simplicity and Unity it states that IQ "will provide the context in which we develop an open, responsive and accountable government" (Nunavut, 1999, p.

4). As a way of living and thinking, IQ is not easily defined and, as I suggested in Chapter Five, it is not easy to imagine how it can be incorporated into governance. Regardless, the incorporation of IQ in government and health care is, for many, integral to achieving healthy communities. Some equate the incorporation of IQ into governance with a return to tradition. One non-Inuit decision-maker participant refers to IQ as "simply traditional knowledge of Inuit." This reflects a lack of understanding or simplification of this complicated term that is meant to be a guiding principle of the territory. In simplifying IQ this way, its incorporation can be seen as successful when decision-makers hold a consultative meeting with Elders or when the government makes a commitment to developing midwifery regardless of where the midwives come from.

The distinction between "tradition" and contemporary governance pervades the discourse of citizen participation in territorial governance. Inuit expertise is often framed as "tradition" while non-Inuit expertise is contemporary, modern. Inuit participation in government is seen as important to the extent that "tradition" needs to be incorporated in government. As explained in Chapter Five, IQ is best explained as a philosophy, or a way of living and thinking that encompasses a range of elements. The legitimacy attributed to IQ by Inuit is not about dichotomizing past and present. The four priority areas of the Bathurst Mandate and the guiding principle of IQ, invoke notions of Inuit knowledge and practice. They speak of integration of Inuit and non-Inuit approaches as well as traditional and contemporary approaches. Rather than countering the presumed complexities of modernity, IQ legitimizes Inuit approaches as valid ways of living in modernity. It is not about simplistic solutions, it is about bringing Inuit into the

governance of their lives. Unfortunately, the word tradition has taken on a reductionist connotation. Tradition is pitted against progress. Reducing Inuit expertise and IQ to the past in this way limits possibilities for participation. It suggests that Inuit knowledge is only applicable in certain ways and certain circumstances.

While the *Bathurst Mandate*, IQ and strategies such as consensus-based legislative decision-making and decentralization set this territorial government apart from others, it needs to maintain a relationship with the rest of the nation. Nunavut is in a difficult position in that it represents the promise of Inuit self-determination, while at the same time trying to fit into a broader, non-Inuit national framework. The dilemma posed by this dual positioning underlies territorial governance of health and health care. The DHSS is caught in this dual positioning as it attempts to provide health care within Canadian and Inuit frameworks. It explains that its mission is "promote, protect and enhance the health and well-being of all Nunavummiut incorporating *Inuit Qaujimajatuqangit* at all levels of service delivery and design" (Nunavut, 2003a, p. 10-1). It is at once both a protector of the people and guided by the people. But how these people will guide health and social services is unclear. Unlike the *Bathurst Mandate*, the Department does not frame its work in terms of community capacity building. Moreover, its internal divisions undermine the potential for the holistic framework of IQ to truly guide health and social services. Its organization mirrors that of southern departments in that it separates programs into specific branches: Healthy Children, Families and Communities, Health Promotion, Health Insurance Programs, Health Protection, and Treatment Programs. Health centres and hospital services are part of treatment programs,

quite separate from Healthy Children, Families, and Communities. The organization of health and social services along southern lines exemplifies the gap between the shared vision of Nunavut as a largely Inuit territory and how this vision is put into practice.

Most participants suggest that Nunavut and its government will contribute to the Inuit struggle for self-determination in the Eastern and Central Arctic. But they see the transition to a new government as difficult.

> It [the creation of Nunavut] has changed my life in some ways. It taught me to be more informed in terms of decisions that are made by our leaders and how it's going to affect us as a public. It made me realize that we have a place in this world as an Inuit group. I feel more strongly about my culture, the changes that have affected culture. The responsibility that we have to make it better for our children, our grandchildren, great grand children. . . But I feel like we've gone back 10 or 15 years. Maybe it's just the transition that I'm feeling right now. Maybe that my mind was set that once we got Nunavut everything would be better just like that. There are some good things happening since the creation of Nunavut and along with that there are some things that have gone back. Some employees at the department level don't have the experience leading to be leaders. The issue of programming is an ongoing issue because nobody is leading. There's no direction from whoever is supposed to be making decisions so that people can start initiating their projects or whatever. (Participant)

Lavoie (2001) describes several approaches to Inuit self-determination in health care (p. 336). One suggests that Inuit employment in health care will resolve difficulties in cross-cultural communication, while another argues that transferring control of health services to Inuit will decolonize the relationship between Inuit society and the nation-state. These approaches clearly inform the dominant discourse of health in Nunavut. In assuming that the mere presence of Inuit will lead to better representation, however, the first further marginalizes Inuit knowledge, experience, and expertise. The second fails to specify how much control is enough as well as how much change the political health care

structure must undergo in order for Inuit to be able to negotiate and/or create locally meaningful health care services (Lavoie, p. 336).

Finally, the GN's status as a public government makes it difficult for Inuit to see how it is their government: how Inuit problems are addressed as Inuit problems; and who is in decision-making roles. The public nature of the territorial government, representing both Inuit and non-Inuit Nunavummiut, has led many to suggest that it does not represent Inuit adequately. Several participants suggest that the idea of a public government actually disconnects the government from the public, which is largely Inuit.

> Government is not going to be the one to come up with the solution because these government programs are geared to everybody. But this is really mostly Aboriginal people here but it's a public government. So I think it's going to have to come from the Inuit leaders and the Inuit organizations because those are the organizations that have money right now. (Participant)

In the following section, I consider the relationship between the public government and Inuit representative organizations by examining the ways in which the NLCA addresses Inuit participation in health governance.

B. The Nunavut Land Claims Agreement

The creation of Nunavut is about bringing decision-making to the people of Nunavut, and, in particular, to the Inuit of Nunavut. It is meant to offer Inuit the opportunity to determine territorial governance. To do so, in addition to its territorial government, the NLCA created a beneficiary organization. Inuit or beneficiary authority resides officially in Nunavut Tunngavik Incorporated (NTI). NTI was established as a private corporation in 1993 to ensure that the promises made in the Nunavut Land Claims

Agreement are carried out (NLCA, 1993, p. 257). NTI now represents the interests of over 21,000 Inuit, for whom the land claim agreement was settled, and is "responsible for advancing and protecting Inuit interests in the creation of the Nunavut Territory in 1999 by assuring that the terms of the Nunavut Political Accord are lived up to" (NTI). The Clyde River Protocol, which governs the working relations between the Government of Nunavut and NTI, suggests that both organizations are committed to "ensuring that Nunavut's governing institutions and political culture operate so as to sustain, and to strengthen, the confidence and optimism of all citizens of Nunavut, Inuit and non-Inuit alike" (Clyde River, p. 2)

According to the Protocol NTI occupies a "special place" because it speaks for the Inuit of Nunavut with respect to the rights and benefits of Inuit" (Clyde River, p. 3). Many Inuit participants refer to the NLCA as the device that ensures their participation in territorial governance. The formalized relationship between NTI and the territorial government stands as a major check for Inuit participation.

While the existence of NTI assures Inuit of some authority in territorial governance, it furthers a division between Inuit and non-Inuit. Many Inuit participants seem reluctant to name the Government of Nunavut as theirs. Some distinguish between the land claim or NTI as an Inuit government and the Government of Nunavut as a territorial government. The establishment of parallel authorities in Nunavut – the public, territorial government and the NTI – complicates governance issues (Jull, 1999, p. 6). At the same time, however, participants see it as necessary. Moreover, because the Arctic political economy is so heavily dominated by the public sector, (Jull, 1999, p. 6)

government is everywhere and difficult to subvert, challenge, change, work with or alongside.

> Inuit have the right to know what they are entitled to. We have a land claims agreement and we do have the right to have these services. And it's important that Inuit have more of a say in the design and delivery of the program. Right now that's not happening. (Participant)

Beneficiary organizations (such as NTI) did not initially identify health as a specific priority area although they identified several areas that many would directly link to health including justice, housing, and other areas. Health, in general, has never received the kind of attention that other aspects of self-determination have garnered. Across Aboriginal communities it has competed with other demands, such as those for control over education and social services, especially child welfare (Waldram, Herring, and Young, 1995, p. 229). The NLCA establishes institutions of public government (including wildlife, water, planning, environment and land use) and without explicitly naming them it assumes that health and education are responsibilities of the public government. A non-Inuit health manager suggests that distinguishing between government and NGOs can be confusing:

> I think people here still and I still have times thinking about public government versus land claims government. It's very confusing. If you look at this chart behind you (NTI and Inuit orgs) which shows the NTI and the orgs, it's horribly complex. And that is the land claims organization, not the Nunavut Government. . . When things are confusing they tend to fall back on the old patterns which are the territory runs it but the Feds really run it. There is no other territory apart from maybe the NWT that has anything like this. (Participant)

One participant explains how the NLCA is meant to put decision-making power in the hands of Inuit:

> Well, through the land claims agreement, Inuit organizations were created to oversee and make sure that Inuit participate in many areas including language, culture, health issues, health programs, in the design of health programs and health services. Under Article 32 of the Land Claims Agreement, for example, the NSDC – the Nunavut Social Development Council[39], is mandated to work with the government, the Nunavut government and the federal government, making sure that Inuit participate in these areas that are mentioned. (Participant)

A health provider suggests that the Inuit representative organizations have led to positive change in communities: "People are more interested and they are talking about rehab, issues around disability, housing, because of organizations like the QIA and the NSDC." The Nunavut Social Development Council (NSDC) was meant to represent Inuit on social issues including health. With the dismantling of the NSDC, NTI has assumed its responsibilities over health and social issues. This shift may result in a louder political voice behind health and social issues. But the potential power of the NLCA to engage Inuit in governance is often lost because of the perception that beneficiary organizations are plagued by conflict and controversy and lack any kind of leadership. Since the birth of Nunavut in 1999, Inuit NGO's have grown in size and leadership has changed several times. Furthermore, staff move between agencies and government positions as leadership, salaries, and/or benefits change. Others suggest that Inuit are poorly informed about the NLCA and the breadth of political power it provides beneficiary organizations:

> A lot of people don't understand what Nunavut is. . . There hasn't been a real effort to educate people about what Nunavut Land Claims is all about. . . A lot of Inuit people still don't understand the opportunities they have. (Participant)

Just as Canadian legal rights of Aboriginal Peoples often reduce rights to property rights, reference to the NLCA often reduces territorial governance discussion to one of

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[39] In 2002, the NSDC's responsibilities were assumed by NTI so that the NSDC is no longer a separate organization.

land and rights over natural resources. This reduction to property contradicts an Aboriginal conception of the relationship with the land as part of the right to be self-governing or self-determining or sovereign – "the right to be responsible" (Monture-Angus, 1999, p. 60). This right to be responsible concerns the right to participate in governance, without which self-determination would be unrealizable. The reduction of rights to property rights is similar to that of the reduction of IQ to tradition. It splits past and present, positioning Inuit knowledge and relationships with the land firmly in the past. The NLCA establishes the territorial government as a public government and the land claims administration organization (NTI) as the body that represents Inuit specifically. This distinction risks the perception that Inuit authority is restricted to land and resource issues. To overcome this, Inuit must see the public government as their government while maintaining the separate authority of NTI. This process has begun but it is unclear how it will continue to unfold. In many ways this process is influenced by territorial-federal relations and how these relations impact on people's perception of their own capacity for participation.

C. Territorial-Federal Relations

The Inuit of the Eastern Arctic have historically differed from other Aboriginal peoples in their relationship with the federal government. Nevertheless, the federal government is responsible for the provision of health care, including primary care, to Inuit as well as First Nations and Métis. In the case of the Inuit of Nunavut, federal

monies set aside for Inuit health is transferred to the territorial government which plans, manages, and delivers health care across the territory.

As with other provinces and territories, health care planning, policy, and delivery in Nunavut are dependent on funding relationships between the territorial government and the federal government. However, due to its vastness, Nunavut's health care costs are disproportionate to its population size. Airfare for medical treatment in Iqaluit, Rankin Inlet, or a city outside of Nunavut can range from $900 to over $2000; add to this the cost of accommodations, food, and other services that may be required such as an interpreter. "Medivac" travel (for medical purposes) to southern Canadian facilities consumes $28.5 million a year, 20% of Nunavut's current health budget ("Health Care Funding", 2003).

The need for funds contributes to federal and territorial relations that are characterized by confrontation and negotiation. The 2001 Legislative Assembly Report concluded by suggesting that the GN needs to push for federal infrastructure investment that "genuinely takes into account the cost of providing services to Canadian citizens in the most challenging geography to be found in the country" (Nunavut, 2001c, p. 5). It highlighted the fact "that Health and Social Services in Nunavut receives less proportionate funding of the total budget than in any other provincial or territorial government. This, despite the fact that additional costs of providing health and social services in Nunavut are even more expensive than elsewhere in Canada, due to patient travel and care providers" (Nunavut, 2001c, p. 5). In early 2003, the three territorial premiers refused to sign a national health care accord because it proposed a per-capita

funding formula. The territorial premiers had proposed a territorial health fund totaling "one-half of one-percent of all new federal funding" ("Pressure mounts," 2003). The premiers walked out when that proposal was dropped at the First Ministers meeting on February 5. By February 17 they had received no response so they returned to Ottawa. At the National Aboriginal Health Organization's Arctic Forum on May 8, Nunavut's health minister joined the NWT's in "once again slamming Ottawa for under-funding northern health care" ("Health Care Funding," 2003; see also Nunavut 2003b, 2003c).

