INUIT FAMILY PERSPECTIVES AND STORIES ABOUT SEXUAL HEALTH AND RELATIONSHIPS IN NUNAVUT

by
Gwen Katheryn Healey

A thesis submitted in conformity with the requirements for the degree of
Doctor of Philosophy
Dalla Lana School of Public Health University of Toronto

© Copyright Gwen Katheryn Healey 2015
Abstract

BACKGROUND: High rates of sexually transmitted infections were a concern among community members in Nunavut. The goal of this study was to explore the perspectives of Inuit youth and parents on the topic of sexual health and relationships.

METHOD: This qualitative participatory research study was conducted within an Indigenous knowledge framework with a focus on Inuit ways of knowing and storytelling. Interviews were conducted in 2011 in 3 Nunavut communities with 17 Inuit youth 16-19 years of age and 20 Inuit parents who had at least 1 teenage son or daughter between 13-19 years of age.

RESULTS: Parents in the study linked their understandings of sexual health with a series of relocation events, which occurred in the Canadian Arctic in the mid 20th century. These relocation events led to widespread disruption of Inuit families, kinships, and attachments by separating young children from their primary caregivers for extended periods of time. The traditional communication pathway about sexual health and relationships was disrupted for many families during this time. Concurrent experiences of child sexual abuse among the parents in this study compounded the trauma of being separated from their families. Severed family attachments during the settlement period and child sexual abuse were the primary factors discussed by parents in this study as contributing to the current state of sexual health in Nunavut. Youth participants identified
parents/caregivers as the preferred source of knowledge about sexual health and relationships, even if they were not learning from them at the present time. They also related sexual decision-making among youth to the broader community context and determinants of health, such as poverty.

CONCLUSION: Taking these findings into account, rebuilding and strengthening family and community relationships can make significant positive contributions to sexual health and relationships by providing supportive networks for adolescents and revitalizing millennia old pathways for knowledge sharing. Directions for public health include supporting parent-adolescent dialogue about sexual health; incorporating holistic individual and collective empowerment-based models for sexual health promotion; and supporting parents to heal from trauma and strengthen family relationships.
I dedicate this dissertation to Iqalungmiut and Nunavummiut - when we work together and support one another, we accomplish great things.
Acknowledgements

A heartfelt ‘qujannamiimaarialuk’ to the parents and youth who shared their stories and experience with me for this study. We learned from each other and I am grateful to have had the opportunity to share stories as Nunavummiut.

This study was acknowledged and supported in principle by Nunavut Tunngavik Inc. and the Chief Medical Officer of Health for Nunavut, Geraldine Osborne. Many relationships (new and existing) were fostered across multiple communities during the various stages of this project with individuals to whom I also express deep gratitude: Shirley Tagalik, Sarah Curley, Marie Ingram, Madeleine Cole, Theresa Koonoo, Sharon Edmunds-Potvin, Candice Lys, Jennifer Noah, Lissie Anaviapik, Ceporah Mearns.

My supervisor Dionne Gesink, and committee members, Gillian Einstein, and Ted Myers, provided support, feedback, and invaluable guidance over the course of my doctoral program, for which I am very grateful. You challenged me to think deeply and broadly, to be critical and questioning, and to pursue excellence in scholarship.

A small amount of funding was provided by the Northern Studies Training Program, which allowed me to provide compensation to participants in this study.

I am grateful for the encouragement of my family and the support of my partner, Jason Akearok. Of particular note, our beautiful daughters, Jaia Qatturainnuk Healey Akearok and Amaija Qamaniq Manuelinha Healey Akearok were born over the course of this PhD. They have and continue to influence my life and spirit in immeasurably exciting ways and for that I am grateful.
The encouragement provided by my community of Iqaluit, Nunavut and the community members who consistently supported me in my studies are gratefully acknowledged. To produce this academic dissertation, I have worked very hard to meet the requirements of both the academic community and the northern Inuit communities to whom I feel morally accountable and with whom I undertook this study. There are many northerners who will be moving into academic careers in the next decade and my hope is that they read this dissertation and feel that it is possible to balance the expectations of the academy with the expectations of our communities. I have been reminded multiple times over the course of this study that Nunavummiut deserve good scholarship. I hope they read this and are further inspired to pursue scholarly work for the benefit of our communities.

Lastly, I wish to say that this dissertation is about sincerity, life, and love. The sincerity of the parents who shared their life experiences with me, and the sincerity I felt as I engaged with them as a researcher, analyst, mother, and community member. It is about the life experiences that parents want for their children and grandchildren in today’s communities; how parents perceive sexual health and wellness; and the love they feel for their families. It is the stories of the families, which I hope to honour in this dissertation. Their lived experience, their lives, and their context form the essence of what I have endeavoured to present. The reason for exploring this topic and telling this story is that this study can inform the development of meaningful interventions, programs and/or services for families in Nunavut who are asking for help.
TABLE OF CONTENTS

Abstract .......................................................................................................................... ii

Acknowledgements ..................................................................................................... v

List of Figures ............................................................................................................... xii

Preamble ....................................................................................................................... 1

PART A – ORIGINS/PROLOGUE .............................................................................. 4

Chapter 1 - Beginnings ............................................................................................. 4

   My Story .................................................................................................................... 4

      Naminiutauvit? Where are you from? ................................................................. 5

      Questions and Motivations .................................................................................. 7

PART B – BACKGROUND ......................................................................................... 10

Chapter 2 - People and Places ................................................................................ 12

   Historical Context .................................................................................................. 12

      Inuit in Nunavut ..................................................................................................... 12

      Colonialism .......................................................................................................... 13

      Settlement ............................................................................................................. 14

      Tuberculosis Epidemic ......................................................................................... 17

      Residential School ............................................................................................... 18

   Contemporary Context ........................................................................................... 21

      Health Services ..................................................................................................... 22

      Public and Population Health ............................................................................. 22

Chapter 3 - A Review of the Sexual Health Literature .......................................... 23
Sexual Health Literature in the Global Health Context ......................................................... 24

Arctic Sexual Health Literature .......................................................................................... 26

Inuit Qaujimajatuqangit – “Inuit Knowledge” ................................................................. 28
  Kinship Relationships ........................................................................................................ 28
  Marriage and Family .......................................................................................................... 29
  Inuit Stories and Teachings About Sexuality .................................................................... 33

Sexual Health Literature in Nunavut Context ................................................................. 35
  Sexually Transmitted Infections ....................................................................................... 36
  Relationships ..................................................................................................................... 38
  Changing Family Lifestyles .............................................................................................. 38
  Engaging in Sex At a Young Age ....................................................................................... 39
  Teenage Pregnancy and Custom Adoption ...................................................................... 40
  Sexual Abuse .................................................................................................................... 41
  Alcohol and Substance Abuse .......................................................................................... 42
  Mental Well-Being ........................................................................................................... 43
  Knowledge about Sexual Health and Relationships ....................................................... 45

PART C – THEORY AND METHOD .................................................................................... 47

Chapter 4 - Paradigms and Perspectives ......................................................................... 47

  Grounded Theory, Social Science Theory, and Indigenous Theory .......................... 47
  A research approach that is mindful of Inuit ways of knowing ................................. 50

  Manuscript 1 - Piliriqatigiinniq “Working in a Collaborative Way for the Common Good”: A Perspective on the Space Where Health Research Methodology and Inuit Epistemology Come Together ................................................................. 51
Chapter 5 – Research Questions and Methodological Approach .................................. 75

Inuuqatigiittiarniq ........................................................................................................ 75
  Intentions ...................................................................................................................... 75
  The formation of the questions .................................................................................. 76
  Preparations ............................................................................................................... 77
  Communities .............................................................................................................. 78
  Engagement of youth and parents ............................................................................ 78

Unikkaaqtigiinniq ......................................................................................................... 79
  Interviewing and the sharing of experiences ............................................................. 79
  Reflection on my interviewing experience ............................................................... 81

Iqqaumaqtigiinniq ........................................................................................................ 81
  Finding meaning and understanding ........................................................................ 81

Pittiarniq .......................................................................................................................... 84
  Consent ....................................................................................................................... 84
  The protection of the stories ..................................................................................... 85
  Accountability .......................................................................................................... 85

PART D - RESULTS AND DISCUSSION ......................................................................... 87

Chapter 6 – Results and Stories ................................................................................. 87

  Review of the Research Questions and the Research Process ................................. 87
    Reflection on How Stories Are Presented ............................................................... 91

RESULTS SECTION 1 - YOUTH PERSPECTIVES ON SEXUAL HEALTH .................. 93
  Interview Context ...................................................................................................... 93
  Stories from Inuit Youth ............................................................................................ 94
List of Figures

FIG. 1: The Piliriqatigiinniq Partnership Model for Community Health Research… 71
FIG. 2: Young girl's amautik...............................................................164
FIG. 3: Inuit woman and child, wearing beaded parka (amautik)......................164
FIG. 4: Beaded amautik .................................................................165
FIG. 5: The flower I created while my daughter was in the hospital ...............167
FIG. 6: Placement of designs .........................................................168
FIG. 7: Finished the flowers ...........................................................168
FIG. 8: Completed work ................................................................168
FIG. 9: Close-up of owl .................................................................168
FIG. 10: Sewn on to my amautik ......................................................168
Preamble

Sexual health is a critical part of public health and is an important part of healthy living. Healthy sexuality involves acquiring the skills, knowledge and behaviours to maintain good sexual and reproductive health throughout life. The World Health Organization (2006) defined sexual health as,

“A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” (WHO, 2006)

The term ‘relationship’ can have different meanings in different contexts including the way in which two or more people, groups, countries talk to or behave toward each other, a romantic or sexual friendship between two people, or the way in which two or more people or things are connected (Oxford, 2013a).