Federal health funding for Nunavut is complex. Federal monies for Aboriginal peoples supports three types of health programs and initiatives: public or community health programs; national initiatives that are directed at health and health-related issues such as the Aboriginal Diabetes Initiative; and individual funding for prescription drugs, dental and vision care, and transportation to and from specific services (Commission, 2002, p. 214). Funding to communities for Inuit health programs differs, in some respects, from First Nations communities in the South. For instance, while some program funding for programs such as Head Start programs goes directly to communities, other funding (e.g., Brighter Futures program funding) goes through the Government of Nunavut.[40] First Nations and Métis communities or tribal associations receive this second set of funding directly. Funding does not go through a provincial government

[40] Health Canada provides funding to the Nunavut Government to manage and administer the following Health Canada programs for Inuit and registered Indians: Brighter Futures, Building Healthy Communities, Mental Health Crisis Management, Solvent Abuse Program and Home Nursing, Canada Prenatal Nutrition Program, National Native Alcohol and Drug Abuse Program (NNADAP) Treatment and Training, and Program Management. It also provides funds for the Time Limited Special Initiative for Canada Prenatal Nutrition Development Funds.

and, as the community or association develops infrastructure, it gains more control. In contrast, for Inuit of Nunavut, federal government makes agreements with the Government of Nunavut which then takes the money and makes agreements with communities. The various funding processes have led to a great deal of confusion in terms of who holds the purse strings for Inuit health. Moreover, much of this funding is program specific and it is unclear if and how Inuit are involved in deciding areas to be funded. Many Inuit-Nunavummiut believe that because of their lack of input and the confusing funding processes they are disadvantaged. One Inuk shares her understanding of the funding relationship with respect to Inuit health:

> Inuit appear to be disadvantaged when it comes to programs and services in the area of health and social. And because we get our funding from the federal government – the funding that is allocated from the federal government – it doesn't go directly to the Inuit people, it goes to the public government – the government of Nunavut. . . It appears that they have a two system that they use to go through the Band of First Nations. And eventually, the funds eventually go through the public government here – through the government of Nunavut. So the funds don't go directly to Inuit. That's how it appears to be. Under Health Canada, the system is First Nations and Inuit – we're all lumped into one. (Participant)

Accessing the funds set aside for communities is largely dependent on community awareness of the funding and capacity for developing funding proposals and implementing programs. Funding announcements are usually posted in Hamlet offices and other community offices. If community members are not aware of funding or do not have access to the resources required to put together a proposal, that money may never be used. One participant explains that the combined lack of leadership and awareness of funding may result in funding that goes unused:

> Originally the hamlet office didn't know what to do with it. They would say "we don't do health". A lot of people didn't know all of this funding was sitting in the hamlet office. Some of the communities had lapsed funding for a year or two. No one was taking leadership until myself and another fellow from Social Services started working on it. (Participant)

Finally, while community programs are accountable to the federal government for the funding they receive, no one is ever accountable to communities for where and how money is spent.

Many participants perceive the Federal Government as holding the purse strings with respect to Inuit health. This perception is fairly accurate as Health Canada continues to fund Inuit, First Nations, and Métis health separately from other Canadians. While direct funding to communities may contribute to self-determination in First Nations, federal funding arrangements for Nunavut confuse assumptions about responsibility, participation, and accountability.

> To have self-government without influence and involvement in health services would be strange. However, there's no doubt in Nunavut, with the Federal government, in fact, being responsible for health care for the people, it shifts the focus a bit. Because there are still a lot of people who think of the Feds, not the territorial government, as being responsible for health services. Because they know they pay for it and they're right. And the NIHB rules around what applies and what doesn't, apply before territorial rules. So, in fact, the territorial government, while it administers health, doesn't control it for 90% of the people in Nunavut. It's the federal government that controls it. Another thing that's interesting is that the land claims organizations in their mandates and in the legislation that set them up have never given them a role in managing health and social services. And yet they're often looked upon as the source of self government. (Participant)

The transfer of funds from South to North contributes to the continuity of dependency. But, in the present, Nunavut would not be viable without this transfer of funds. While federal-territorial relations complicate the struggle for self-determination and self-

reliance, direct federal funding to communities may help communities to build capacity needed for this struggle. This is, in part, dependent on what sort of capacity this funding provides for. It is also dependent on how communities and community members see their own potential for engagement in health governance.

D. Regional and Community-Level Health Governance

There are few ways in which participation in health governance is fostered at a community or regional level. At one time, regional boards administered regional health services. These boards were a result of federal devolution of health governance to territories. The Baffin Hospital Board was formed in 1981 as a testing ground for the transfer of health resources from the federal government to the GNWT. This Hospital Board eventually became the Baffin Region Health Board in 1986. Regional Health Boards reported to the Territorial Health Board and the Department of Health. In a study of regional health boards, John O'Neil (1990) found that the roles and responsibilities of the boards included: management of health services and operational policy and control; appointing health care staff; setting long range health service development plans; appointing, evaluating and ensuring professional standards for medical and nursing staff; obtaining and administering adequate financing of health services; and providing adequate personnel, equipment and facilities for patient care, health education and health research.

These boards were similar to Regional Health Authorities in other parts of Canada, in that money was transferred from the territorial government (GNWT) to each

regional board which would then administer health services and programs. The relationship between the GNWT's department of health and regional health boards was characterized by struggle. It is widely believed that the health boards contributed to a lot of financial wastage and that regional management contributed to unequal services across regions.

With the founding of the new territory in 1999, the Government of Nunavut attempted to narrow the gap between communities, regions, and territorial government by dismantling the boards and governing from a territorial level thereby increasing transparency between regions and the territorial government. One participant suggests that the dissolution of the boards "should create a greater opportunity to create a greater degree of equity, to move more quickly in service change, to have less of a super-structure, overhead costs and so on." Another participant suggests that there is "a tremendous kind-of economy of both money and management opportunities to deliver more consistent services than if we had health boards." Some suggest that the dissolution of the regional health boards was meant to take out a "layer of bureaucracy and to make more of a direct link [between communities and government] with respect to policy type decisions" (Participant). It was hoped that this "direct link" would also reduce the overhead costs that resulted from the regional board process.

While the dissolution of the boards may contribute to greater transparency between territorial government and regional services, some perceive it as reducing the autonomy of regions with respect to their health services:

> They weren't as dependent on a government for the various controls that a government puts in place. They were much more like a hospital is in Ontario

> where they have their own board of directors and have a degree of independence. Where they wrestle all the time with the government about the amount of money they should get but once they get it they have a lot of latitude under the health legislation to spend it and manage their own affairs... (Participant)

Another participant explains that while the boards were representative and engaged communities in governance, they had limited authority:

> In my view, the government, because they're the primary funders, still call the shots so that the Boards had very limited authority. Under the GNWT I don't think that the government paid a lot of attention to the Boards. (Participant)

Communities may have been represented on their regional health board but there was no formal link with the community. This reduced the potential for boards to allow for locally developed service design. The administration of health and social services in the Eastern Arctic has historically lacked local levels of governance, or any sense of connection between regions or with the Western Arctic. Because health for Inuit was largely controlled by the federal government, boards were unable to develop local structures.

The inability of regional health boards to effectively link communities and regional governance is contrasted by the success of education boards. Local Education Authorities (LEAs) were formed in the 1970s; by the time regional education councils were established in 1993 there was already a long-standing history of community involvement in education governance. These councils comprised representatives from each of the local education authorities. Monies were transferred from councils to LEA. Regional Boards were seen, by many, as enabling local-level control over decision-making. This was not the case with health. While many communities attempted to establish various committees dealing with health in the 1980s and 1990s there were never

any established links between these councils and territorial or federal government. Moreover, boards operated rather separately from territorial governance.

The dissolution of the boards seems to contradict the emphasis the GN has placed on decentralization. While the DHSS administers territorial health care through three regional offices (Pangnirtung in the Baffin Region, Rankin Inlet in the Kivalliq region, and Cambridge Bay in the Kitikmeot region), these regional offices are not comprised of regional representatives nor do they provide the specific region with any autonomy. They are administrative branches of territorial government. The DHSS is not decentralized in the same way that regional health boards, district health councils, or regional health authorities decentralize. Decision-making continues to be centralized. To provide for some community engagement, the territory requires that each hamlet establish a Health Committee which will link health centres, communities, regional government and territorial government. These committees are committees of the Hamlet Council. The Community Health Committee is not a new innovation. Community Health Committees have existed throughout the Arctic for decades. They have been responsible for promoting community health but have had no financial or health management authority.

In theory, the Community Health Committee will give voice to communities in decision-making around health planning, policy and delivery. In the short term these committees are to "provide an interim process for capturing community concerns or issues regarding health and social services program delivery for community residents" (Johnson, 2001a, p. 2). In the long-term these committees would connect "the

community, its partners, and the Nunavut Government regarding" alignment of the policies, programs and system relationships of the particular community with the vision of *Pinasuaqtavut* – the *Bathurst Mandate* (Johnson, 2001a, 2). In this sense, they resemble health boards but they do not have decision-making power nor do they have any fiscal responsibilities.

At this point, several communities have active health committees but it is unclear whether they have any direct impact on planning, management, or delivery of health and social services. The GN initially piloted the Community Health Committee idea in several trial communities including Gjoa Haven, Kugluktuk and Cambridge Bay. Hamlet Councils appointed community members to sit on the Committees. The Committees then established their terms of reference and consulted with community members to develop strategic plans. Terms of reference are similar across these three communities. Cambridge Bay's Committee (Johnson 2001a), for example, defines their committee as comprising several qualities and goals:

- Autonomous as representatives of the citizens of Cambridge Bay
- An active voice in the retention of the Committee and selection of its members, and control over approved budget and resources
- Long term, continuous, Council commitment and support to expeditiously act upon the recommendations of this Committee
- Open access to information and people, and a direct voice to Council
- A significant voice in planning and implementing a Community Wellness Plan
- The Committee, its members, and its recommendations are taken seriously

One of the first things each of these committees have done is consider the elements that make up a "well community." Gjoa Haven's committee included the following elements: Inuit values and beliefs, cultural activities and life skills, people as happy, self-directed

and empowered, housing, employment, food, education, families, good communications, a radio station, services and resources, service providers, infrastructure, transportation, funding, participation, getting out on the land, spirituality, and volunteering (Johnson, 2001b). Kugluktuk's list is shorter but similar and includes strong "generational values and ties" as well as the recognition of Kugluktuk's and its potential influence at all levels of government (Johnson, 2001c, p. 3). In addition to advising and advocating on behalf of the community, Gjoa Haven's committee is unique among the three in stating that it will be involved in hiring of Health and Social Services staff and assisting in their orientation (Johnson, 2001a, p. 6).

> The health committees are very much in a beginning stage. What we are trying to get them to look at is two fold... The first job was to become familiar with health and social issues within the community. And start thinking holistically how the community can deal with that. Secondly then, is to work with the health and social staff in their roles in dealing with those issues - but to work with them more in advisory and facilitative capacities. We see two roles: one is that they should be able to influence the nurses and social workers and the CHRs on how they do their work in the community. But, hopefully, they'll also help them and advocate for them. (Participant)

While health committees in these three communities may be actively engaged in setting goals, terms of reference and so on, participants in Rankin Inlet, Igloolik, and Iqaluit rarely mention them. Most participants, including some who were active in Hamlet administration and councils, were unfamiliar with their community's health committees and were unable to direct me to health committee members. Moreover, while these committees may have a voice in identifying local concerns and, in Gjoa Haven they may have some say in hiring, it is not clear that they will have any direct involvement in policy, planning and delivery.

By increasing public access to decision-making processes, citizen committees such as community health committees, can open up the governance process, making it more responsive to communities (Box, 1998, p. 85). To provide for this, however, citizen committees need to operate "inside" the governmental structure as a recognized part of the organizational hierarchy. While Community Health Committees in Nunavut are a product of territorial government it is unclear how strong their reporting relationship is with the DHSS and whether they can have a real impact on local health governance. Richard Box (1998) suggests that if committees are merely advisory bodies they will fail to bring citizens into governance for a number of reasons (p. 89-90). First, a lack of responsibility and authority compromises its ability to make a difference in public policy. Second, if participants do not have a good understanding of the services they oversee, their ability to impact policy is further limited. Third, public accountability fades if citizens who volunteer to participate in governing are not given a chance to make a meaningful contribution. Without responsibility or authority these Community Health Committees will struggle for legitimacy at various levels within their communities, local and territorial governance, and service provision.

E. The Front Line

The final enabling influence or institutional factor that I consider in this web of governance is that of front line health service. Participants emphasize the need for more Inuit health care professionals, planners, and decision-makers.

> We need more Inuit translators. And there are no Inuit nurses. I know a couple in the nursing program and I think that's good. We need Inuit nurses. (Participant)

> If you look at all the nurses and the physicians and the specialists, x-ray staff, all the decision-makers at the top. They are all "white" people. And it's been like that as long as I can remember, although things can change… We have to make sure that we're allowing them to expand into all these areas - putting into place affirmative action, education, being role models. (Participant)

Concerns about the invisibility of Inuit in decision-making and frontline health care positions pervade the discourse of health policy, planning, and delivery in Nunavut. Inuit do participate in health provision but only in certain roles. They are interpreters, clerks, CHRs, and Maternity Care Workers. Their limited, and often marginalized, participation in front-line care provision contributes to a lack of understanding of how services currently operate and how they could potentially be transformed. Nurses are often the most or the only accessible professional health care provider in Nunavut communities. In addition, all communities have a CHR and most communities also have social workers and few have dental therapists. On the front-lines of health care provision, Inuit are most likely to occupy CHR, interpreter and administrative support positions. Of the 193 Inuit currently employed by DHSS, 127 provide administrative support, 49 are categorized as paraprofessionals[41] (an increase from 41 in 2001) and nine as professionals (up from six in 2001)[42] (Nunavut, 2002a). A nurse comments on the importance of local-level training in referring to the CHR position:

> People were critical of . . . training [CHRs] when most of them don't stay in their jobs anyway. Well, number one we don't lose them that fast because they are prestigious positions in the communities. But also, I hardly know one CHR that has quit that hasn't gone on to bigger and better things. So the CHR training and

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[41] Paraprofessionals are likely CHRs, Maternity Care Workers and interpreters. Professionals include social workers, dental therapists.

[42] Six Inuit hold middle management positions, one is in Senior Management and one holds an Executive position.

> the position are growth things. People become more confident, more skilled and then they get involved in committees and in the government of Nunavut. So anything that helps people to develop their skills is important. One of the biggest problems for Nunavut is the lack of people with the knowledge and the skills that are required to get the tasks done. (Participant)

As I suggested in Chapter Five, the CHR embodies many of the tensions involved in engaging communities in an imposed system. While the CHR is to play a role in the community level health decision making, along with nurses and social workers, they often become secretaries, interpreters, liaisons, and have very little time to do health promotion or prevention work (Nunavut, 2001c). A joint legislative committee recommended clarification of the CHR role and suggested a more direct link between the CHR and the Community Health Committees to facilitate the development of coordinated, community-based decision making, in conjunction with the Community Health Committees (Nunavut, 2001c). While CHR's are a crucial link between health services and communities, often taking on leadership roles in engaging communities in consultations, their potential roles continue to be limited by lack of staffing at health centres and lack of clarity around their scope of authority.

The current state of nursing recruitment and training in Nunavut highlights some of the issues around both Inuit and non-Inuit participation in the delivery of health care. Nurses are recognized across the territory as crucial to health care provision in the territory. From messages placed in newspapers during National Nursing Week proclaiming nurses as the "champions for health" (Health and Social Services, 2001) to significant efforts to attract nurses from as far away as Australia, the Government of Nunavut has voiced a strong commitment to nursing and to addressing recruitment and

retention problems in the territory. Given the unique nature of remote nursing practice, recruiting nurses from other parts of the world and attracting new people to the profession are not easy tasks.

> You are on-call 24 hours a day, working by yourself, dealing with emergencies. I was here when there was a plane crash and was the first on-call. How do you deal with that kind of trauma and deal with it yourself as well? That's why I'm not still doing clinical. (Participant)

Despite the difficulties, nurses from around the world are drawn to nursing in the Arctic. The GN has banked on this, promoting jobs as far away as Australia. But soon after the establishment of Nunavut, the Standing Committee on Culture, Education and Health (Nunavut, 1999b) questioned the wisdom of hiring additional staff from the South given the expense, not to mention the difficulties with recruitment, retention, and housing, and considerations that come from more investment in the community itself (p. 13). It recommended community involvement in new approaches to mental health, community-wellness with more community-based decision making. It is unclear how this recommendation to involve the community in new approaches to wellness and mental health is unfolding. But its recommendations that the GN invest in Telehealth, the Nunavut Nursing Program, and the Capital Plan (investing in physical infrastructure) have become priorities of the Government.

The Nunavut Nursing Program is an attempt to address the near invisibility of Inuit in health professional positions in their communities. It is based on the assumption that nurses are central to health care provision. But Inuit are not so easily attracted to this profession. Two participants explain their perspectives on this phenomenon. Both suggest that more Inuit are needed in health care positions.

> We need to make the work attractive so people would want to stay in it long term, not just one or two years. Salary and benefits might be a factor. We need to have school curriculum that gets that training going. . . The school curriculum is part of it but so are parents. . . To attract people to health care you need role models, benefits, appropriate school curriculum, parents have to be involved. (Participant)

This participant ends with an emphasis on parent roles. Another Inuk participant, whose daughter is considering the Nunavut Arctic College nursing program agrees that more Inuit are needed but expresses some apprehension about seeing an Inuit nurse or doctor.

> There would be advantages to having Inuit nurses. There's a lot of technical work in medicine and there's no proper translation in Inuktitut. If there were some Inuit nurses, the translation would be better, they could get better explanations. . . For myself, I think I'd still prefer to be seen – not that I'm being prejudiced – but I'd probably be more confident seeing a non-Inuit nurse or doctor. (Participant)

Inuit and non-Inuit are often treated differently in terms of their potential contributions to health care. In the above quote this Inuk admits that she would prefer to see a non-Inuit nurse or doctor. She feels that they would have better qualifications because they are trained in the south. The Nunavut Arctic College nursing program began in Iqaluit in 2000. There are very few people enrolled in the nursing program and none have graduated yet. Individuals who are attracted to the nursing program are often women with children. Without significant financial assistance they may not be able to afford the program and the time required to be a student. A long-standing complaint concerning health services in the North is related to the lack of Inuit health personnel beyond the level of clerk/interpreters, community health representatives, nursing assistants or dental therapists.

These five institutional contexts (territorial government, the NLCA, federal government, community health committees, and front-line providers) constitute a

complex field of health governance in Nunavut. Each context represents various strategies to encourage Nunavummiut participation and factors that both enable and disable participation. These strategies are both shaped and restricted by discourses of health which construct Inuit expertise as marginal to non-Inuit expertise and Nunavummiut lives as risky and in urgent need of help. They are also shaped and restricted by discourses which shift discussions away from health; that suggest that self-reliance and self-determination are key priorities of Nunavut and that IQ and Inuktitut are central to self-determination. In the following section, I consider the ways in which these various institutional factors and the strategies they employ are implicated in two cases of health governance.

II Two cases of citizen engagement in health planning and policy

In this section, I consider how the five institutional areas addressed in the previous section interact with pre-disposing (structural and social) and precipitating (interests and interest groups) influences in enabling or disabling citizen engagement in health policy, planning and policy. I examine how the establishment of Nunavut as a largely Inuit territory and a broader Inuit struggle for self-determination shape or could shape health governance by requiring participation. I look first at a community response to early childhood and parenting education. I then explore struggles at various levels of governance around midwifery. In these case studies, I attend to several "dimensions of participation" including: the overall approach taken to participation; who initiates

participation and the specific means used to involve participants; the extent of community participation; and the breadth or depth of community involvement (Abelson 2001).

A. *The Igloolik Early Intervention Project*

Igloolik is a community with a long history. It was a stopping point for Inuit for centuries prior to the onset of explorers, trading posts, and missions. It has long been an *Inuit place*. Community members have a great deal of civic pride referring to Igloolik as the "cultural capital" of Nunavut. Many Igloolik residents and those who have moved from Igloolik refer to themselves as a people quite distinct from other Inuit. The development of the Igloolik Early Intervention Project highlights issues related to health governance including federal-territorial-community relations, community capacity, and funding.

Nunavummiut concerns around early childhood education and parenting skills have grown alongside national Aboriginal concerns. In response to these concerns, the First Nations and Inuit Health Branch of Health Canada has explored child and youth development as principal policy tracks for addressing health concerns related to children and youth (Stout and Kipling, 1999). To facilitate programs for early childhood education and development it supports community initiatives through Head Start and other initiatives to support communities.

In autumn 1995, Igloolik community members became concerned about early childhood education as attendance in kindergarten dropped significantly. Several Inuit and non-Inuit Igloolik community members mobilized in response to growing concerns

around early childhood and parenting education and support. They brought a complement of proposal writing skills, linkages with other community services, and Inuit Elders. The group became aware of federal funding and put together proposals for Community Action Funds. By 1996 they had obtained funding needed to implement a "home program" – bringing educational activities into homes for individual preschoolers. In Fall of 1996 they put together a proposal to Health Canada for the Igloolik Early Intervention Project. In November 1997 the Igloolik Early Intervention Project (IEIP) "started small" through a Head Start program. Jeela Aqqiaruq, Head Start Centre Coordinator, explains that "As we developed confidence, skills and developed ideas, we looked at community needs and built on from there" (IEIP). The Igloolik Early Intervention Project is now "recognized as a vital part" of the community (Allen and MacDonald, 1999, p. 37).

The IEIP offers child-centred and family-oriented activities, balancing "values, traditions and culture" (IEIP). The core program is the Head Start program for four year olds in which virtually all four year olds in the community participate[45]. Other programs include play programs for infants and toddlers, home programs, evening and parenting programs, teen parenting programs and a prenatal nutrition program. This is a child-centred developmental program designed to reflect the values, traditions, and culture of Igloolik. A popular weekly sewing circle brings Elders and others together. An infant play group reinforces family ties and connects parents with other parents. Through the Home Catch-Up program, the IEIP creates and delivers special activity kits for children

with special needs, with a focus on the four year old. Program participants state that the Centre "is a place to go," to "share stories" (IEIP). Emphasizing the incorporation of Inuit traditions into learning seems more about legitimizing Inuit knowledge and experience, and reconnecting Elders and youth, than a reduction of "tradition" to a throwback from a static past.

The IEIP has become a sustainable service in the community for several reasons. It was initiated through a grassroots effort that brought together both Inuit and non-Inuit expertise in early childhood and parenting education. It provides consistent and sustainable services by providing "hands-on" training and pairing of staff so that "if one leaves the project the other can keep it going." The pairing of staff encourages staff to "take risks with new ideas and receive immediate and constructive feedback for their efforts" (IEIP: Allen and MacDonald, 1999, p. 36). A significant factor in the IEIP's success has been the community-level capacity for obtaining funding and dealing with limited funds. "People of Igloolik have learned to tailor programs with the least amount of money" (IEIP). The IEIP is funded by Aboriginal Head Start, Healthy Children Initiative, Canadian Prenatal Nutrition Program, and Brighter Futures.

Many interview participants suggest that it is difficult to access funding or to know how to access funding for community-based initiatives. An Inuk interview participant comments on the funding issue:

> They [Inuit] do get that funding through proposals to the government. But, the communities don't have enough people working for them that can write these proposals. So, in a sense, the communities are at a disadvantage because there is

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[43] Ninety-two percent (36 of 39) of possible 4 year old children in the community (Allen and MacDonald, 1999).

> no capacity in the community and there is no development of capacity so that communities can start to take advantage of what's there. Now, the Inuit organizations use money for training so that Inuit people know what is available. (Participant)

The task of seeking and obtaining funding is ongoing at the Head Start Centre. In addition to programs and special activities, staff and volunteers discuss funding at weekly meetings. They look for funding opportunities in newspapers, radio, television, and the Hamlet office bulletin boards but they find that the most valuable resource is networking (IEIP). The issue of funding is a central theme in a video that the Centre put together to share their experience of establishing programs with other communities. The video gives advice on involving Elders, networking, diversifying programs, seeking funding, putting together proposals. Moreover, the video is indicative of one community's commitment to assist other communities.

While the funding comes from the federal government, residents view the program as their own. They crafted the IEIP initiative according to their own vision. Moreover, community members have pooled resources and skills to construct and renovate the centre. The IEIP is unique in its breadth of services. But there are other similar community-based and community-driven initiatives across the territory. The establishment of pre-natal nutrition programs, for example, attempts to address nutrition and food access issues. Across the territory, these locally-run, federally-funded programs engage pregnant women and new mothers in cooking, shopping, and nutrition education Many Nunavut communities have these pre-natal nutrition programs. By and large, these programs depend on the awareness, willingness and capacity of the community. Those

that are successful have stories of grassroots organizing and collaboration similar to the Igloolik Early Intervention program.

The IEIP's success highlights the interconnection of pre-disposing, precipitating, and enabling factors. The community's sense of itself prior to colonialism, a collective vision of community self-determination and the presence of Inuit-based success stories such as Igloolik Isuma Productions may contribute to a clearer vision of how individuals can engage themselves in program development and governance. Within this environment, a growing concern with the lack of early childhood programs catalyzed mobilization around the issue. Finally an awareness of funding opportunities, the presence of leadership within the community, and relations between Inuit and non-Inuit and across community groups and organizations enabled participation in the development and maintenance of the IEIP.

B. Maternity Care Legislation and Provision

The "Simplify and Unify" section of the *Bathurst Mandate* suggests that IQ will provide the context in which we develop an open, responsive and accountable government'" (Nunavut, 1999a, p. 4). As I suggested in Chapter Five, while there is widespread commitment to the notion of IQ, its implementation in territorial governance is not an easy task. The prioritization of IQ echoes Northerners' refusal, in the establishment of Nunavut and its government, to accept that their language, culture, traditions, and wildlife harvesting were the crude obstacles to progress that governments

had claimed (Jull, 1999, p. 5). But incorporating IQ into governance processes that are borrowed from the South is complicated.

The development of midwifery-based maternity care services provides for an examination of how notions of expertise and knowledge influence citizen participation. To date, there has been little effort to incorporate Inuit expertise or practitioners at the Rankin Inlet Birthing Centre. A nurse and long-time Northerner explains that Inuit knowledge and experience around such things as childbirth are not visible in communities and any linkage with the community health centres or nursing stations are tenuous, often obstructed by staff turnover and perceptions that health centres are illness centres. A nurse explains:

> I think that the bulk of people have tended to shy away from bringing that to the health centre because they see the health centre in a pretty southern-style, traditional mode. Quite frankly, I think the nurses tend to function that way and haven't necessarily encouraged it. Some health centers where they have nurses that have been in the community longer and are engaged more with the community you'll probably see that they will know somebody in the community who may be able to help a person through more traditional approaches. (Participant)

The lack of visibility of traditional Inuit knowledge around birthing is an example of the significant gap between local knowledge and the knowledge that inform services.

Through the 1980s and 1990s, across Southern Canada, midwives were organizing, establishing jurisdictional standards of practice and training programs, and struggling for legitimacy at community, national, and legislative levels. While many Canadians were talking about bringing childbirth back into women's lives and homes, many Aboriginal people were talking about bringing childbirth back into their communities. In the early 1990s, in response to Inuit lobbying for community birthing

and the high cost of evacuating women for childbirth, the Government of the Northwest Territories supported the implementation of a midwifery-based birthing centre in Rankin Inlet as a pilot project. In 1995, its status changed from pilot project to a full program with a staff of three midwives, two Inuit maternity workers and a clerk interpreter. The Rankin Inlet birthing centre is currently functioning outside provincial legislation, but "its long-term survival seems promising" (Carroll and Benoit, 2001).