This dissertation explores Inuit family definitions and perspectives on sexual health and relationships in Inuit communities in Nunavut using a community research model based on Inuit ways of knowing. Inuit communities want to see research that is conducted in a way that is respectful and responsive. Sexual health has been highlighted as a serious public health concern in Nunavut because the territory reports the highest rates of chlamydia and gonorrhea infections in all of Canada. This dissertation addresses both of those community concerns and contributes new perspectives on northern research and
sexual health.

In the span of about four decades, Inuit communities have changed rapidly, and a number of events, such as forced settlement, residential school, and medical evacuation for Tuberculosis outbreaks, permanently changed the ways in which people engaged in relationships with each other. The research question for this study was:

*Given the rapid societal changes experienced in Nunavut, and the changed/changing nature of relationships at the individual, familial, and community level that are a result of this experience, how do youth and parents of youth in Nunavut conceptualize sexual health and relationships today? And how can this topic be studied in a way that is respectful and mindful of Inuit ways of knowing and understanding wellness?*

For this study, I spoke with both youth and parents of youth in three regionally distinct communities to create a picture of how they define sexual health and relationships today, and what knowledge is encompassed in those terms. The stories of the parents were the most enlightening; therefore this dissertation focuses primarily on their stories and experiences. In this document, the rich stories of community members are woven into the greater storytelling context that exists in Inuit communities. The end goal of this study has been to honour the stories and experiences shared with me about sexual health and relationships in Nunavut, as well as to incorporate my understandings into a model for health research that is grounded in an Inuit ways of knowing. Ultimately, we share our stories to convey our knowledge, our skills, and to make note of areas in our lives that require action or assistance. It is with this in mind that I have written this dissertation and it is my hope that action will be one of the outcomes of this study.
In addition to the manuscripts, preliminary chapters expanding on relevant theory, methods, results, and a final synthesis and discussion chapter are also presented.

**Organization of the Dissertation**

This document follows the format of a manuscript-based dissertation, which is constructed around a set of related original manuscripts. It is divided into 4 parts.

PART A, contains *Chapter 1*, in which I discuss the importance of storytelling in Inuit culture and articulate my own story for the reader.

PART B, contains *Chapter 2*, in which I provide a review of historical and contemporary context of Inuit in the Eastern Canadian Arctic, and *Chapter 3*, in which I provide a critical review of the literature related to sexual health in the Arctic and in Nunavut, specifically.

PART C, contains *Chapter 4*, in which I articulate the theoretical underpinnings of this study and present the first manuscript, and *Chapter 5* in which I explain how the theoretical model was applied for the implementation of this study.

PART D, contains *Chapter 6*, in which I present the findings of the study, which are structured around 3 manuscripts, and *Chapter 7* in which I present the discussion of the findings and concluding remarks.
PART A – ORIGINS/PROLOGUE

Chapter 1 - Beginnings

Storytelling is an important part of life and learning in Indigenous cultures, and this is particularly true in communities across Canada’s North (Bennet & Rowley, 2004; Bird, Wiles, Okalik, Kilabuk, & Egeland, 2009; Cardinal et al., 2004; Corntassel, Chaw-win-is, & T’lakwadzi, 2009; S. Harper, Edge, & Cunsolo Willox, 2012; Kovach, 2009; Moffitt & Vollman, 2004; Moody & Laurent, 1984; Wilson, 2008). Our stories are rich with history, lessons, information, philosophy, language, and spirituality (Christopher, McDermott, & Flaherty, 2011a; Kalluak, 2009a; Kral, Idlout, Minore, Dyck, & Kirmayer, 2011; Kral & Minore, 1999; NCI & QIA, 2011; Stott, 1986; Vorano, 2008; Wachowich, Awa, Katsak, & Katsak, 1999; Wexler, 2006). Kovach (2009) argues that story is not only data, but also a method in Indigenous research. Storytelling comprises a significant portion of this study and the stories of the participants, northern histories, and my own stories are captured in this dissertation. To fully understand the meaning and significance of the stories and work that are discussed in this dissertation, the reader must understand where the stories came from. For this reason, I will first introduce myself and my community. The language I have used for the chapter headings and subheadings in this dissertation are reflective the language we use to discuss these topics in our communities.

My Story

“To know who I am in the world as a person and as a researcher, for some audiences requires a statement of race, class, gender, ethnicity, dominant belief systems, and academic theoretical leanings. On the Inuk side, it requires – most importantly – a
knowledge of who my parents are, who my relations are, how many children and grandchildren I have, if any, and what lands I am connected to and associated with.”

- Janet Tamalik McGrath (McGrath, 2011)

Namimiutauvit? Where are you from?

To understand where and how this work originated, the reader must understand my context and origins. What Tamalik described in the above quote is true. When we greet each other in the North, we establish a connection based on the community we are from and to whom we are related. Sometimes we find that relationships already exist between us that we didn’t know about. In other cases, we form new relationships. These relationships are the beginning of our interaction and the stepping point from which we move forward together. So in keeping with the custom to which I am most familiar, I will introduce myself this way. My name is Gwen Katheryn Healey. I was born and raised in Iqaluit, Nunavut. I am the eldest of two girls. My father (now retired) was the music teacher at the local high school in Iqaluit (formerly Frobisher Bay, Northwest Territories). My mother (also retired) ran the laboratory at the Baffin Regional Hospital for over two decades. My spouse is originally from Sanirajaq (Hall Beach, NU) and later moved to Iqaluit for school. We have two young girls, whom I have given birth to over the course of this PhD. Their arrival into my life (our lives) over the course of this study is relevant to the story that this dissertation will tell. Our girls carry the names (and traits) of family members from my spouse’s home community. When I speak of myself or of my family to other Nunavummiut\(^1\), people of the Amittuq region (where my spouse’s family is from) know my family, embrace me as a family member, and explain to me exactly how we are

\(^1\) ‘Nunavummiut’ is the Inuktitut word meaning ‘people of Nunavut’
related through marriage and how they are related to my children through naming, kinship, and family. When I meet new people in other communities, they will often know my parents if they have ever been to Iqaluit, and will tell me stories of them. They speak of how my father taught them, or how they met my mother at the hospital while they were escorting a sick relative. And vice versa, I often know their children or their grandparents, or grew up with one of their family members. Because of the extensive family and community relationships that exist in our region, many families in Nunavut are connected and/or related in some way.

My story begins at the Baffin Regional Hospital in what was then known as Frobisher Bay. I was born in this hospital and raised in Iqaluit, the Inuktitut name for my community, which means ‘fish’ or more specifically, Arctic char. Our town was built in an area that was (and still is) known as a wonderful place to harvest Arctic char. I was raised in this community and completed all of my elementary and secondary schooling here. Participating in community activities both in the town and on the land was part of my upbringing. My childhood included berry picking, camping, and fishing in equal parts mixed with figure skating lessons, Girl Guides, and gymnastics. My childhood memories are of sewing with unilingual elders in school, swimming at the local pool, hiking on the hills picking berries, ski-dooing on the sea ice, sleepovers with school friends, and watching movies and television when cable was finally introduced in the late 80s. In school we read books like Frozen Fire (Houston, 1981) and Dogsong (Paulsen, 1985) as often as we read Nancy Drew (Stratemeyer, 1930) or The Babysitters Club (Martin, 1987). In my daily childhood life, my parents, my sister, and I comprised a tight family unit that participated in many activities together, including, ski-dooing, traveling, and simply
talking. In addition, members of the community taught me many things from Inuit stories and legends, to how to butcher walrus or seals, to first aid and emergency survival on the land.