This birthing centre was established with the intent of expanding it to a regional service which would offer ongoing training of community-based maternity care workers and possibly midwives. Since its inception, however, it has been plagued by recruitment and retention problems, often operating with only two midwives and only one maternity worker for over two years. One participant explains:

> It is short staffed and there is high burnout rate. There have been about 40 midwives through here. It is an ideal setting to have a midwife from here if we had five or six job-sharing. That's the way it should be (Participant)

While the birthing centre has faced many operating difficulties, many Rankin Inlet women are pleased to have midwives and local birthing options. Moreover, communities across Nunavut are demanding midwifery-based care. But the discussion of midwifery at the territorial level is often stalled or derailed by concerns around standards, safety, legislation, and recruitment. One participant states:

> For eleven years, this issue came to the board every year. There is concern around the care available though. We have nurses in communities but we don't have the services for an emergency birth in the communities. It's all about standards. Standards are not done by governance structures they are set by medical bodies. Maybe we need the political will at the community level to get this going – perhaps an MLA to get community control over setting standards. (Participant)

As explained in Chapter Five, discussion around maternity care in Nunavut is burdened by notions of risk. Such notions do not appear to have had the same deterrent effect on the development of midwifery-based maternity care and training in Nunavik, Québec.[44] Long before the establishment of the Rankin Inlet Birthing Centre, Inuit of Nunavik fought for the introduction of the Innuulitsivik Health Centre in Povungnituk. The establishment of this midwifery-based birthing centre was driven by Inuit of the community, in particular, but also championed by physicians who recognized midwifery as a viable solution to costly and disruptive maternity care practices. Its impact has been much deeper than simply reintroducing midwifery; it appears to have brought back a desire to integrate local knowledge into the health care structure (Lavoie, 2001, p. 348). With this birthing centre, 85% of all coastal births are now happening in Povungnituk, with the remaining 15% taking place in the outlying villages, or in the south in the case of high risk pregnancies or complicated labour. The Centre claims a low caesarean rate and improved perinatal statistics (Tookalak, 2000). Nellie Tookalak, a community midwife from Povungnituk, explains what the birthing centre means to the community:

> Our community sees our Maternity as a major accomplishment in regaining our dignity. We are the leaders of our Maternity and we have the support and partnership of our professional co-workers. Our Maternity has been through many changes in the past few years. In the beginning our women used to ask their questions to the Qallunaats not to us [Inuit midwives]. Now women ask us the

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[44] Notions of risk recently influenced community-based midwifery practice in Nunavik when local level training of Inuit midwives in Povungnituk was challenged by the Québec government in the late 1990s. In 1999, the Québec government legalized midwifery as an autonomous profession but restricted the practice of Aboriginal midwives. The new legislation recognizes Inuit midwives by including them in the Québec Order of Midwives, provided they restrict their practice to the Nunavik territories. Aboriginal midwives currently in training at Inuulitsivik are thus unable to apply for a midwifery license. (Carroll and Benoit, 2001).

> questions and they trust us. It means our self-esteem, not only personal but as a community is coming back. (Tookalak, 2000)

Conversely, an Inuk woman from Nunavut suggests that "the community is not involved at all" in the birthing center:

> In Nunavik the community demanded, created change and they are taking ownership over it. Here, the birthing centre started with a nurse from outside, East, and yes, it's what Inuit women want definitely, but it came from someone outside. It's a difficult situation. (Participant)

Local struggles over the management of birthing practices reveal the underlying assumptions of two cultures and the tension between them (Kaufert, P. and O'Neil, 1993). Nunavummiut are not simply demanding midwifery, they are demanding midwifery-based care that is informed by Inuit knowledge, tradition, and experience. But, as one participant explains, "the self-esteem of Inuit people is so low that they don't think of themselves as good enough to pass on that knowledge."

> The community and the centre agreed that training would happen but it's not happening. It really has to come from the community and the government. If it comes from midwives it comes from the outside. The community has to push for it then it will happen. (Participant)

The institutionalization of aspects of life such as childbirth positions people in a struggle to maintain tradition, identity, and culture. The introduction of modern birthing practices have affected, transformed, and, in many ways, obliterated traditional Inuit experiences and knowledges around childbirth (O'Neil and Kaufert, 1997). For the first time in a long time, this Birthing Centre is now staffed by three midwives and services are being expanded to the region allowing "low-risk" women from across the Kivalliq region to choose Rankin Inlet as their childbirth location rather than Yellowknife or

Churchill. The GN has committed to expanding midwifery services. In its 2003-2004 Business Plan, the DHSS has identified three related priorities: to explore certified midwifery training; to expand Rankin Inlet's service across the Kivalliq territory; and to develop Maternity Care Worker training to expand midwifery services across the territory. The local demand for the incorporation of Inuit knowledge persists.

In this case, potential enablers to Inuit participation in maternity care are disabled through the imposition of southern approaches as well as pervasive notions of risk. Existing North-South relations and the marginalization of Inuit expertise contributes to a context where engagement in maternity care provision or planning is difficult and often impossible. At the same time, the success of Inuit in Nunavik and the combination of local and national efforts have sustained the struggle for local birthing.

These two cases expose how Nunavummiut are variously engaged and disengaged from health policy, planning and delivery. Sherry Arnstein (1969) places levels of self-governance along a ladder of participation. At the top of the eight-rung ladder she lists three declining levels of power-sharing: full control, delegate power, and partnership. In the middle are three degrees of tokenism, placation, consultation, and informing. At the bottom of the ladder are two levels of non-participation: therapy and manipulation. At the top citizens have full self-governance, while at the bottom citizens are manipulated into thinking they have influence by serving on advisory bodies that have no power (Box, 1998, p. 83). The IEIP is an example of partnership where a community group partners with the federal funding agency to provide service. Their autonomy is bounded to a certain extent by the national guidelines that they are required to follow in order to

receive funding. It is further bounded by their ties to an annual funding process. At the same time, the IEIP is a case of self-government over a service, as the group has the capacity and autonomy to determine its programs and the strategies to provide them. The on-going negotiation over midwifery in Nunavut shifts along the ladder as communities experience varying levels of involvement in the discussion. Whether citizens are truly engaged in decision-making around midwifery is yet to unfold. In the final section of this chapter, I consider how local engagement in health governance is implicated in the building of Nunavut as a manifestation of the Inuit struggle for self-determination.

III Whose Change, For whom, By whom?

The establishment of Nunavut was meant to overcome the paternalistic system of governance that controlled the lives of Inuit. This new territory would engage citizens in governance of their own lives. In subverting the sovereign power of Canada over Inuit and Federal Government authority over the territories, new strategies have attempted to bring authority to a local level. Many of these strategies, however, have engaged Nunavummiut in processes of trying to fit into a Canadian or southern-Canadian mold.

The establishment of Nunavut presents a challenge to Inuit and non-Inuit in Nunavut to pursue Inuit self-determination within the context of a public government and the framework of a broader non-Inuit nation. However, as Inuit and non-Inuit come together to do governance they often reduce the other's perspective. Inuit knowledge and experience is often equated with "tradition" while non-Inuit knowledge and experience is often equated with colonialism. The word tradition arises frequently in the discourse of

Nunavut as a territory and as an Inuit territory. Giddens (2000) refers to tradition as an unquestioned practice, one that needs no alternative (p. 59). IQ and attempts at Inuit participation are not recalling tradition as some kind of unquestioned practice or as the only approach. Efforts to engage fellow Nunavummiut in governance, to craft Nunavut as an Inuit territory, cannot be reduced to a dichotomy between past and present, tradition and modernity. This dichotomy contributes to an unnecessary, and unhelpful, splitting of peoples. Nunavummiut, both Inuit and non-Inuit, are demonstrating that participation in governance requires that we rethink how our assumptions guide practice as well as how we locate ourselves and others in governance.

One of the dominant tensions that arise out of health governance in Nunavut is the conflicting notions about who the territorial government represents and who it is constituted by. Territorial government is either framed as "us" or "them." While Nunavummiut demand more from government they also struggle for self-reliance. But self-reliance must necessitate a government that is perceived as "us" rather than "them." Self-reliance requires active citizenship.

Active citizenship occurs when people are engaged in deliberation to influence public-sector decision-making (Box, 1998, p. 73). As Nunavut begins to establish itself as a territory, Nunavummiut are engaged to various degrees in governance. Their engagement depends on a range of "pre-disposing" factors including individual and collective memory of colonialism and pre-colonialism, community cohesiveness and structural factors, and connectedness within communities and across the territory. It depends on precipitating factors including an interest in addressing particular problems

and interest groups (such as Inuit non-governmental organizations) who mobilize around such problems. It also depends to a great extent on the institutional contexts for decision-making. In this chapter I have focused on these "enabling influences" because of the newness of institutional contexts and relationships within and beyond the territory. The hope for governance that facilitates the kind of participatory framework that Inuit envisioned with the crafting of Nunavut, lies with the ways in which the web of institutional factors work together.

Because notions of health and health care have been so recently imposed on Inuit and health governance has consistently been assumed to be the realm of government (usually federal), Inuit are rather disconnected from health governance. But that does not diminish their commitment to addressing a broad range of social problems, to crafting a new, largely-Inuit territory, and continuing to work for self-determination.

Richard Box (1998) proposes four principles of citizen governance or four ways to facilitate citizen participation. The first, the scale principle, is about keeping public decision making and policy implementation as close to the people who are affected by it as possible. This allows citizens to participate directly and meaningfully in self-governance (p. 20). While Nunavut has a small population, decision-making is out of reach for the majority of Nunavummiut because of limited access to leadership positions and weak links between government and communities.

The democracy principle suggests that the "best" public decisions are those that result from public access to information and free and open discussion, rather than the preferences of elite groups, or deliberation limited to elected representatives (Box, 1998,

p. 21). While information related to decision-making and health planning is often readily accessible in Nunavut, deliberation is limited to elected representatives or executive decision-makers. Moreover, information related to health governance is often viewed as the domain of health "experts"

The third principle, the accountability principle, suggests that residents are the "owners" of their communities, so they should be the people making the necessary decisions about which public services to offer and how to operate them (Box, 1998, p. 21). This principle informs much of the discourse on governance in Nunavut. Nunavummiut now face the task of bringing decision-making to the people Relationships between federal, territorial, regional, non-governmental, and community agents will both complicate and facilitate this process. Finally, the rationality principle requires that when making decisions about public policies and programs, citizens, elected representatives, and public service practitioners should "strive to understand and clearly express their values, assumptions, and reasons for the choices they make" (p. 21). With language, knowledge, and perceptual barriers this will not be an easy principle to apply. To overcome the divide that restricts Aboriginal participation in governance requires "a measure of creativity and a break with past policies, laws and practices, both of which are hard for Canadian governments to imagine" (Monture-Angus, 1999, p. 64).

CHAPTER SEVEN

Concluding Thoughts

Nunavut's status as a new, largely Inuit territory, commands our attention. It states that we can no longer treat the Eastern and Central Arctic as a vast, frozen, empty space dotted here and there by small groups of people. Nunavut territoriality demands that we recognize these groups as communities which, together, constitute an important geographical and political space within the nation. Its establishment as a territory marks the culmination of decades of negotiation, struggle, and cooperation. It also marks the beginning of a new approach to governance.

In the preceding chapters, I have pointed to several ways in which health is implicated in the ways Nunavummiut think about who they are and the consequences of this for their engagement in health governance. This research has relevance for various communities including the social sciences, Inuit and non-Inuit and, remote, rural, and northern communities. It makes several important contributions to the study of health, ethnicity, governance, and citizenship. It contributes to the elaboration of a Foucauldian post-structuralism through practical social research. This research points to the instability of power relations and joins in efforts to rethink the way we organize and govern health and our lives. In this chapter I consider these contributions as well as directions for future research.

I Contributing to the Shifting Ground of Sociology

This research makes an important contribution both to the current shift in the sociology of health and ethnicity and to the broader post-foundational shift in the social sciences. It does so by drawing on a post-structuralism that attempts to bring multiple, shifting meanings to the foreground; and by linking up with a post-colonialist effort to interrogate and challenge colonial narratives.

In Chapter Two, I distinguished between two predominant approaches in the sociology of health: social productionist and social constructionist. While social productionists explore how social factors produce or shape health, illness, and medicine, social constructionists attend to the intersubjective creation of meaning, treating health, illness and medicine as socially constructed. Power for the productionist is something that is held and wielded. For the constructionist, it is the potential for your claims to be heard and is less important analytically than the claims themselves. Some constructionists suggest that power itself is a social construct and, as such, can only be examined as the result of claims-making. A Foucauldian post-structuralism subverts this productionist-constructionist division within sociology by suggesting that relations of meaning are relations of power. Rather than something that is wielded, power is the wielding; it is strategies that both parties use in their relations with one another. In this exploration of health governance in Nunavut, I have avoided any attempt to define health or link illness to any particular causes. At the same time, I am concerned with power as it is implicated in Nunavummiut conceptions of health. As such, I have examined how

relations are implicated in the ways in which Nunavummiut come to think about health and health care and the implications of this for their participation in health governance.

I join with others in the social sciences who challenge the dominance of biomedicine by calling attention to diverse notions of health (Cant and Sharma, 1999; Pawluch, Cain, and Gillett, 1998; Kleinman, 1995; Baer, 1991; Anyinam, 1990; Wardwell, 1994). At the same time, I remain cognizant of the risk of reinforcing dichotomies between biomedical and lay discourses, disease as physiological and illness as subjective, notions of modernity and traditionalism. In positing biomedicine against all other approaches we suggest that the others all share something in common – their "primitive", pre-biomedical status. We call them alternative, holistic or traditional. This last term exposes the real crux of the problem. We treat tradition as implying "primitive", "of the past", something different from and preceding modernity. In this way, things of modernity are seen as being more advanced. Aboriginal peoples such as the Inuit demand that we think, instead, of tradition as "of a people". Tradition in this sense refers to a particular way of thinking and doing health that may be different, and may include biomedicine, but is of a different school of thought, experience or expertise. For instance, if I say "She paints in the tradition of cubism," I am not suggesting that she is using a primitive technique, one not so advanced as another. I am linking her with a group of artists who see the world in a particular way, and express that vision in a particular way. Foucault's post-structuralism helps avoid these splits by providing for an exploration of the ways in which we come to attribute meaning to these things. Inuit of

Nunavut challenge this split through their emphasis on IQ, not as something of the past but something of Inuit.