Over the course of this project I have spent quite a bit of time trying to articulate who I am in this work. I have made every effort to be reflexive. Since I set out on this venture, I have become another person. The first question I am asked by non-Inuit is whether or not I am Inuk. The first question I am asked by Inuit is what community I am from. What matters is what family and community I am connected to and how we might share a common relationship. I am not Inuk. I was raised in an Inuit community. My spouse and my children are Inuit. Inuit customs, practices, and epistemologies have contributed to the worldview that I hold, because they have always been, and will always be, a part of my life and my upbringing. Members of my community form part of my extended family, not because we share a biological connection but because we have lifelong relationships with each other. When thinking about my role in this research, I have asked myself a number of questions: What story is this research telling? What is the motivation for undertaking it? What is my motivation? Am I an advocate? A deep-thinker? A mother? A parent? A daughter? A friend? A community member? Am I helping or hindering? Are the words helpful or hurtful? In the next section, I will explicate some of the answers I have found to these questions to situate the context of this dissertation for the reader.

Questions and Motivations

As a young person in my community, I searched for ways to right what I perceived to be wrongs in our school, and later, in our community. The nature of my personality is
such that I want to see justice and fairness in the activities or pursuits that I engage in.

When I was 14 years old, my classmates began dropping out of school to have children. With no childcare, the students did not have the support to finish their diplomas and these students were unable to return to school. I ran for the student council and spent the next two years working with other like-minded students to create a daycare in the school for our peers. Fortunately for us, there was also political motivation to see students graduate from Grade 12 and the daycare became a reality. By having their children cared for nearby, young mothers, my peers, were able to return to school to finish Grade 12. Some mothers were even able to continue breastfeeding. The daycare also promoted and supported student engagement with the children, and all students, whether they were parents or not, contributed volunteer hours to help at the centre. From this experience, I learned the joy that can come from exploring an issue and seeking solutions that restore harmony and make the people in our lives happier.

Throughout my post-secondary schooling, I returned home to Iqaluit during the summer breaks to work. After graduation from university, I spent a year working in Norway and Finland for a circumpolar post-secondary education initiative. Seeing other Arctic communities was a revelation. The same strength of relationships, the same sense of community, which we had in our town, existed in these other Arctic villages. Except they had infrastructure, cell phones, heated sidewalks, and a university located at the same latitude as Pond Inlet, Nunavut. It was remarkable to me. I knew then what I wanted to spend my life doing. I returned to Iqaluit to work in the health field and, at the same time, applied to graduate school to study community health and epidemiology. I had so many questions about health in my community, in other communities in Nunavut,
and in other Arctic indigenous communities. After completing my masters degree, I returned to Iqaluit to found the Qaujigiartiit Health Research Centre, an independent community organization that promotes and leads health research which is conducted by, for, and with community members within a model that promotes both Inuit and Western ways of knowing and understanding health. During the initial years of Qaujigiartiit’s development, I spent much time traveling to different communities in the territory to host engagement sessions with the public. The purpose of these public engagement sessions was to discuss the health concerns of community members. People would come from all across the territory to attend these meetings. High-level policy analysts, mayors, stay-at-home mothers, youth, teachers, and medical professionals all attended and all contributed equally to the dialogue. Everyone told stories. One of the many concerns which people brought forward was the high rate of unplanned or unwanted pregnancies among teenagers. Many parents felt the tradition of custom adoption (described further later in this document) was being ‘used’ as a means for teenagers to absolve themselves of responsibility for their actions. It was also placing stress both emotionally and financially on the immediate or extended families who adopted the baby(ies). People also talked about the very high rates of sexually transmitted infections, chlamydia and gonorrhea, in Nunavut and how this was frightening to many of the people who attended these dialogues.

These comments prompted me to reflect on my own high school experience and the number of young mothers I knew. I began to think more deeply about the topic at hand. I wondered; why were my peers getting pregnant at the age of 14? It was common in our school and we didn’t think anything of it at the time. Why are the rates of these sexually
transmitted infections so high? Was there a knowledge barrier? We had all received the same sex health education in grades 5, 6, 7, 8, 9, and again in Grade 12 biology. My mother talked to us at home about sexual health. Did other children get the same talks from their mothers? Do parents and children have those conversations today? Where are they learning about this topic? Are they learning about it in school? How do parents feel about it? And the questions continued.

At the same time, the opportunity arose to pursue doctoral studies in the field of public health, which would allow me to explore these questions further, and hopefully find answers that would make a positive contribution to the lives of people in our communities, particularly young people. I knew this would be the focus of my doctoral work.

**PART B – BACKGROUND**

Sexual health has been highlighted as a serious public health concern in Nunavut because the territory reports the highest rates of chlamydia and gonorrhea infection in all of Canada. In 2009, Nunavut reported high rates of chlamydia and gonorrhea, both of which are sexually transmitted infections, (3772/100,000 and 1,588/100,000, respectively), compared to Canadians (259/100,000 and 33/100,000, respectively) (NDH&SS, 2012). In addition, in the year 2000, the rate of teenage pregnancy in Nunavut was 161.3/1,000 compared to 38.2/1,000 in all of Canada (Archibald, 2004). McKay (2006) reported the rate of pregnancy among Nunavumiut ages 15-19 to be 119/1,000. Both of the high rates of chlamydia and gonorrhea and the high rate of teen pregnancy were highlighted by community members in a series of consultations.
conducted by the Qaujigiartiit Health Research Centre between 2006-2008 in Nunavut (Healey, 2006a, 2006p, 2007). This study was prompted by those community concerns.

In the span of approximately four decades, Inuit communities changed rapidly, and a number of events, such as forced settlement, residential school, and medical evacuation for Tuberculosis outbreaks permanently changed the ways in which people engaged in relationships with each other. The context of the family lives of Inuit changed significantly from a nomadic, independent, subsistence lifestyle to a sedentary lifestyle governed by a foreign authority (the Canadian Government). When I began this study, I hypothesized that the sexual health concerns of Nunavut community members today were related in some way to the changes in lifestyle and sense of community in the North.

The focus of this study has been to answer the following questions: *Given the rapid societal changes experienced in Nunavut, and the changed/changing nature of relationships at the individual, familial, and community level that are a result of this experience, how do youth and parents of youth in Nunavut conceptualize sexual health and relationships today? And how can this topic be studied in a way that is respectful and mindful of Inuit ways of knowing and understanding wellness?*

This dissertation explores Inuit family perspectives on sexual health and relationships in Inuit communities in Nunavut using a community research model based on Inuit epistemology and methodology. Inuit communities want to see research that is conducted in a way that is respectful and responsive. I have taken great efforts in this study to ensure that the context and findings are presented in a way that is respectful to Inuit history and to Inuit ways of knowing and understanding wellness. In the following chapters the context of the study is expanded on, including sections on the historical and
contemporary context of Nunavut, a review of Inuit Qaujimajatuqangit (Inuit knowledge) related to the subject that is documented, and a review of the literature on sexual health in Nunavut.

Chapter 2 - People and Places

In this section I will provide an overview of historic and contemporary information about the people and communities, which are the focus of this study: Inuit in the territory of Nunavut, Canada. First, I will provide a summary of the population and historic context of the transition of this region of the Arctic in the last several decades. Second, I will provide an overview of the context of today’s communities and health and wellness concerns among Inuit in Nunavut.

Historical Context

In this section I will provide a brief overview of the Inuit population and the historic transition of this region of the Arctic in the last several decades.

Inuit in Nunavut

Inuit are the indigenous inhabitants of the North American Arctic, whose homeland stretches from the Bering Strait to east Greenland, a distance of over 6,000 kilometres. Inuit live in Russia, Alaska, Greenland and the Canadian Arctic and, despite the distances between communities, share a common cultural heritage, language and genetic ancestry. Inuit have occupied these Arctic regions for 5000 years (ITK, 2005). Before contact, small groups of families travelled together to different camps and hunting grounds. In the
Qikiqtaaluk\(^2\) region alone, for example, Inuit lived in small, kin-based groups in over 100 locations throughout the region\(^3\) (QIA, 2010).

Of the approximately 150,000 Inuit living in the circumpolar region today, 45,000 live in Canada’s North. Nunavut is one of the four Canadian Inuit Nunangat\(^4\): Nunavut, Nunavik (Northern Quebec); Inuvialuit (northern Northwest Territories; and Nunatsiavut (northern Labrador). Nunavut occupies the largest geographical area of all the Inuit Nunangat, and became Canada’s third Territory in 1999 under the Nunavut Act.