Throughout this research, I have not been concerned with discovering the true meaning of health, ethnicity, Aboriginality, or any other term. I have been concerned with how particular meanings come to be and how processes of meaning-making are implicated in the ways people govern themselves. I have examined the ways in which Nunavummiut and Canadians create and sustain meanings around health, Nunavummiut, governance, Nunavut. I began, in Chapter Four, by looking at the ways in which Inuit have been located – how they have been represented, how they have been employed in the shaping of the nation, how they have seen themselves – in the building of Canada. In Chapter Five I considered several techniques of discipline and resistance that constitute health and health care discourse in Nunavut. This discourse, in turn, frames governance and policy discussions. Moreover, these techniques reflect several tensions that complicate and facilitate the crafting of governance and the participation of Nunavummiut in governance. The tensions that arise in discussions of health status, policy, planning, and delivery in Nunavut are not simply about varying notions of health and illness, they are about different assumptions about what constitutes knowledge as well as whose voices need to be and are part of the discussions.

I suggested that these six techniques are "technologies of the self" or ways of constituting selves within and through systems of power. They give shape to fluid, multiple concepts of the subject. There is not one way of understanding one's self or

one's relationship with others, with governance, with the territory and with health care. These six techniques are part of "webs of discourses" (to use Laclau and Mouffe's [2001] term) within which Nunavummiut are positioned in multiple, intersecting ways.

This research builds on efforts across disciplines to reframe identity, ethnicity and Aboriginality as hybrid. Nunavut and Nunavummiut have been and are continuously shaped by factors including: the ways in which Inuit collectively identify space, previous territorial administrative processes, Inuit and non-Inuit relationships and families, colonialism, trade histories, resource exploration, circumpolar northern relations, the shaping of Canada as a specific geographical space, the establishment of Nunavut as a territory, the land claim agreement, and the development of public government. This establishment of Nunavut is an act of place-making. Because place-making always involves a construction, identity then has to be explained not as something that is possessed but as a mobile, often unstable relation of difference (Gupta and Ferguson, 1997, p. 13).

As I suggested in the concluding thoughts of Chapter Five, the CHR embodies hybrid subjectivity, a "subject-in-process", or "borderland" subjectivity. These borderland identities are subsumed under the nation along with other "asymmetrical identities" including sub-state nationalisms and diasporas (Kaplan, 1999, p. 37). This borderland subjectivity fits well with the multiple, shifting conceptions of self expressed by Nunavummiut. It captures the multiple realities that Nunavummiut live in. Within a borderland, such as Nunavut, there are at least three separate spatial identities. There is the identity based on the state controlling the area, there is the identity based on the

nation within which the occupants most identify, and there is a third borderland identity that is generated from the occupancy and symbolism of the borderland itself (Kaplan, 1999, p. 37). In this way, the notion of borderland provides a way of defining rural and remote communities that open our discussions to the multiple ways in which citizens of these communities locate themselves and the implications of this for health governance. This framing of rural and remote regions as borderlands respects the complexities of issues arising in these regions.

This notion of borderland subjectivity has implications for the way we look at citizenship. It highlights some of the obstacles to participation in governance as well as some of the ways in which participation may unfold. Borderlands exist on the margins and things of the borderlands are marginalized. In assuming that Aboriginal citizenship and rights rest on some "pre-contact" status, we assume that ethnicity, Aboriginality, or non-Aboriginality are static notions. To be recognized as a group with a special form of rights, Aboriginal peoples must be framed as first peoples, peoples that were here prior to other peoples. The idea that Aboriginal people must connect their present rights to the far distant past denies them one of the fundamental characteristics of self-determination: cultures and peoples do change over time (Monture-Angus, 1999, p. 101). Moreover, when we hinge Aboriginal rights on this notion of pre-contact, we turn "the reality of contact, that is, the sharing of diverse cultures formerly separated by an ocean, into a story only about the impact Europeans had on Aboriginal people" (Monture-Angus, 1999, p. 101). We need to rethink what constitutes citizenship. This research suggests that citizenship is best framed, as Brodie (2002) suggests, as a set of practices linked to

governance. It is not merely membership or particular rights. It is a hybrid identity. Governance is about the way we engage in health policy, planning, and provision. It is "the historically shifting and politically negotiated (and enforced) relationships among the three principal domains of a liberal-democratic polity – the state, civil society and the economy – as well as the ways in which citizens and groups articulate their interest, exercise their rights and obligations, and mediate their differences" (Brodie, 2002, p. 54). It includes the entire range of activities of citizens, elected representatives, and public professionals as they create and implement public policy in communities (Box, 1998, p. 2). In Chapter Six, I explored the challenges to engaging in health governance.

The Commission on the Future of Health Care in Canada (2002) attributes "deep and continuing disparities between Aboriginal and non-Aboriginal Canadians both in their overall health and in their ability to access health care services" to several factors: competing constitutional assumptions, fragmented funding to health care services, inadequate access to health care services, poorer health outcomes, different cultural and political influences (p. 211-212). In highlighting the constitution and access and using comparative terms such as poorer and different, the Commission emphasizes its view of health as a right of citizenship. While I certainly agree that health is a right of Canadian citizenship, I argue that we need to reframe our discussion of health disparities within Brodie's notion of citizenship as a set of practices linked to governance. This would bring about a discussion of citizen engagement in health governance which would be much more relevant to the differences across communities and regions and to self-determination movements. It would also enable an exploration of how disparities arise

from the ways in which political rationalities constitute subjectivities and the possibilities for engagement in health governance. It would provide for an inquiry into what we mean by "participation" or "engagement" and how these can be differently defined. This research points to the need for further exploration into the ways in which relations between diverse collectives within settler societies such as Canada complicate citizen engagement in health governance and in the governance of their lives and communities.

II Exploring Possibilities for Social Transformation in the North

If we treat Aboriginality and citizenship as hybrid and, therefore, unstable how is self-determination possible? How can Nunavummiut engage in and re-organize governance in such a shifting context?

Many criticize Foucault for being too pessimistic about possibilities for social transformation. Sawicki (1996) suggests that while Foucault is skeptical about the prospects of total emancipation, he believes it is possible to alter particular normalizing practices (p. 165). He emphasizes the importance of expanding our sense of possibility in the presence rather than imagining alternative social orders (Sawicki, 1996, p. 172). If power is a set of relations characterized by inequality, as he suggests, then it is "always local and unstable" (Clough, 2001). Struggles for self-determination expose the contestability of power relations and the multiplicity of meanings that arises from these relations.

We think of Canada as "multicultural." Characterizing Aboriginal citizenship in Canada with the "nation-to-nation paradigm" complicates this multicultural vision

because it provides First Nations, Inuit and Métis with status that sets them apart from the category of ethnic minority and places them on a level with the two "founding" British and French peoples (Cairns, 2001, p. 28). Movements for self-determination challenge our notion of Canada as a multicultural democracy where many cultures make up one body.

Instead of isolating self-determination movements to particular minority groups, Jorge Valadez (2001) suggests that we treat a combination of sociopolitical doctrines as jointly providing a theoretical base for multicultural democracies. In this way all groups are framed as involved in some movement toward self-determination. He distinguishes between three forms of self-determination. "Accomodationist cultural groups" seek self-determination within the institutional structures of the majority society. Others strive for self-determination through autonomous governance within the boundaries of the state or seek autonomous self-determination through greater control of the state's political apparatus within their territories (Valadez, p. 13-15). In other instances, cultural groups seek secession and either independent statehood or irredentist integration (Valadez, p. 13). Valadez suggests that together, these three sociopolitical doctrines jointly provide a theoretical base for multicultural democracies (p. 17). If we look at self-determination as shaping the nation in this way, we can begin to appreciate the similarities and differences across struggles.

Many Nunavummiut suggest that self-determination is about involvement in decision-making, planning and provision. As a product of Inuit struggles for self-determination, Nunavut is expected to bring power to define, determine, establish, and

evaluate policy-making, planning and delivery of health services to the local, largely-Inuit community level. The establishment of Nunavut shapes new institutional contexts for decision-making which both encourage and impede participation. One of the dominant tensions that arose out of the exploration of health governance in Chapter Six is the way in which Inuit representative organizations are framed as "us" and territorial government is framed as "them." In addition to the divide between public government and Inuit, many Inuit Nunavummiut find it difficult to see themselves in health governance because they see health as southern terrain. Perceptions around who has authority to deal with problems, to address problems, to define strategies and solutions vary across the territory. The establishment of the new territory of Nunavut is meant to engage citizens in governance of their own lives. In subverting the sovereign power of Canada over Inuit, new strategies have attempted to bring authority to a local level. Many of these strategies, though, have engaged Nunavummiut in processes of trying to fit into a Canadian or Southern-Canadian mold.

Inuit, however, challenge conventional notions of government, governance and expertise with their emphasis on IQ and self-reliance. They speak of IQ not as specific tools or methods but as an alternate perspective on the world, illness, and governance. They attempt to reframe governance in terms of Inuit experience and expertise. At the same time, they are not rejecting non-Inuit expertise and experience. While several participants raised concerns about the imposition of southern systems and approaches, most suggested that undoing the relationship between North and South, Inuit and non-Inuit is impossible. Most suggest, rather, that they would like to transform the

relationship from one of dependency to one of cooperation. Many Inuit are married to non-Inuit and have raised families and communities together. Many non-Inuit have lived in the North for decades and some were born and raised in the North.

This research points to two significant challenges posed by Nunavut and Inuit self-determination. The first is to Inuit and Nunavummiut, more generally, to shape a territory that meets the vision set out in the Bathurst Mandate while remaining flexible to the multiple visions of Nunavummiut. The second is to Canada and Canadians to open up to the possibilities of new governance models and strategies. To meet this challenge we need to recognize how our engagement in governance discourse affects others. We need to consider our own contribution to colonialism. And we need to work together to explore how we can recognize collective struggles for self-determination while maintaining some national unity. The pathway to a new relationship is paved with the long-term commitment to share definitional power (Monture-Angus, 1999, p. 43).

III Directions for Future Research

This research points to several directions for future research. It calls for further exploration and consideration of the ways in which citizenship and participation connect and how this connection is implicated in governance. This study points to the need to examine citizenship and participation in rural and remote communities and how they relate to the complexities of health governance in these communities. Finally, it calls for reflection on our roles as researchers in Aboriginal research and of the ways in which colonial relations unfold in research processes.

The growing body of research on citizen participation in health governance raises questions about the role and implications of public participation in health systems governance (Abelson and Eyles, 2002). While this work calls attention to a broad spectrum of communities, citizens, and citizen groups, this work does not address how remoteness and citizenship struggles contribute to or complicate participation in health governance. Rural, northern, and remote communities often struggle with limited access to health services, not to mention the planning and policy-making processes that affect access and quality. Moreover, these communities are often Aboriginal communities, engaged in self-government and citizenship negotiations. We need to explore how citizenship struggles complicate possible engagement in processes that dictate the access to as well as the kind and quality of health services. We need to ask how notions and standards of accountability are differently defined and applied within various models of and struggles for self-government. And we need to consider the implications of self-government and citizenship struggles in remote, northern, and rural communities, for local participation in health governance.

Rural, remote, and northern communities present the opportunity to deepen our explorations of citizenship and governance, not by providing a microcosm of the greater urban community, but by adding further complexity to the questions we pose. Rural and remote communities are often framed as "backward", needing to be brought closer to the urban. Governance for these communities is assumed to be less complicated than for urban centres. This exploration of health governance in Nunavut suggests that the

complexities of rural and remote communities hold the potential to challenge what we think of as appropriate strategies for health and health care.

Wharf (1991) suggests that rural and remote communities are particularly suited to exploring aspects of policy and practice which enhance social services in all communities (p. 132). He claims that because these communities are small in terms of population, geographic size, and the number of social service agencies, community control is easier to conceptualize, plan and implement than in a large urban centre. Moreover, the small number of key politicians and professionals in a rural or remote community can more easily converge their interests and initiate action and politicians can consult with citizens on the direction and shape of a new policy (Wharf, p. 136). In presenting rural and remote communities as ideal labs for policy research, Wharf seems to suggest that rural and remote communities comprise homogenous collectives. While I agree with Wharf's call for greater attention to policy and governance issues in rural and remote communities, I disagree with his assumptions about the ways in which these communities constitute ideal contexts for the development of strategies that can be translated to urban centres. I contend that rural, remote, and northern communities experience governance issues and complexities unique to rural and remote communities. Moreover, this research suggests that the diversity among and between such communities makes it difficult to generalize in the way that Wharf suggests is possible.

Concerns around childbirth and maternity care came up again and again in my discussions with Nunavummiut about health. Inuit suggest that childbirth and maternity care as particularly important to self-determination. As increasing numbers of

communities engage in struggles for self-government, maternity care reform offers a particularly salient way of exploring citizen participation in the governance of health services for remote, rural, and northern communities. A significant body of research exists which points to the social costs of evacuation for childbirth as well as Inuit struggles to bring birthing back to their communities (Chamberlain and Barclay, 2000; Davis-Putt, 1993; Kaufert and O'Neil, 1990; Sennett and Dougherty, 1991). There is new interest in comparative work to explore the politics and organization of maternity care across nations with different political and economic structures (DeVries, Benoit, Teijlingen, and Wrede, 2001). Exploring maternity care governance across regions and across nations could provide new and important insight about the intersection of citizenship struggles and participation in health governance.

Post-structuralism and post-colonialism provide a particularly useful framework for these kinds of explorations. Foucault's analysis of governmentality calls attention to mechanisms of power, their histories, and how they are perpetuated and challenged. Post-colonialism questions historical accounts and colonial subjectivities. Framing questions within these two approaches facilitates exploration of governance and citizenship as processes that are socially, politically, and historically located.

Sawicki (1991) suggests that "one of Foucault's most important insights is his insistence that one's theoretical imperatives and commitments be motivated by specific practical imperatives. He wrote from the perspective of a specific intellectual engaged in specific interventions (Sawicki, 1991, p. 108-109). The post-foundational turn emphasizes the link between theoretical and practical questions. In doing so, I believe it

reinforces the notion that we cannot separate the theoretical from the methodological Our methods choices are very much rooted in our approach to the world and to research As such, we need to think seriously about how our methods choices shape our research processes and how we engage in research. Moreover, we need to consider how we treat the "field" in our research.