**Colonialism**

For most indigenous\(^5\) populations globally, cultural changes have been imposed or produced invariably though legislation, colonization, war, disease, and industrialization (Trimble, 2005). Cultural changes among colonized peoples have largely occurred as a result of force rather than choice, for example, to relocate to another geographic area and potentially adopt cultural traditions of a new host culture. Kirmayer, Tait and Simpson (2009) argued that over the past century, Canadian and American government policies have continued the initial processes of colonization and have (and continue to) destroyed indigenous cultures and ways of life through forced settlement, the creation of reserves, relocation to remote regions, residential schools, chronic underfunding and poor resourcing of essential services such as health care and education, and bureaucratic control (Kelm, 1998; Kirmayer, Tait, & Simpson, 2009; Miller, 2000; Neu & Therrien,

---

\(^2\) *Qikiqtaaluk*, means ‘big island’ and is the Inuktitut word for Baffin Island.

\(^3\) The Qikiqtaaluk region is the largest of Nunavut’s three regions: Qitirmiut (western Nunavut); Kivalliq (Central Nunavut and Belcher Islands); and Qikiqtaaluk (Baffin Island, Ellesmere Island, and neighbouring communities).

\(^4\) *Inuit Nunangat* means Inuit lands in Inuktitut.

\(^5\) An official definition of “indigenous” has not been adopted by any UN-system body. Instead the system has developed a modern understanding of this term based on: self-identification at the individual level and accepted by the community and pre-colonial/pre-settler historical continuity (UN, n.d.). In Canada, indigenous peoples include the First Nations, Metis and Inuit and are commonly referred to as ‘Aboriginal’.
Nearly three centuries ago, the arrival of European whalers and explorers to the Canadian Arctic marked a significant turning point in the health of Inuit. Interaction with European visitors through trade and gift exchange resulted in the introduction of infectious diseases, which quickly took their toll among the Inuit population. Traffic in the Arctic continued to increase over time with the creation of trading posts, the arrival of explorers, cartographers, and missionaries, and the efforts of the government to build schools (Boas, 1998; INAC, 1996a, 1996k; ITK, 2005; Jenness, 1991; Manning, 1946). During the 1920s, 1930s, and 1940s, tuberculosis, influenza, and STI infections repeatedly ravaged Inuit populations (ITK, 2005; Sandiford Grygier, 1994; Waldram et al., 2007). That time is well recognized in Nunavut as marking the beginning of a cultural shift for Canadian Inuit from a nomadic, subsistence lifestyle to working and living in communities year-round.

**Settlement**

Before the arrival of other peoples, Inuit lived a nomadic lifestyle in *ilagiiit nunagivaktangat*\(^6\) or camps. Although the process of relocation to communities began as a response by Inuit to the presence of traders, explorers, and missionaries, it took new form with the systematic efforts of the government in the 1950s to ‘resettle’ Canada’s North. At that time, the Canadian government implemented resettlement programs in the eastern Canadian Arctic in an effort to: 1) protect Canada’s sovereignty post-World War II; 2) facilitate the opening of trading posts by the Hudson’s Bay Company; and 3) police, educate, and provide health care for remote populations (INAC, 1996a; Kirmayer, Brass, 

\(^6\) Inuktitut terminology meaning, “a place used regularly or seasonally by Inuit for hunting, harvesting and/or gathering” (QIA, 2010)
As a result, Inuit were relocated to southern Canada to cut relief costs; to remote High Arctic regions to maintain sovereignty and support the on-going economic initiatives of the Hudson’s Bay Company; and off the land and into settlements to facilitate the provision of supplies, education and medical care. Increased attention was directed to reports of Inuit starvation as the number of caribou across the North declined and/or migration patterns changed, particularly in the Kivalliq region of central Nunavut (Harrington, 1950; Mayes, 2009). In the Qikiqtaaluk region, many hunters lost their dogs to an outbreak of encephalitis, leaving them without a means of transportation, which had an impact on hunting and food provision (INAC, 1996), further complicating the settlement experience for Inuit. The Report of the Royal Commission on Aboriginal Peoples (1996) noted that in these years government administrators were concerned with the reports of health and welfare coming out of the North, and they came to see the North as being in a state of crisis, which required immediate attention and this hastened the government initiative to form settlements (INAC, 1996). Early in this period, one high-ranking official wrote that his job was “to hasten the day when in every respect the Eskimos can take their own places in the new kind of civilization which we—and they—are building in their country” (Fonds, 1957). This idealized view, which did not take into account the perspectives of Inuit, was never realized (QIA, 2010). In the process, however, opportunities arose which allowed Inuit to adapt their own styles of leadership and coordination to the new situation (QIA, 2010).

The changes imposed on Inuit by the Government of Canada to achieve this goal were rapid — this was not a gradual progression from a traditional to a modern way of life, but a complete transformation (QIA, 2010). Inuit were not consulted about these
changes, and many never knew why they were imposed on them. For their part, the agencies of the Government of Canada that were responsible for the transformation, primarily Indian and Northern Affairs Canada and the RCMP, are still not fully aware of their own history in the Arctic or the effects of their decisions and actions (QIA, 2010). In 1950, the population of about 2,200 Inuit lived mostly in small, kin-based groups, called ilagiiit nunagivaktangat, in over 100 locations across the Qikiqtaaluk region (QIA, 2010). Ilagiiit nunagivaktangat were chosen by Inuit for the access they gave, seasonally or year-round, to favourable sites for hunting and harvesting. By 1981, four times as many people lived in just 13 permanent settlements. A few settlements had originated as trading posts, so they remained close to good hunting and harvesting areas. For the remaining posts, the single most important criterion for government was that they were accessible by sea or would fit into planned air routes, therefore many of the settlements were not located near good harvesting areas. (INAC, 1996k; QIA, 2010). For example, the communities of Arviat⁷, NU was built on a coastal swamp, far from the inland caribou herds that the Inuit had followed for centuries. The Report of the Qikiqtani Truth Commission states that Inuit have suffered and continue to suffer from this lack of attention to their hunting and harvesting needs (QIA, 2010)

Although life on the land was never easy, the autonomy and self-sufficiency that were part of life on the land were lost when families moved into settlements (QIA, 2010). Elders speak passionately and eloquently about the ties of kinship that united members of each ilagiiit nunagivaktangat. Each person within a kinship group was valued for his or her contribution to the group’s wellbeing and success (Bennet & Rowley, 2004; Kral et

⁷ formerly known as Eskimo Point
Excellence was highly respected, whether it was in hunting, problem solving, leadership, or sewing. At the same time, a tradition of humility dictated that gifted individuals should not boast or otherwise demonstrate pride (Briggs, Ekho, & Ottokie, 2000; QIA, 2010). Although conflicts were inevitable, they were minimized or resolved as quickly as possible, because they had the potential to put the group survival at risk (ITK, 2005; Jenness, 1991; NCI & QIA, 2011; Ootoova, Atagutsiak, & Ijjangiaq, 2001). Inuit families were close, and guided by a set of beliefs that valued family, kinship, and the bonding relationships that supported the survival of the group (Bennet & Rowley, 2004; Briggs et al., 2000; NCI & QIA, 2011; Peterloosie, 2011; Pudlat, 2011).

**Tuberculosis Epidemic**

At the same time, Inuit were being ravaged by epidemics and illnesses, especially tuberculosis. By 1956, one in seven Inuit was living in a tuberculosis sanatorium in southern Canada (Sandiford Grygier, 1994). Widespread infection resulted in the relocation of individuals to southern hospitals and sanatoria for treatment (MacDonald, Hebert, & Stanbrook, 2011). The Canadian Government sent a supply ship, the *C.D. Howe*, to travel to Arctic communities to provide medical care primarily for the treatment of tuberculosis. Patients were assessed in each community and those who were too sick to stay in the community remained aboard the ship until it reached port. At this point, the patients were transferred to hospitals and sanatoria in southern Canada (Olofsson, Holton, & Partridge; Sandiford Grygier, 1994). The intensive treatment of active cases combined with the medical evacuations resulted in successfully reducing the rate of infection to almost nil in the following decades (Orr, 2013). However, as a result of the evacuations for medical treatment, families became separated. Children were left without parents and
parents had their children taken away. Those individuals often lost their language and ties to community and some never returned home (Sandiford Grygier, 1994). The lines of communication within families were broken, and knowledge about sexual health and family relationships, among other topics, was not shared between the parent and child generations that were separated during this epidemic.

Tuberculosis continues to be a significant medical issue in Nunavut. In 2010, Nunavut recorded the largest tuberculosis outbreak in the territory’s 10-year history (MacDonald et al., 2011). At least 100 new active cases were documented, which indicates a population rate of infection 62 times the Canadian average.