In linking research questions to particular constructions of place such as rural, remote, and northern, we have to attend to the ways in which we engage ourselves in these fields. This requires a decentring of the field, as Gupta and Ferguson (1997) suggest. By decentering "the field" Gupta and Ferguson (1997) suggest that we might facilitate a move away from "the field" as outside, to a mode of study that attends to the interlocking of multiple social-political sites and locations (p. 37). As we interrogate North-South or rural-urban relations in our own nation, or compare across borders in an increasingly interconnected world, this approach to the field will enable us to better account for our positioning as researchers. It would not only decentre the field but also the researcher as expert.

As a non-Aboriginal researcher, I am uncertain about my relationship with Aboriginal research. I believe there is a place for non-Indigenous researchers in projects that interrogate colonial relations The challenge is to find ways of doing research that decentres our own roles as researchers and work to build partnerships in research processes. There are many potential forms for such partnerships. Linda Tuhiwai Smith (1999) examines several proposed strategies for engaging Aboriginal people and communities in research that is first framed by Aboriginal peoples. First, "the mentoring

model" brings in authoritative Aboriginal people to guide and sponsor the research. In another, "the adoption model", the researcher is incorporated into the daily life of Aboriginal people, sustaining a life-long relationship which extends far beyond the realms of research. The "power sharing model" requires that researchers "seek the assistance of the community to meaningfully support the development of a research enterprise". And "the empowering outcomes model", is one in which questions are framed by the Aboriginal community. While these approaches provide for potential collaborative work, they do not challenge assumptions that underlie the research focus and the translation processes (Smith, 1999, p. 177). They may not challenge hierarchies of knowledge and assumptions about legitimacy. Smith (1999) proposes, instead, "bicultural" or partnership research. This involves both indigenous and non-indigenous researcher working on a research project and shaping that project together (p. 178).

We need to consider ways of involving ourselves in this fifth model as well as the implications of such involvement for research, academic institutions, communities, and funding bodies. This requires that we challenge our own notions of our expertise as "social scientists" and give up some of the authority that comes with that. When we embark on the exploration of social phenomenon we need to acknowledge our own locations. In doing so, our questions might change. We need to look for ways of doing collaborative research. We need to help build capacity for research in Aboriginal communities. We need to be available and we need to respect requests to back off. Most importantly, I contend, we need to work to break down barriers not only within academia but across communities. In doing so, we can open up our own research processes to the

stories told in other disciplines and fields as well as the strategies used to tell those stories.

Inuit are using a broad range of strategies to tell their stories and to engage each other and non-Inuit in dialogue. Faye Ginsburg (2002) suggests that Flaherty's 1922 film "Nanook of the North" obscures the engagement with the cinematic process by Allakanallak (the Inuk actor who plays Nanook) and others who worked on the production in various ways as technicians, camera operators, film developers, production consultants. In its attempt to mimic ethnographic narrative, it erases the roles that its objects play in putting the story together. It is part of a history of unequal "looking relations" (Gaines, 1988 in Ginsburg, 2002) Zacharius Kunuk's subversion of these unequal looking relations with his film "Atanarjuat – The Fast Runner", is exemplified as the credits role and we see who is behind the making of the film. We see actors as actors and film crew as film crew. We see Inuit telling an Inuit story. We see Inuit using technology introduced by the South. This subversion is not about turning the camera on one's self. It is about taking the camera and telling a story from one's own perspective. As the credits role, Kunuk reminds us that it is a story being told, acted and filmed.

In closing, it seems fitting to give the final word to participants.

> I think before Inuit self-determination is possible, not only Inuit but northerners have to have a sense of wellbeing.... I don't know if it's whole or more complete before Inuit self-determination will be possible. (Participant)

> I think people need a place to tell their stories. Because people have never really aired their problems, they've grown and grown until they're unmanageable. So I think these organizations [government and NGOs] can help bring these stories out into the public eye.... I think these organizations can really act as a place where

they can get the stories out from these people who are hurting inside. I think that's the biggest role that they can play right now. (Participant)

[I would like to see] Inuit people becoming more assertive in their own cultures to the point of saying I'm very good at this, so good I can make money at it. There is a lot of hidden talent out there. Some people just need that little push to bring out their talents. (Participant)

I realize that with Nunavut just starting or being in the beginning stages that there are transition years these are going to take time but I see a lot of really good things happening so that we have more control over education and other things… It's more of a challenge for me right now but I'm enjoying the challenge. Maybe because I feel that I have more ownership. (Participant)

It's important to have Nunavut. It's just important to us to grow up here, to live here, and to continue living here. (Participant)

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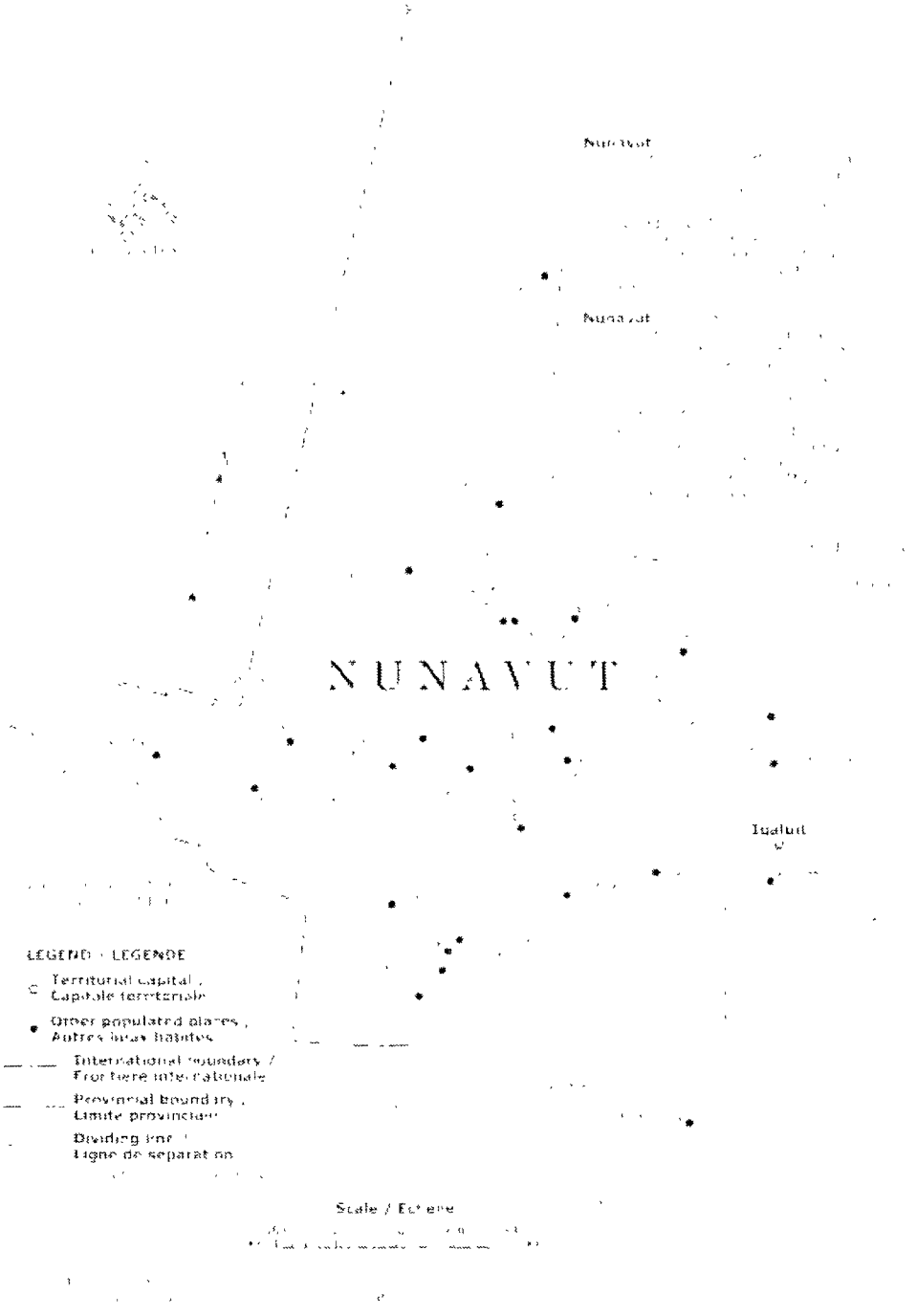
Appendix A


NUNAVUT
Iqaluit
LEGEND / LÉGENDE
Territorial capital /
Capitale territoriale
Other populated places /
Autres lieux habités
International boundary /
Frontière internationale
Provincial boundary /
Limite provinciale
Dividing line /
Ligne de séparation
Scale / Échelle

Appendix B

Appendix C

Consent to Participate in Research
Experience and Practice: Health, Health Care and Self-Determination in Nunavut

You are invited to participate in an interview for the research study conducted by Sara Tedford of the Department of Sociology, McMaster University.

Purpose of the study
The purpose of this study is to develop an understanding of how residents of Nunavut understand and experience health, health care and self-determination. This study is funded by a Social Sciences and Humanities Research Council of Canada Doctoral Fellowship.

Procedures
You are invited to participate in a one and a half (1.5) hour interview with Sara Tedford. The interview will be audio-taped only with your permission. The interview will be conducted in a language of your choice and in a location of your choice. If you choose to have the interview conducted in a language other than English or French, Sara Tedford will employ an experienced translator to assist. You will receive a copy of the interview transcript once it has been transcribed. You will be provided with a written summary of the project in a language of your choice and you will have access to the final report.

Potential Risks and Discomforts
There is a risk that discussing your health experiences could be upsetting to you. Sara Tedford will be able to refer you to support services where you can further discuss any issues of concern that may arise during the interview.

Potential Benefits of the Study
The study will give participants an opportunity to discuss views of and experiences with health, health care and self-determination. This study will contribute to understandings of the connection between self-determination and health as well as the potential for new approaches to health care planning.

Compensation
You will receive compensation for any travel and child care expenses incurred due to participation in this interview.

Confidentiality
All information that you provide will be treated with the strictest confidence. You will never be identified by name or any other distinguishing features in any written, verbal, aural, or tape-recorded documents related to this study, and any identifying information that you provide will be treated with the strictest confidence. Pseudonyms will be used in transcription and in all reports. Any code linking the pseudonym to you will be kept in a

secure place at McMaster University for the duration of the study so as to safeguard your anonymity and any other person you refer to in your interview. The tapes, codes and written notes concerning your interview will be kept in a secure place where only the researcher will have access to them throughout the duration of the study. Once the study is completed the codes and tapes of the interview will be destroyed. Once your interview is transcribed you will receive a copy of the transcription. You will then have the opportunity to make changes to your transcription or withdraw your interview in its entirety from the study.

Participation and Withdrawal from the Study
You can choose whether to participate in this study or not. Your involvement in the study will have no effect on your current employment position nor on any health care services you receive. If you volunteer to be in this study, you may withdraw at any time without consequences of any kind. You may also remove your data, in part or in whole, from the study at any time during or after the interview. You may also refuse to answer any questions that you don't want to answer.

Rights of Participants
You may withdraw consent at any time and discontinue participation without penalty. You are not waiving any legal claims, rights or remedies because of your participation in this study. This study has been reviewed and received ethics clearance through the McMaster Research Ethics Board (MREB). It has also been reviewed and has received a research license (#0500301N-M) from the Nunavut Research Institute. If you have questions regarding your rights as a research participant, contact:

MREB Secretariat	AND/OR	**Nunavut Research Institute**
McMaster University		Nunavummi Qaujisaqtulirijikkut
1280 Main Street W. CNH-114		Box 1720, Iqaluit, NT X0A 0H0
Hamilton, ON L8S 4L9		Tel.: (867) 979-4108
FAX: 905-540-8019		Fax: (867) 979-4681
Telephone: 905-525-9140, ext 24765		E-mail: slenri@nunanet.com
Email: grnbell@mcmaster.ca		www.nunanet.com/~research

Sara Tedford and her Faculty Supervisor, Dorothy Pawluch, can be contacted at: the Department of Sociology, 6th Floor KTH McMaster University, 1280 Main St West, Hamilton ON L8S 4M4.
Sara can also be contacted at tedforsk@mcmaster.ca and [Nunavut address and phone number].

I understand the information provided for the study "Experience and Practice: Health, Health Care and Self-Determination", as described above. My questions have been

answered to my satisfaction and I voluntarily agree to participate in an interview for this study. I have been given a copy of this form.

_____ _____

Name of Participant Signature of Participant

_____

Date

In my judgement, the participant is voluntarily and knowingly giving informed consent and possesses the legal capacity to give informed consent to participate in this research study. Furthermore, I respect the terms of confidentiality outlined herein and am bound to these terms.

_____ _____

Signature of Investigator Date

I respect the terms of confidentiality outlined herein and understand that I am bound to these terms. I agree to treat all information provided in this interview with the strictest confidence.

_____ _____

Translator's signature Date

Appendix D

ᐊᐢᑭᑭᑦ ᐊᐱᖅᓯᖅᑕᐅᓂᖅᓗᑦ ᖃᐅᔨᓴᓂᓂᖅᑎᑦ
ᐊᑐᖃᒡᑕᓂᓂᖅ ᐅᑦᑐᖃᒡᑕᓂᓂᓗ: ᐃᓐᓂᐊᓕᕆᔨᑕᑕᓂᖅᑎᓪ, ᐃᓐᓂᐊᓕᕆᔨᖅᑕᐅᓂᓂᖅᑎᒃ ᐊᒻᒪᓗ ᓇᒻᒥᓂᖅ
ᐱᓕᕐᓇᖅᓯᓪᓕᐊᓂᖅᑎᒃ ᓄᓇᕗᒻᒥ

ᖃᐅᔨᓴᐅᔨᕐᓗᓂᑦ ᐱᖃᑕᐅᔨᓴᐅᔨᕐᓗᑦᓯᓐᓂᑦ ᐊᐱᖅᓯᓂᐊᕐᓂᑦᓗᒍ ᖃᐅᔨᓴᔨᓂᐅᓂᐊᖅᑐᑦᓗᑦ ᑲᒪᓂᐊᖅᑐᓂ ᓯᐅᕐᐅᕐ
ᑎᐊᑦᕗᑦ ᐃᓄᓕᓪᓂᓂᓗᑦ ᐱᓕᓪᓚᐃᐊᑯᓘᖅᓯᒪᓕᕐᓂᖅ, ᒪᖅᒪᔭᑎᑐ ᓯᓚᑐᑐᒍᔨᖅᓴᕐᕕᖅᑎᒥ.