**Residential School**

Before formal schooling was introduced, Inuit children learned the skills they needed to carry out their traditional roles by observation and practice (Bennet & Rowley, 2004; Pudlat, 2011). Inuit boys (primarily) learned how to hunt, and thus feed and take care of a family, by accompanying their fathers and grandfathers on hunting trips, as young as five years of age; the knowledge and skills they acquired included understanding weather, navigation, ice and snow conditions, and animal behaviour (ITK, 2005; J. Karetak, 2013; NCI & QIA, 2011; QIA, 2010; Wachowich et al., 1999). Girls learned equally important skills, such as animal preparation, gathering eggs, berries, plants and foods, preparing skins, sewing clothing, making *kamiik*[^8], child rearing, and home care by watching and helping their mothers (Briggs et al., 2000; Mancini Billson & Mancini, 2007; NCI & QIA, 2011; Ootoova et al., 2001; Wachowich et al., 1999).

[^8]: A *Kamik* (two: *kamiik*; plural *kamiit*) is a boot made of sealskin or a combination of sealskin and caribou or polar bear. *Kamiit* are only known to be made by Inuit women.
In the first 60 years of the twentieth century, attempts by outsiders to teach children reading, writing, and arithmetic were scattered and inconsistent (McGregor, 2010). Following the Second World War this began to change as informal networks of education were replaced by a new government program which aimed to make Inuit into full Canadian “citizens” (QIA, 2010). In 1951, the first government-regulated school for Inuit was opened in Chesterfield Inlet (Pauktuutit, 2007). Government officials initially expected that Inuit could be easily convinced to place their children in school hostels for all or a portion of the school year while parents and non-school-age siblings returned to their camps. Officials were surprised to find that Inuit parents who agreed to schooling were not prepared to leave their children in the care of others. Families came to the settlement with their children, living in tents until housing was available. Both the written record and Inuit testimony (QIA, 2010) showed that most Inuit had reason to believe that they would lose family allowances\(^9\) if they did not send their children to school. This was a very serious threat, since family allowances had become essential to the survival of many families at the time because they were now unable to harvest and were dependent on the stores and trading posts to acquire goods for their families.

Exposure to residential schools for Inuit in Nunavut occurred in recent history. (King, 2006; Pauktuutit, 2007; QIA, 2010). For some communities, up to three generations of Inuit children were sent away from their families to attend day schools in the larger communities (Pauktuutit, 2007). Some children were sent much farther away than the nearest settlement, to residential schools in Churchill (Manitoba), Chesterfield

---

\(^9\) A family or child allowance is a monthly government payment to families with children to help with the costs of child maintenance. Canada introduced family allowance payments in 1945 as the first universal welfare program. Today, the family allowance payment no longer exists, however the child tax credit and universal childcare benefit could be considered the equivalent.
Inlet, Yellowknife, Inuvik, and Iqaluit. Others were sent to live with *Qallunaat*\(^{10}\) families in southern cities, such as Ottawa, Edmonton and Halifax. This caused great anguish for both the parents and the children (Pauktuutit, 2007; QIA, 2010). Residential schools for Inuit continued to open into the 1960s and by 1963, 3,997 Inuit children were attending these schools (King, 2006). In June 1964, 75% of 6 to 15 year old Inuit children and youth were enrolled in the schools (King, 2006). These students are the parents, grandparents, uncles, and aunts of today. In the context of sexual health, this is the generation that is raising the young Nunavummiut of today either as parents, adoptive parents or grandparents. As described earlier, through interactions with parents and extended family, children learned the skills and roles that they were expected to carry out later in life in order to care for and protect a family. Before settlement, information and messages about sexuality and sexual behaviours were shared with young Inuit by parents and family members, as has been the case in many societies globally (Bennet & Rowley, 2004; Allen et al, 2008).

The motives and rationale behind the processes implemented by the Canadian government during the resettlement time period have been argued in the Arctic. Inuit of northern Canada, as with other indigenous groups in Canada, have experienced, and are continuing to experience, a shift in their way of living and traditional practices over the last several decades (Condon, 1987, 1990; G. Healey & Meadows, 2008; INAC, 1996k; ITK, 2001, 2005). This dramatic and rapid cultural shift has been linked to loss of language in the younger generations and, therefore, knowledge. First, loss of language has an impact on the social determinant of education because some Inuit are not fully

\(^{10}\) *Qallunaat* is the Inuktitut word that is commonly used for ‘white person’ or ‘non-Inuk’.
literate in English or Inuktitut. Second, McGrath (2011) demonstrated in her theory of Inuktitut knowledge renewal, that Inuktitut can be viewed to be the foundation of Inuit epistemology. Therefore, the cultural shift, which has threatened language, has also threatened the very foundation of Inuit knowledge and ways of knowing. The significant and life-altering movement of the Inuit to either southern, High Arctic, or other northern locations had an impact on the transmission of knowledge and education and learning systems among Inuit (INAC, 1996k; QIA, 2010; Tester & Kulchyski, 1994). I hypothesized that this, in turn, has impacted the transmission of knowledge, beliefs, and attitudes related to sexual health and romantic relationships. This will be discussed in greater detail later in this dissertation.

**Contemporary Context**

Today, there are 25 communities in Nunavut ranging in size from a population of 150 to a population of 7,100 (NBS, 2013). All of the communities are geographically isolated from each other and are only accessible by air, water, or snowmobile in winter. The population of Nunavut in 2011 was 31,906, of whom approximately 85% are Inuit (StatsCan, 2011a). Fifty-two percent of Nunavummiut speak the Inuit languages of Inuktitut or Inuinnaqtun at home (StatsCan, 2011c). Nunavut has a very young population compared to Canada as a whole. In 2011 57.3% of the Nunavut population was comprised of those 24 years of age and younger compared to 29.2% in the whole of Canada (StatsCan, 2011a).

Communities in Nunavut are now larger, permanent settlements, and the size of the community plays a significant role on social relations among its members (Condon, 1987). Some people perceive less control over young people and greater influence on
behaviour from other individuals outside of the family in newer, larger communities (Archibald, 2004). Today, there is a chronic shortage of housing contributing to overcrowding among many families with young children in almost every community in Nunavut (Egeland, Faraj, & Osborne, 2010; StatsCan, 2010). Influences from media, television, education system, and other sources (Condon, 1987, 1990, 1995); as well as residential schooling (Kirmayer, Brass & Tait, 2000; Pauktuutit, 2007), parents coping with significant stress and mental health and wellness issues (Curtis, Kvernmo, & Bjerregaard, 2005; Kirmayer et al., 2000; Kirmayer et al., 2009; Waldram et al., 2007; Wolsko, Lardon, Mohatt, & E., 2007) and settlement into larger communities (Archibald, 2004) have contributed to a shift in traditional way of life in contemporary communities. This has also shifted how young people learn about sexual health, which will be discussed in greater detail in the next chapter.

**Health Services**

Nunavut has one hospital (Iqaluit, NU), and two larger health centres in regional centres (Rankin Inlet and Cambridge Bay, NU) staffed by physicians. Health centres staffed by community health nurses service the rest of the communities, and physicians make visits to these communities throughout the year. This dearth of services means that patients are often sent to tertiary care facilities in Yellowknife, NT, Edmonton AB, Winnipeg, MB, or Ottawa, ON if more advanced or complex care is required.

**Public and Population Health**

Tuberculosis continues to be a challenge in Nunavut. More than 100 new active cases were documented in 2010, a population rate 62 times the Canadian average (MacDonald et al., 2011). Pervasive social determinants in Nunavut such as poverty; lack
of adequate housing and overcrowding, food insecurity, and trauma are intermeshed with the quality of life for many Nunavummiut (NDH&SS, 2005; Healey & Meadows, 2008). Public health services and health promotion initiatives are largely the domain of the Government of Nunavut, Department of Health. These programs consist of maternal-child health supports (e.g. well-baby clinics, immunization clinics, breastfeeding support, prenatal nutrition programs), chronic disease management, environmental health, anti-tobacco use initiatives, infectious disease control, oral health, and nutrition and food security initiatives (Health, 2014). For the past four years, the Government of Nunavut has worked on the development and implementation of a sexual health strategy, which includes recommendations for clinicians and for curriculum development (Health, 2012). In 2013, the Department of Health launched the “I Respect Myself” sexual health website in the four official languages of Nunavut, with information about reproductive health, terminology and slang, relationships, the health of the body, and sexually transmitted infections (Health, 2013), at the time of the writing of this dissertation, these initiatives had not been evaluated, so their impact is not clear.

Chapter 3 - A Review of the Sexual Health Literature

In this section, I will first provide an overview of sexual health literature in the global health context and in the Arctic context. In the following sections, I will provide an overview of Inuit traditional knowledge and perspectives on the topic of sexual health and relationships, and discuss important topics related to sexual health specifically in Nunavut.
**Sexual Health Literature in the Global Health Context**

Sexual health has not always been a topic of discussion in public health but is now recognized as an important health promotion concept with the potential for improving population health in a broad range of areas related to sexual behaviour. These include human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS), sexually transmitted diseases (STDs), viral hepatitis, teen and unintended pregnancy, and sexual violence (Douglas & Fenton, 2013). The current working definition of sexual health according to the World Health Organization (2006) is (p. 5):

“...a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”

One of the overarching goals of this study is to support positive and meaningful action on the issue of sexual health in the North. In 2010, the World Health Organization developed a framework for action on this and identified additional key concepts in sexual health (WHO, 2010). It states that:

- **Sexual health is about wellbeing, not merely the absence of disease.**
- **Sexual health involves respect, safety and freedom from discrimination and violence.**
- **Sexual health depends on the fulfillment of certain human rights.**
• Sexual health is relevant throughout the individual’s lifespan, not only to those in the reproductive years, but also to both the young and the elderly.

• Sexual health is expressed through diverse sexualities and forms of sexual expression.

• Sexual health is critically influenced by gender norms, roles, expectations and power dynamics.

• Sexual health needs to be understood within specific social, economic and political contexts.

I believe that relationships with peers, partners, family and community are also key concepts that must be added to this list. For that reason, I have framed the questions in this dissertation around both sexual health and relationships.

Globally, research aimed at improving sexual health through the investigation of interventions and sexual behaviour has increased in recent decades (Wellings et al., 2006). In an analysis of sexual behaviour data from 59 countries, Wellings et al. (2006) described a substantial diversity in sexual behaviour by region and sex. They found that there was no universal trend towards earlier sexual intercourse, but that a shift towards later marriage in most countries has led to an increase in premarital sex, the prevalence of which is generally higher in developed countries than in developing countries, and is higher in men than in women (Wellings et al., 2006). Monogamy is the dominant pattern everywhere. Having had two or more sexual partners in the past year is more common in men than in women (Wellings et al., 2006). Condom use has increased in prevalence almost everywhere, but rates remain low in many developing countries (Wellings et al, 2006). Sexually transmitted infections other than HIV are important global health issues,
which Low et al. (2006) argued have been neglected as a public-health priority and control efforts continue to fail. Sexually transmitted infections, by their nature, affect individuals who are part of partnerships and larger sexual networks, and in turn populations. Low et al. (2006) argued that interventions delivered to whole populations, or groups in whom the risks of infection and onward transmission are very high, will have the greatest potential effect, however, strong evidence for the effectiveness of most interventions on population-level outcomes is scarce.

Regional variations in sexual behaviours described by Wellings et al (2006) are indicative of social, economic, and political determinants of sexual behaviour, which also have implications for interventions. Although individual behaviour change is central to improving sexual health, efforts are also needed to address the broader determinants of sexual behaviour, particularly those that relate to the social context (Wellings et al, 2006). The evidence from behavioural interventions is that no general approach to sexual health education or promotion will work everywhere, and no single-component intervention will work anywhere. Comprehensive behavioural interventions, which (1) take into account the social context in individual-level programs, (2) attempt to modify social norms to support uptake and maintenance of behaviour change, and (3) understand the structural factors that contribute to sexual behaviour, are needed (Wellings et al., 2006).

**Arctic Sexual Health Literature**

Recent studies in the Arctic have primarily focused on examining sexually transmitted infection rates and causes. In a study of sexually transmitted infections in the North American Arctic and Greenland, Gesink Law, Rink, Mulvad and Koch (2008)
found that Arctic regions consistently reported higher rates of infection than their southern counterparts. A recent study in Greenland found the presence of an emerging sexually transmitted infection, *Mycoplasma genitalium* with symptoms similar to those for *C. trachomatis* and *N. gonorrhoeae* (Gesink et al., 2012). In 2006, Alaska reported high rates of chlamydial infection (715 cases/100,000 population) compared with the United States as a whole; northern Canada reported high rates of chlamydial infection (1,693 cases/100,000) and gonorrhea (247 cases/100,000) compared with southern Canada; and Greenland consistently reported the highest rates of chlamydial infection (5,543 cases/100,000) and gonorrhea (1,738 cases/100,000) in the Arctic (Gesink Law, Rink, Mulvad, & Koch, 2008). Rates were high for both men and women, although the highest incidence of infection was predominantly reported for young women in their early twenties. The authors noted that community-based participatory research was needed to improve sexual health in Arctic communities and to engage community members in the collection of data and the development of appropriate interventions.

Within the general Arctic population, the Circumpolar Inuit population is a subset of the population, which includes the Inuit/Inupiaq whose lands extend from northern Alaska, across Canada, to Greenland; the Yup’ik in central and south-western Alaska; and the Chukotka peninsula in Russia (Bjerregaard & Young, 1998). The little research that has explored sexual health and related determinants among the Circumpolar Inuit, has included studies on sexually transmitted infections (Bjerregaard, Young, Dewailly, & Ebbeson, 2004; Healey, Aronson, Mao, Schlecht, & Mery, 2001; Toomey, Rafferty, & Stamm, 1987), reproductive health (Bjerregaard et al., 2003; Emdal-Navne, 2008), and
most recently, community-based participatory research to inform the development of interventions (Rink, Montgomery-Andersen, & Anastario, 2014).

**Inuit Qaujimajatuqangit – “Inuit Knowledge”**

The term *Inuit Qaujimajatuqangit* is used in place of ‘traditional knowledge’, but is also used to refer to Inuit perspectives, worldviews, and other knowledge that belongs to Inuit. This dissertation focused on understanding the current perspectives of Inuit families on the topic of sexual health and relationships. In this section, Inuit knowledge related to sexuality, sexual health, and relationships, are outlined to provide cultural perspectives on the topic for the reader.

**Kinship Relationships**

From a relational knowledge and Inuit epistemological perspective, kinship is the foundation of Inuit social organization and life (Briggs et al., 2000; Kral et al., 2011). Kinship extends beyond familial and biological connection to other non-biological affiliations including adoption, friendship, marriage or partnership, and namesake (Emdal-Navne, 2008; Kral et al., 2011; Nuttall, 1992). In one of the few oral histories of Nunavut, which shares the voices of Inuit elders, it is said that Inuit believe that three essential parts made a human: body, soul, and name (Bennet & Rowley, 2004). A nameless child was not fully human; giving it a name, whether before or after birth, made it whole. Inuit did not have family surnames. Instead, each person’s name linked him or her to a deceased relative or family friend, and the spirit of the person who has passed on lived on in the child (Bennet & Rowley, 2004). Often the children will carry traits of their namesake or avvrainnuk, such as hunting or sewing skills, and will be protected by the
name-soul connection. Names can be revealed through dreams (Bennet & Rowley, 2004). The relationship between the child and the family of the namesake strengthened family bonds and created extended family networks that would support the child throughout life (Karetak, 2013; Tagalik, 2011). The name bestowed upon the child was the first step in establishing a community around an individual beyond the immediate family and provided connections to others (Bennet & Rowley, 2004; QHRC, 2012). This tradition is still prominent in Inuit communities today and it has been my observation that the naming tradition has been part of a process of reclaiming Inuit family relationships after the separation events of the settlement period.

**Marriage and Family**

Before settlement, families had more control over the actions of the members of the group. Interactions with parents far outweighed the importance of interactions with peers (Condon, 1987). Children learned valuable behaviours, such as self-restraint, patience, non-aggressiveness, generosity, and responsibility, by watching parents lead by example (Bennet & Rowley, 2004; Condon, 1987; Healey & Meadows, 2008).

Painngut Peterloosie (2011) highlighted the importance that was placed on the openness of the relationship dialogue between romantic partners in discussing, for example, menstruation, sex, or sexual satisfaction.

**Arranged Marriage**

Accounts from elders talking of their own experiences with marriage and family demonstrate that a number of practices were common among Inuit even in geographically separated *Ilagiit nunagivaktangat*. Pre-arranged marriages, for example, were a common custom. Marriages were arranged by the parents and elders of the camp and, occasionally,
between people who lived in neighbouring camps (Bennet & Rowley, 2004; Briggs et al., 2000). In some cases, the betrothed children grew up together in the same camp, formed a friendship and a bond, and knew they were intended to become a family unit. Qinuayuaq Pudlat (2011) described this traditional marriage system working well in the past because groups, and later communities, were small. The couples lived by the advice provided to them by the family group and followed in the footsteps of their parents. “They were very happily married, helping and working together” (Pudlat, 2011, p. 76). Other accounts from different camps tell stories of husbands and wives being introduced to each other for the first time as they are sent off to the camp of the family they had been married into (Bennet & Rowley, 2004; Wachowich et al., 1999).