ᐱᓵᕐᐊᑎᖏᓐ ᖃᐅᔨᓴᔨᓂᐅᑦ

ᖃᐅᔨᓴᔨᕈᑕᐅᓂᐊᖅᑐᑦᓯᓚ ᑕᒪᓐᓇ ᐱᓵᕐᐊᑎᑦᓚᓐᓇᒍ ᖃᐅᓂᖅ ᓄᓇᓚᐅᕐᕕᑦ ᓄᓇᕗᑦᒥ ᑐᐸᔨᐅᒪᓂᖃᖅᑎᒪᖏᑦᑕ
ᑎᐊᒻᒪᓗ ᐊᑐᖅᑎᑎᕐᒪᖏᑦᑕ ᐃᓐᓂᐊᓕᕆᔨᑕᑕᓂᖅᑎᒃ. ᓇᓪᒥᓂᖅ ᖃᒪᑎᑦᑎᐊᓂᖅᑎᒃ ᐊᒻᒪᓗ ᓇᓪᒥᓂᖅ
ᐱᓕᕐᓇᖅᓯᓪᓕᐊᓂᖅᑎᒃ. ᖃᐅᔨᓴᔨᓂᐅᕐᕕᖅ ᑭᓇᐅᔭᖃᖅᖄᑕᐅᕐᓂᖅ ᑭᓪᓕᓯᓂᐊᖅᑎᓂᒃ ᐊᒻᒪᓗ ᐃᓄᐃᑦ
ᖃᐅᔨᓴᖅᑎᓂᐊᖅᑐᒃ ᐃᓂᓯᒪᔭᕐᓂᒃ. ᑕᐃᒪ ᐅᖃᐅᔨᓯᒃ ᐊᑐᐸᒪᔭᐃᑦ ᐊᑐᔨᓗᒍ ᐱᓕᕐᓇᖅᓯᓪᓕᐊᓂᖅᑎᒃ
ᖃᓪᓗᓈᑎᑐᖅᓯᒪᔨᑦᑕ ᐅᐃᓱᐊᑎᑐᓪᓗ. ᓯᐅᕐᓗ ᑎᐊᕐᓂᑦ ᑐᓴᕆᒥᒃ ᐃᑲᔪᕐᒥᒃ ᐊᑐᔨᓗᒍ.
ᑐᓂᓯᔭᐅᑲᔭᖅᑐᑎᓪᓗ ᑎᑎᕆᖅᓯᒪᓕᕐᒥᒃ ᐊᐱᖅᓯᐸᑎᓂᓂᖅᑎᒃ ᑎᑎᕆᖅᑕᐅᑭᖅᓯᒪᓕᓂᖅᑲᑦ. ᑐᓂᓯᔭᐅᑲᔭᖅᑐᑎᑦ
ᑎᑎᕆᖅᓯᒪᓕᕐᒥᒃ ᓇᐃᓪᓂᓕᖅᓯᒪᓕᕐᒥᒃ ᐱᓪᓚᐊᖏᓐᓂᓂᒃ ᐃᓪᓕᐊᑦ ᐅᖃᐅᔨᓯᖏᓐᓄᒍᑦ ᒪᓕᓪᓗᒍ ᐊᒻᒪᓗ
ᑭᖏᑦᓪᓗᓂᖅᑲᓪᓚᕐᒥᒃ ᓇᐃᓪᓂᓕᕆᔨᓴᕐᕕᖅᑎᓪᓗᑎᒃ.

ᑲᔪᓯᖏᓪᓕᒍᑕᐅᔪᖏᓐᓇᖅᑐᑦ ᐊᒻᒪᓗ ᐊᑲᐅᖏᓪᓕᓪᓕᐅᑭᑕᐅᔪᖏᓐᓇᖅᑐᑦ
ᑲᔪᓯᖏᓪᓕᒍᑕᐅᔪᖏᓐᓇᕆᓪᓚᑦ ᐊᑲᐅᖏᓪᓕᓪᓕᐅᑭᖅᑕᐅᔪᖏᓐᓇᖅᑐᑦ ᐅᖃᖅᑐᑎᓪᓗᒋᑦᑐᖅᑐᑦ ᑕᑯᔭᐅᓯᒪᔪᓂᖅ ᐊᒻᒪᓗ
ᐊᑐᖅᑕᐅᓯᒪᔪᓂᖅ ᐃᓐᓂᐊᓕᕆᔨᑕᑕᓂᖅᑎᓪᓗᑎᑦ, ᓇᓪᒥᓂᖅ ᑲᒪᑎᑐᑎᐊᓂᖅᑎᓪᓗᑎᑦ ᐊᒻᒪᓗ ᓇᓪᒥᓂᖅ
ᐱᓕᕐᓇᖅᓯᓪᓕᐊᓂᖅᑎᓪᓗᑎᑦ. ᑕᒪᓐᓇ ᖃᐅᔨᓴᔨᓂᐅᔪᖅ ᐃᑲᔪᓂᖅᑲᓪᓚᕐᒥᒃ ᑐᓴᕆᒥᒃᑐᖅᓯᒪᓕᕐᓂᖅᑲᑦ
ᐊᑕᐅᐊᓂᖏᓐᓂᒃ ᓇᓪᒥᓂᖅ ᐱᓕᕐᓇᖅᓯᓪᓕᐊᓂᖅ ᐊᒻᒪᓗ ᐃᓐᓂᐊᓕᕆᔨᑕᑕᓂᖅᑎᓪᓗᑎᑦᑕᐅᖅ ᓄᑦᓂᒃ
ᖃᓄᖅᑑᓇᐅᑎᓂᔪᓂᒃ ᐃᓐᓂᐊᓕᕆᔨᑕᑕᓂᖅᑎᓪᓗᑎᑦ ᕿᑐᓄᑦᓯᕐᓗᑎᓂᓕᕐᓇᖅᑐᓂᒃ.

ᐊᓯᖏᑦᑕᐅᓂᒃ

ᖃᐅᔨᓴᐅᔨᕈᑕᐅᓂᐊᖅᑐᑦᓯᓚ ᑕᒪᓐᓇ ᐱᓵᕐᐊᑎᑦᓚᓐᓇᒍ ᖃᐅᓂᖅ ᓄᓇᓚᐅᕐᕕᑦ ᓄᓇᕗᑦᒥ ᑐᐸᔨᐅᒪᓂᖃᖅᑎᒪᖏᑦᑕ
ᑎᐊᒻᒪᓗ ᐊᑐᖅᑎᑎᕐᒪᖏᑦᑕ ᐃᓐᓂᐊᓕᕆᔨᑕᑕᓂᖅᑎᒃ. ᓇᓪᒥᓂᖅ ᖃᒪᑎᑦᑎᐊᓂᖅᑎᒃ ᐊᒻᒪᓗ ᓇᓪᒥᓂᖅ
ᐱᓕᕐᓇᖅᓯᓪᓕᐊᓂᖅᑎᒃ. ᖃᐅᔨᓴᔨᓂᐅᕐᕕᖅ ᐅᓇᓱᐊᖅᑐᓂᒃᑐᖅᓯᒪᓕᕐᓂᖅᑲᑦ ᐊᒻᒪᓗ ᓇᓪᒥᓂᖅ ᐃᓄᐃᑦ
ᐱᓕᕐᓇᖅᓯᓪᓕᐊᓂᖅᑎᒃ ᐊᑐᖅᑕᐅᓯᒪᔪᓂᖅ ᐊᒻᒪᓗ ᐊᑐᖅᑕᐅᓯᒪᔪᓂᖅ ᐃᓐᓂᐊᓕᕆᔨᑕᑕᓂᖅᑎᓪᓗᑎᑦ.

ᐊᐱᕐᓂᖅᑕᐅᓂᖅ

ᐊᐱᕐᓂᖅᑕᐅᓚᐅᖅᑐᓂᑦ ᑲᒃᖏᑦᑕᐅᑎᒥᓂᓪᓂᒃ ᐊᒻᒪᓗ ᖃᑐᑦᖏᓚᐃᑦ ᕿᐃᓕᕆᐅᕐᓴᑎᒥᓂᖏᑦᑕ
ᐊᐱᖅᓯᓂᐊᖅᑕᐅᓂᒃ ᐱᓵᕐᐊᑎᑦᓚᓐᓇᒍ.

ᐅᓴᖅᑕᐅᔪᓐᓇᖅᑐᑦ

ᑐᓴᖅᑕᐅᔪᓕᒫᑦ ᐃᓕᓐᓂᒃ ᑲᒪᒋᔭᐅᓂᐊᖅᑐᑦ ᑲᙳᓇᖅᑑᓗᒋᑦ. ᐊᑏᑦ ᐅᖃᐅᓯᕆᔭᐅᓚᐅᖅᓯᒪᔾᔫᖕᒋᑦᑐᖅ ᐅᑉᐱᓘᓐᓃᑦ ᐊᓯᐊᒍᑦ ᑕᐅᑦᑐᐃᑦ ᓇᓗᓇᐃᖅᑕᐅᓚᐅᖅᓯᒪᔾᔫᖕᒋᑦᑐᖅ ᑎᑎᖅᑲᑎᒍᑦ. ᐅᖃᐅᓯᖅᑎᒍᑦ. ᓂᐱᑦᑎᒍᑦ ᐅᑉᐱᓘᓐᓃᑦ ᓂᐱᓕᐅᖅᑕᒥᓂᕐᓂᒃ ᖃᐅᔨᓴᕐᓂᕐᒥ. ᐊᒻᒪᓗ ᓇᓗᓇᐃᖅᓯᒍᑎᑦ ᑲᒪᒋᔭᐅᓂᐊᖅᑐᑦ ᑲᙳᓇᖅᑑᓗᒋᑦ. ᐊᑎᓚᖕᒋᑦᑕᕐᓂᒃ ᐊᑐᕋᔭᖅᑐᑦ ᑎᑎᕋᖅᑕᐅᓕᖅᑲᑕ ᐊᒻᒪᓗ ᑐᓴᕐᓴᓕᒫᓂᑦ. ᖃᓄᐃᓐᓇᑦᑎᐊᖅ ᖃᐅᔨᓴᐅᖁᓇᒍ ᑐᖅᑯᖅᓯᒪᔭᐅᑦᑎᐊᓂᐊᖅᑐᑦ ᒫᒃᒫᔅᑐ ᓯᓚᑦᑐᓴᕐᕕᔾᔪᐊᖓᓂ ᖃᐅᔨᓴᕐᓂᖅ ᐊᓂᒍᓚᐅᖅᑳᑎᓐᓇᒍ ᖃᐅᔨᔭᐅᖁᓇᑎᑦ ᐊᒻᒪᓗ ᑭᓇᐅᓐᓇᑦᑎᐊᖅ ᐅᖃᐅᓯᒥᓃᑦ ᖃᐅᔨᓴᐅᖁᙱᑕᐃᑦ ᐊᐱᖅᓱᖅᑕᐅᑎᓪᓗᑎᑦ. ᓂᐱᔅᓴᐃᑦ. ᐊᑐᐊᕋᐃᑦ ᐊᒻᒪᓗ ᑎᑎᖅᑕᐅᓯᒪᔪᑦ ᐊᐱᖅᓱᖅᑕᐅᒍᑎᒥᓂᑦ ᑐᖅᑯᖅᑕᐅᓯᒪᑦᑎᐊᓂᐊᖅᑐᑦ ᖃᐅᔨᓴᖅᑎᒧᑦ ᑭᓯᐊᓂ ᑲᒪᒋᔭᐅᔪᓐᓇᖅᑎᑉ ᖃᐅᔨᓴᕐᓂᓕᒫᖏᓐᓂ. ᖃᐅᔨᓴᖅᑏᑦ ᐱᔭᕇᑐᐊᖅᑲᑦ ᐊᑐᖅᑕᐅᔪᑦ ᓂᐲᑦᑐ ᓱᕋᐃᔭᖅᑕᐅᓚᔭᖅᑐᑦ. ᐊᐱᖅᓱᖅᑕᐅᒍᑎᒥᓂᑦ ᑎᑎᖅᑕᐅᓯᒪᓕᖅᑐᐊᖅᑲᑕ ᓇᓯᐅᔾᔨᕕᐅᓚᔭᖅᑐᑦ ᐊᔾᔨᙳᐊᓂᒃ. ᑕᐃᒪ ᐱᕕᖃᑦᑎᐊᕋᔭᖅᑐᑦ ᐊᓯᔾᔨᖅᑕᒪᓐᓂᕈᕕᑦ ᑎᑎᕋᖅᓯᒪᔪᓂᒃ ᐃᑉᕕᑦ ᒥᔅᓵᓄᑦ ᐳᑉᐱᓘᓐᓃᑦ ᐲᖅᑕᐃᓐᓇᓄᓗᒍ ᐊᐱᖅᓱᖅᑕᐅᒍᑎᒥᓃᑦ ᖃᐅᔨᓴᕐᓂᒥᓂᕐᒥ.