**Spousal Exchange**

Early accounts from Arctic explorers, traders, and missionaries have created a somewhat negative stereotype of Inuit as promiscuous in their sexual liaisons (Jenness, 1991; Lantis, 1946; Rubel, 1961). The typical scenario is that of an Inuit man who displays his generosity to strangers by offering ‘the use of’ his wife or daughters (Houston, 1971; Jenness, 1991; Lantis, 1946). Jenness (1991) reported observing a few instances of spousal exchange among the members of the camp in which he lived in the early 20th century. When asked why they engaged in the exchange, the response was that the two husbands were cousins so the exchange of partners was permitted (Jenness, 1991, p. 357). This answer does not provide much insight to the external observer, and Jenness expressed in his journals his frustrations with his lack of understanding of this custom. The accounts of this practice, which were documented by explorers and researchers, were almost always written by men (Jenness, 1991; Lantis, 1946; Rubel, 1961). Explorers and
researchers in the Canadian North at the time were predominantly men, so this is not surprising. Jenness (1991) and others (Rubel, 1992) reported that spousal exchanges were negotiated by men and were based on a pre-existing familial or collegial relationship. From their accounts, it would appear that women were not involved in the discussion. Given the openness and reciprocity known to have existed between Inuit couples (Peterloosie, 2011), this is difficult to believe. There is no female perspective on the topic, therefore, I feel there is a gendered bias toward male domination of the exchange in the documentation of the practice.

In their research in the western Arctic, Stern and Condon (1997) believed that the attitudes of Inuit regarding sexuality and relationships were mitigated by a host of demographic, social, and economic realities. They and other researchers have examined economic explanations for spousal exchange including the strengthening of ties between families, the extension of kinship networks, access to abundant hunting grounds, and the creation of alliances between families of different regions (Condon & Stern, 1993; Rubel, 1961; Stern & Condon, 1997). Jenness (1991) reported a story about a man, Ahkiatak, taking the wife of his cousin, Ituqunna, on an extended trip through the lands occupied by Ituqunna’s family. The other husband and wife remained at home together. The temporary partnership ensured welcome to a stranger and provided Ituqunna the opportunity to visit with her family (Jenness, 1991).

Stern and Condon (1997) reported that missionaries actively repressed the practice of spousal exchange in the western Arctic. Equally problematic for the missionaries during this period were what they perceived to be premarital and extra-marital relations, which later seemed to increase in response to the disappearance of spousal exchange as a
legitimate social practice (Stern & Condon, 1997). The missionaries may have inadvertently contributed to an increase in what they perceived to be illicit sexual activity by eliminating a culturally approved and open system of spousal exchange (Stern & Condon, 1997).

Interestingly, Stern and Condon (1997) and Jenness (1991) observed Inuit families in the same small region of the western Arctic, which was a prominent area for whaling in the late 19th century. The number of different events may have become enveloped in the oral history of that region. It is difficult to tease out what was happening in the social lives of Inuit given the different accounts and perspectives from non-Inuit who were visiting the North during that time. It is difficult to know to what extent Inuit participated in or valued this custom because the knowledge and memories of this practice, which existed in the Inuit oral tradition, were suppressed.

Ultimately, the historical record on this topic is poor, and it is difficult to be critical of the information available about the practice of spouse exchange because so much knowledge about it has been lost.

Polygamy and Polyandry

There are reported instances of polygamy and polyandry in Inuit history. In Bennet and Rowley (2004), Ikayukta makes reference to her experience of becoming the second wife of a man although the context of this scenario is not discussed. Prominent, award-winning Inuk story-teller and filmmaker from Iglulik, Nunavut, Zacharias Kunuk, makes reference to polygamy in his works Atanarjuat (2001) and Journals of Knud Rasmussen (2006) (Kunuk, 2001; Kunuk & Cohn, 2006), which are based on Inuit stories, accounts, legends, and oral histories. In the film Atanarjuat, members of the camp suggested to
Atanarjuat to take a second wife to go hunting with him while his first wife remained at the camp to give birth. In the case of Atanarjuat, having a wife to accompany him on a multi-week hunting trip was important for the preparation of the skins, drying the meat, and setting up camp.

In my personal discussions with community members, one of the circumstances in which a man or woman may have had multiple spouses would have been in the case where, for example, a man in the camp passed away and the wife and children joined another family and vice versa. In these cases, this was done to ensure the survival of the remaining spouse and children. Without a husband to hunt for food and provide for the family they would have surely starved to death; without a wife to provide clothing, tents, and kamit, they would have frozen to death.

**Inuit Stories and Teachings About Sexuality**

Sexuality is a term that can encompass ideas such as sexual orientation, sexual preference, physicality, desire, and sensuality (Oxford, 2013c). Sexuality has long been a strong part of Inuit legends, stories, art, and performance. Inuit performance art, such as Uajeernerq (Greenlandic Mask Dancing), Inuit throat singing and Inuit drum dancing. Inuit performance arts are inherently sexual in nature. The colours and shapes depicted on the face with make-up in Uajeernerq dancing represent male and female genitalia (Williamson Bathory, 2012). Throat-singing and drum-dancing were banned by missionaries when they first entered the Qikiqtaaluk region of Nunavut, because they felt the sounds were overtly sexual in nature and that the drumming stirred sexual feelings that were not in keeping with Christian beliefs at the time (Laugrand & Oosten, 2010). Since that time, drum dancing and throat singing have experienced a revival and are now
part of regular community and school-based activities. David Hiquaq (Serkoak), a long-time Nunavut educator from Arviat, Nunavut, is credited with the revival of drumming practice throughout Nunavut (Pfieff, 2012).

One of the most well known Inuit legends is about the creation of the sun and the moon. In this story, which takes place in a dark igloo, a woman discovers that the person she has been engaging in sex with appears to be her brother. In disgust and fear, she runs out into the snowy darkness, her brother chasing her. They lift up to the heavens, and become the sun and the moon, forever chasing each other and separated for breaking the taboo that forbids siblings from having sex. There are a number of Inuit legends that feature a character engaging in sex with animal spirits. In fact, when I was growing up, an elder came our school to tell us the story of how the Qallunaat came to be: she told the story of a woman who had sex with an Inuit sled dog and gave birth to Qallunaat. That explained why they (Qallunaat) were so hairy. This legend originated over 100 years ago in Greenland (Harper, 2012).

In an essay about Inuit art and sexuality, Vorano (2008), discussed how Inuit art, such as carvings or drawings were highly sexual in nature before the 20th century. For example, carvings may have featured enlarged genitalia or human-animal spirit interactions. This changed over the course of the past century as a result of the influence of missionaries and later the residential school experience, which instilled a sense of shame about Inuit culture, language, and sexuality (Vorano, 2008). Further amplified by the mass-marketing of the “cute, happy-go-lucky Eskimo” (Graburn, 2011; Vorano, 2008, p. 125), such depictions robbed Inuit men of their sexuality and masculinity. Few Inuit

---

11 Qallunaq (plural: Qallunaat) is the common Inuktitut term for a white person/person of European descent.
men were likely aware of these depictions at the time, however the imprint of this marketing on popular culture has remained to this day. As a result, the ‘Southern’ appetite for Inuit art has shifted more toward depictions of the small Inuit hunter, qajait\textsuperscript{12}, inuksuit\textsuperscript{13}, and ‘exotic’ Arctic animal figures such as narwhal, polar bears, and walrus, and less on sexual beings, spirits, and cosmology (Vorano, 2008, Graburn, 2011).

What can be pieced together from historical accounts, oral histories, and the words of elders, indicates that sexuality among Inuit was historically open, humorous, spiritual, and featured prominently in music, performance, and storytelling (Harper, 2012; Kappiannaq, 2000; Vorano, 2008; Williamson Bathory, 2012).

**Sexual Health Literature in Nunavut Context**

Today, discussions of sexual health in Nunavut are largely linked to the high rates of sexually transmitted infections and unintended pregnancy (Healey, 2006a, 2006c, 2007; Steenbeek, 2005). A number of concerns about sexual health among youth in Nunavut have been identified by community members and in the literature. Sexual health and teen pregnancy have been identified in community consultations as priority areas for research with Nunavut communities (Healey, 2006a, 2006p, 2007; ITK, 2001). Beyond the scope of what is taught in school, and the efforts of community health practitioners in communities, there have been few scattered sexual health education resources or programs available in Nunavut until very recently. Some of the most pressing issues centering around sexual health in Nunavut today include: sexually transmitted infections; engaging in sex at a young age; teenage pregnancy; custom adoption; sexual abuse;

---

\textsuperscript{12} A qajaq (plural: qajait) is a one-person boat made of skins, wood, and/or bone invented and used by Inuit for the harvesting of marine life.