ᐱᖃᑕᐅᓂᖅ ᐊᒻᒪᓗ ᐱᖃᑕᐅᔪᓐᓂᕐᓂᖅ ᖃᐅᔨᓴᕐᓂᕐᒥ

ᐃᓱᒪᖅᓱᖅᑎᐊᖅᑐᑎᑦ ᐱᖃᑕᐅᔪᒪᒍᕕᑦ ᐱᖃᑕᐅᔪᒪᙱᑦᑯᕕᑦᑑᓐᓂᑦ ᖃᐅᔨᓴᕐᓂᕐᒥ. ᐱᖃᑕᐅᓂᑦ ᖃᐅᔨᓴᕐᓂᕐᒥᑦ ᖃᓄᐃᓐᓇᑦᑎᐊᖅ ᐊᑐᐃᓂᖃᔾᔫᖕᒋᑦᑐᖅ ᐃᑉᕕᑦ ᐃᖅᑲᓇᐃᔭᕐᕕᖕᒥ ᐅᑉᐱᓘᓐᓃᑦ ᐋᓐᓂᐊᓯᐅᖅᑕᐅᒍᑎᒋᐹᑦᑕᕐᓂᒃ. ᐱᖃᑕᐅᒪᒍᕕᑦ ᖃᐅᔨᓴᕐᓂᕐᒥ, ᖃᖓᑐᐃᓐᓇᑦᑎᐊᖅ ᖁᔭᓈᕐᓇᖅᑐᑦ ᐊᑭᖏᖅᑲᖓᙱᓪᓗᑎᑦ ᑭᓱᑐᐃᓐᓇᑎᐊᒥᑦ. ᐲᕐᓇᖅᑐᒍᓗ ᐊᐱᖅᓱᖅᑕᐅᒌᑦ, ᐊᑖᙱᕐᓗᒍ ᐅᑉᐱᓘᓐᓃᑦ ᐃᓚᐃᓐᓇᖓ. ᖃᐅᔨᓴᕈᑕᐅᔪᒥ ᖃᖓᑐᐃᓐᓇᑦᑎᐊᖅ ᐅᑉᐱᓘᓐᓃᑦ ᐊᐱᖅᓱᖅᑕᐅᒦᖅᓯᒪᓕᕈᕕᑦ. ᑭᐅᔪᒪᙱᑦᑕᕐᓂᓗ ᑭᐅᒋᐊᑐᙱᑦᑐᑎᑦ ᐊᐱᖅᑯᑕᐅᔪᒥᒃ.

ᐱᔪᓇᐅᑎᖏᑦ ᐊᐱᖅᓱᖅᑕᐅᔪ

ᖃᖓᑐᐃᓐᓇᑦᑎᐊᖅ ᖁᔭᓈᕐᓇᖅᑐᑎᑦ ᐊᒻᒪᓗ ᐊᐱᖅᓱᖅᑕᐅᔪᓐᓂᕐᓗᑎᑦ ᐊᑭᓕᔭᕆᐊᖃᙱᓪᓗᑎᑦ. ᓱᕋᐃᔾᔪᖏᓐᓇᕕᑦ ᒪᓕᒐᐅᔪᓂᑦ. ᐱᔪᓇᐅᑎᐅᔪᓂᑦ ᐅᑉᐱᓘᓐᓃᑦ ᐋᖅᑭᐅᒪᒍᑕᐅᔪᓂᑦ ᐱᖃᑕᐅᓂᓇᓚᐅᖅᑕᓐᓂᒃ ᖃᐅᔨᓴᕐᓂᐅᔪᒥ. ᖃᐅᔨᓴᕐᓂᐅᔪᖅ ᕿᒥᕐᕈᔭᐅᓯᒪᓪᓚᑦ ᐊᒻᒪᓗ ᐅᑉᐱᓐᔭᐅᔪᓂᑦ ᑐᑭᓯᑎᑕᐅᑎᑦᑎᐊᓚᐅᖅᑐᑎᒃ ᒫᒃᒫᔅᑐ ᖃᐅᔨᓴᕐᕕᖕᖓᑕ ᑲᑎᒪᔩᖏᑦ. ᕿᒥᕐᕈᔭᐅᓯᒪᓪᓗᓂᓗ ᐊᒻᒪᓗ ᓚᐃᓴᓐᓯᖅᓯᒪᓪᓗᑎᒃ (3----) ᓄᓇᕗᑦ ᖃᐅᔨᓴᕐᕕᖓᓐᓂ. ᐊᐱᖅᑯᑎᔅᓴᖅᑲᕐᕕᑦ ᐱᔪᓇᐅᑎᑎᑦ ᐱᔪᐊᑎᒋᓪᓗᒋᑦ ᖃᐅᔨᓴᖅᑕᐅᓂᑦ ᒪᓕᓪᓗᒍ, ᑐᑭᓯᒋᐊᕐᕕᒋᔪᓇᖅᑕᐃᑦ.

ᒫᒃᒫᔅᑐ ᖃᐅᔨᓴᕐᕕᖓᑕ ᑲᑎᒪᔩᑦ ᑎᑎᖅᑭᖓ
ᒫᒃᒫᔅᑕ ᓯᓚᑦᑐᓴᕐᕕᔾᔪᐊᖓ
1280 Main Street W., CNH-111
Hᐊᒥᓪᑕᓐ, ON L8S 4L9
ᓱᑲᑦᑐᒃᑯᑭᑦ: 905-540-8019
ᐅᖄᓚᐅᑖ: 905-525-9140, ext 24765
ᖃᕋᓴᐅᔭᑎᒍᑦ ᑐᕌᖓ: grntof1@mcmaster.ca

ᐊᒻᒪᓗ/ᐅᑉᐱᓘᓐᓃᑦ ᓄᓇᕗᒥ ᖃᐅᔨᓴᕐᕕᒃ
ᓄᓇᕗᒥ ᖃᐅᔨᓴᖅᑐᓕᕆᔨᒃᑯᑦ
ᑎᑎᖅᑲᖅᑲᐅᑦ 1720, ᐃᖃᓗᐃᑦ,
ᓄᓇᕗᑦX0A 0H0
ᐅᖄᓚᐅᑖ: (867) 979-4108
ᓱᑲᑦᑐᒃᑯᑭᑦ: (867) 979-4681
E-mail: slenri@nunanet.com
www.nunanet.com/~research

ᓯᐅᕋ ᑎᐊᑦᕗᑦ ᐊᒻᒪᓗ ᐊᖏᔪᖅᑳᖓ, ᑐᐊᕋᑎ ᐸᓚᒃ, ᑐᑭᓯᒋᐊᕐᕕᐅᔪᓇᖅᑑᒃ ᐅᕙᓂ ᐱᓕᕆᕕᐊᓂ ᐃᓄᓕᕆᓂᕐᒧᑦ, 6 ᖁᖅᑎᖓᓂ 9+) ᒫᒃᒫᔅᑐ ᓯᓚᑦᑐᓴᕐᕕᔾᔪᐊᖓ, 1280 ᓚᙵᓂᓴ ᐳᑎ ᐱᕿᐅᑎ, ᐦᐊᒥᓪᑐᓂᑦᓯᓴ ᓕᓇ ᓘᓐᐳ ᒃᓚᒃ. ᓯᐅᕋ ᑎᑎᕋᕐᕕᐅᔪᓇᕐᒥᔪᖅ ᐅᕗᖓ tedforsk@mcmaster.ca ᐊᒻᒪᓗ (ᓄᓇᕗᒥ ᑐᕌᖓᓄᑦ ᐊᒻᒪᓗ ᐅᖄᓚᐅᑎᖓᓄᑦ).

ᑐᑭᓯᔪᖓ ᐅᖃᐅᓯᐅᔪᑦ ᖃᐅᔨᓴᕐᓂᕐᒥ "ᐊᑐᖅᑳᑦᑕᕐᓗᓂ ᐊᒻᒪᓗ ᐆᑦᑐᖅᑳᑦᑕᕐᓗᓂ: ᐋᓂᐊᑦᑕᐃᓕᓂᕐᒥᒃ, ᓇᒻᒥᓂᖅ ᑲᒪᒋᑦᑎᐊᓂᕐᒥᒃ ᐊᒻᒪᓗ ᓇᒻᒥᓂᖅ ᐱᔪᓇᖅᓯᐅᑉᓕᐊᓂᕐᒥᒃ", ᐅᖃᖅᓯᒪᓪᓚᑦ ᖁᕕᓂ.

ᐊᐱᖅᑯᑎᒃ ᑭᐅᔪᐅᑦᑎᐊᖅᑐᑦ ᓈᒻᒪᒋᓪᓗᒋᑦ ᐊᒻᒪᓗ ᐊᖏᖅᑯᖓ ᐱᖃᑕᐅᔪᒪᓪᓗᖓ ᐊᐱᖅᓱᓂᕐᒥ ᖃᐅᔨᓴᕐᓂᐅᔪᒥ. ᐊᔾᔨᖓᓂᒃ ᐆᒪ ᑐᓂᓯᔪᐅᓯᒪᔪᖓ.

ᐊᑎᖓ ᐱᖃᑕᐅᔪᑉ	ᐊᑎᓕᐅᖅᑕᖓ ᐱᖃᑕᐅᔪᑉ

ᐅᓪᓗᖓ

ᑐᑭᓯᔭᒃᑯᓪᓕ. ᐊᐱᖅᓱᖅᑕᐅᔪᖅ ᐊᖏᖅᓯᒪᑦᑎᐊᖅᑐᖅ ᐊᒻᒪᓗ ᖃᐅᔨᒪᓪᓗᓂ ᐅᓂᒃᑳᕈᑎᖏᑦ ᐊᖏᕈᑎᕆᓯᒪᒻᒪᕆᑦ ᐊᒻᒪᓗ ᑎᒍᒥᐊᖅᑎᐅᓪᓗᓂ ᑐᓂᓯᓂᐊᖅᑐᓂ ᐊᖏᕈᑎᒥᓂᒃ ᐊᐱᖅᓱᖅᑕᐅᓂᕐᒧᑦ ᖃᐅᔨᓴᕐᓂᐅᔪᒥ. ᐊᒻᒪᓗᑦᑕᐅᖅ, ᑐᑭᓯᑦᑎᐊᖅᑐᕆᑦ ᑐᓴᖅᑕᐅᔪᓇᐊᖃᓐᖏᓐᓂᖏᑦ ᑕᕝᕙᓂ ᑎᑎᕋᖅᓯᒪᔪᑦ ᐊᒻᒪᓗ ᒪᓕᒋᐊᖃᖅᑐᒋᑦ ᐊᑐᕐᑯᔭᐅᔪᑦ.

ᐊᑎᓕᐅᖅᑕᖓ ᖃᐅᔨᓴᖅᑎᐅᑉ	ᐅᓪᓗᖓ

ᑐᑭᓯᑦᑎᐊᑦᑲ ᑐᓴᖅᑕᐅᔪᓇᐊᖃᓐᖏᓐᓂᖏᑦ ᑎᑎᕋᖅᓯᒪᔪᑦ ᑕᕝᕙᓂ ᐊᒻᒪᓗ ᑐᑭᓯᓪᓗᖓ

ᒪᓕᒋᐊᖃᑦᑕᕐᓂᒃ. ᐊᖏᖅᑯᖓ ᐅᓂᒃᑳᕈᑕᐅᔪᑦ ᑕᕝᕙᓂ ᐊᐱᖅᓱᕐᓂᐅᔪᒥ ᑲᖏᓇᖅᑑᓗᒋᑦ ᑲᒪᒋᓂᐊᖅᑭᑦ.

ᑐᓴᔨᐅᑉ ᐊᑎᓕᐅᖅᑕᖓ	ᐅᓪᓗᖓ

Appendix E

Nunavummi Qaujisaqtulirijikkut / Nunavut Research Institute
Box 1720, Iqaluit, NU X0A 0H0 phone:(867) 979-4108 fax: (867) 979-4681 e-mail: slcnri@nunanet.com

March 16, 2001

NOTIFICATION OF RESEARCH

PLEASE BE ADVISED THAT SCIENCE RESEARCH LICENCE No. 0500301N-M **HAS BEEN ISSUED TO:**

Sarah Kristina Tedford
Department of Sociology
McMaster University
1280 Main Street West
Hamilton, Ontario
L8S 4M4 Canada
905-546-0337

TO CONDUCT THE FOLLOWING STUDY:
Experience and Practice: Health, Health Care and Self-Determination in Nunavut

SUMMARY OF RESEARCH:
This is an exploration of how Nunavut residents link health, heath care and self-determination. Many planners have identified health and well being as key planning areas for the new territory I hope to explore understandings of these and the innovative ways in which health is being framed within a model of self-determination. I will conduct interviews with planners, health practitioners , members of non-government organizations and community members This research will take place in Iqaluit, Igloolik and Rankin Inlet.

THE STUDY WILL BE CONDUCTED AT: Iqaluit, Igloolik, Rankin
BETWEEN: March 01, 2001 - March 30, 2002

Mary Ellen Thomas
Manager, Research Liaison

DISTRIBUTION:
Lands Officer, Kivalliq Inuit Association
Lands Officer, QIA
Executive Director, NSDC
Mayor/SAO, Iqaluit
Mayor/SAO, Rankin Inlet
Mayor/SAO, Igloolik
Director Policy and Planning, Department of Health and Social Services

Appendix F

Interview Guide

Thank you for volunteering to participate in an interview for the study "Experience and Practice: Health, Health Care and Self-Determination in Nunavut." The purpose of the interview is to provide you with an opportunity to discuss your views and experiences of health, health care and self-determination in Nunavut. The interview is meant to be an open, conversational style discussion. I have some questions that I would like to ask but you should feel free to direct the conversation to the issues and topics that you feel are relevant and want to discuss. You can refuse to answer any of my questions and may choose to withdraw at any time. With your permission, I would like to tape record the interview. During the interview you may choose to rewind the tape and listen to something you have said. You may also erase any part of the tape during the interview. Do you have any questions regarding this project or the interview?

Health

What do you think of when you hear the word health?
How do you define this word - health?
How would you describe your own health?
What is important to your health?
What aspects of your life do you feel are related to health?
How does living in Nunavut affect your understanding of what health is?
How does living in Nunavut affect your health?

Health Care

What are your health care needs? How do you address your health care needs?
How do you feel they should be addressed?
What would help you to address your health care needs?
What are the health care needs of your community?
Can you tell me a bit about this community?
How does your community deal with its health care needs?
What health care services are available currently?

Health Care Planning

Are you satisfied with the way health care is delivered here in Nunavut?
Do you feel that health care services could be organized differently? If so, how?
What do you feel could be done differently?

Self-Determination

Are you aware of any changes in Nunavut's health care services or delivery?
If so, do these changes reflect your understanding of health and health care needs?
What role do you think the Nunavut government should play in health care?
What sort of control would you like to have over health care?
How do you connect health to self-determination?
What is your vision for Nunavut?
Has the establishment of Nunavut as a new territory changed your life in any way?