\textsuperscript{13} An inuksuk (plural: inuksuit) is a man-like figure made of large rocks, which Inuit have used for millennia as markers, that point to the direction of harvesting grounds or mark a cache of food, etc.
alcohol and substance use; and knowledge and beliefs about sex.

**Sexually Transmitted Infections**

In 2009, Nunavut reported high rates of chlamydia and gonorrhea, both of which are sexually transmitted infections, (3772/100,000 and 1,588/100,000, respectively), compared to Canadians (259/100,000 and 33/100,000, respectively) (NDH&SS, 2012). Although all bacterial STIs in Canada pose a significant health threat, genital chlamydia may represent one of the most serious. In Canada, genital chlamydia is the most commonly reported notifiable disease and the magnitude of morbidity associated with sexually transmitted chlamydial infections is very large (PHAC, 2010). For example, infection during pregnancy can lead to a number of complications, including premature rupture of membranes, preterm delivery, neonatal infections, low birth weight and stillbirth as well as early or repeated pregnancy loss. There are societal and community costs for a person who becomes infected with an STI including social exclusion, personal rejection, low self-esteem, family strain, and potential sterility as a result of prolonged infection, particularly in the case of a woman (PHAC, 2010). In addition, costs to the health care system for a pregnant woman who contracts chlamydia can result in the following costs: cost of treatment for mother and child; additional costs for severe health problems associated with STIs, such as miscarriage, ectopic pregnancy, low birth weight baby, pneumonia, and preterm birth, which requires a medical evacuation to a larger hospital (PHAC, 2010).

In a report profiling cancer rates in the period 1992-2001 in Nunavut, the most common cancer among women was cancer of the cervix, which accounted for 30% of all (malignant and in situ) cancers diagnosed in women (Healey, Plaza, & Osborne, 2003).
Approximately 75% of cervical cancer cases in Nunavut were diagnosed between the ages of 20 and 39. In a large study of Human Papilloma Virus (HPV) in the Canadian Arctic, data from Pap smear examinations from almost 15,000 women living in the NWT, Nunavut, Labrador or the Yukon were collected (Owens et al., 2012). HPV typing results and demographic information were linked for analysis (Owens et al., 2012). The overall HPV infection rate of 25.8% among the women in the study was higher than for most countries but is similar to Denmark and the USA. There was no comparable rate available for Canada. In the sample, the infection rate among the Indigenous women was significantly higher than for non-Indigenous women (31.6% versus 18.9%) and the difference remained even after adjustment for the different age distributions between the two groups (Owens et al, 2012). The proportion of critical HPV types, or the types associated with cervical cancer, among HPV-positive women in the cohort was 78.6%, regardless of ethnicity. This is considerably higher than the proportion found for the British Columbia (13.9%) and Ontario (9.6%) cohorts and more in line with the proportion reported for Nunavik (70.6%) (Owens et al, 2012). The authors suggest that women in the North, regardless of ethnicity, may be more at risk of infection with higher risk types of the virus (Owens et al, 2012).

A limited research study conducted in 2002 with a small sample of high school (n = 71) and college age youth (n = 31) in a Nunavut community found that 20% of high school students reported having been treated for an STI, and all respondents stated they knew where to get free condoms (Cole, 2003). It is unclear from this study if the students who were treated for infection became aware of where to access free condoms after the incident of the sexually transmitted infection or before.
Relationships

Romantic relationships, especially among youth, follow the contemporary Western model of love based on individualism and choice (Condon, 1987, 1990). Trouble in romantic relations was the triggering factor in most suicide attempts by Inuit, and Kral et al. (2009) reported youth threatening their partners with suicide when arguing. In a study of 66 high school and college-age Inuit in Nunavut, youth narratives highlighted their experiences of stress in these relationships and the need for guidance (Kral et al., 2011).

Changing Family Lifestyles

Family is the primary context in which the child grows, develops an identity, is socialized, is hurt and healed, and struggles with powerful developmental issues (Santisteban & Mitrani, 2005). The family is a naturally occurring unit and the context in which most intense behaviour-shaping experiences can occur. In recent years, increased attention has been given to the role of the family in predicting and understanding the sexual behaviour of adolescents (Lenciauskiene & Zaborskis, 2008).

Arnakak (2006) highlights that for Inuit, the family unit has always played a central role in life and in survival, and this connection was disrupted by colonization. Every person had a specific and essential role to play in making contributions toward family survival and the education of young children and adolescents (Arnakak, 2006). In Nunavut, as in many other jurisdictions, parents and family are no longer the single source for information about sexual health knowledge and behaviours, if they are a source at all in today’s modern world (Archibald, 2004; Condon, 1987, 1990, 1995; Steenbeek, Tyndall, Rothenberg, & Sheps, 2006; Strasburger, 2008). Settlement reflected
a new pattern of community life, and the large cohorts of young people growing up and attending school together in community settings was newer for Inuit (Condon, 1990). Only three generations ago Inuit were living in extended family camps on the land, and many middle-aged Inuit today were born on the land\textsuperscript{14}. The aggregation of Inuit onto government-run settlements changed Inuit life enormously. Kinship-based social organization was disrupted. The large number of children growing up together and learning about the late 1960s culture in the South at the sanatoria and residential schools, developed a new youth culture wanting more independence from their parents (Condon & Stern, 1993). These young Inuit followed the Western style of relating more among themselves than with older generations (Kral et al., 2011). Today, the school system, peers, television, Internet, media, community members, teachers, and others currently play a role in the transmission of attitudes, knowledge, and beliefs about sexual health behaviours. This has had consequences for the reproductive health (e.g., adolescent pregnancies and STIs) and wellbeing of the Inuit community (Steenbeek, 2005).

Westernization and colonization have been identified as factors in sexual health, as with the abandonment of traditional medical practices, the accumulated wisdom, knowledge, and skills of the Inuit regarding the life cycle, reproductive health, and family planning which now cease to be shared by Inuit families, and as a result, many Inuit parents and grandparents no longer felt competent to instruct their children (Gesink Law et al., 2008; Steenbeek, 2005).

**Engaging in Sex At a Young Age**

There are no data currently available in Nunavut reporting the age in which youth

\textsuperscript{14}‘On the land’ is a term often used in the North to refer to the nomadic camps and outpost sites occupied by Inuit before and even after settlement. In the NWT and Labrador, the term ‘in the bush’ is used in a similar fashion.
are starting to engage in sexual activity, however, local clinicians have noted that teen girls are attending prenatal clinics at 13 and 14 years of age and older (M. Cole, 2013). Sexual intercourse at an early age, having multiple sexual partners, and unprotected sex put all teens at risk of sexually transmitted infection (STI) and of unwanted pregnancy. The younger a person is when he or she becomes sexually active, the longer they are at risk of unwanted pregnancy or of contracting a sexually transmitted infection.

Pregnancies place additional physiological stress on young women’s bodies as well as influencing other socio-economic factors in the lives of the young girls, such as income, social support and a high rate of attrition among high school students (Archibald, 2004). Research has also shown that first intercourse at an early age is related to risk behaviours such as unprotected sex, alcohol consumption and smoking (PHAC, 2010).

**Teenage Pregnancy and Custom Adoption**

In 2000, the rate of teenage pregnancy in Nunavut was 161.3/1,000 compared to 38.2/1,000 in the rest of Canada (Archibald, 2004). McKay (2006) reported the rate of pregnancy among Nunavummiut aged 15-19 to be 119/1,000. In a qualitative study of teen pregnancy among young Inuit students and adults living in Ottawa, ON at the time of the study, respondents indicated that pregnancy itself is not as much of an issue as the specific circumstances or context in which the mother becomes pregnant. For example, if the woman is too young; if she is single; does not have the skills or maturity to care for a baby; has to drop out of school; does not have the money to buy necessities for the baby; if her parents end up caring for the baby (custom adoption); or if she is depressed or overwhelmed by the pregnancy, this creates short and long term hardships for the mother and challenges the healthy development of her family (Archibald, 2004).
In traditional Inuit custom adoption, Inuit families give a child to an extended family member, such as an aunt and uncle or grandparents. In Inuit society this practice is very common. Birth parents often see their adopted children daily and often have close relationships with them. A family may potentially adopt their biological child out to another family, and then later adopt someone else’s into their family (Bennet & Rowley, 2004). Custom adoption strengthened community ties, helped create families, and ensured children had the best possible home. Through the Aboriginal Custom Adoption Recognition Act passed in 1994, the Federal Government began to support custom adoptions in Indigenous Canadian communities. In recent years, however, some Nunavut community members have expressed concern that the practice of custom adoption is being abused and becoming a way for teenagers to deal with unwanted pregnancies in Nunavut, instead of for its intended purpose of fostering relationships, networks and bonds between multiple families (Archibald, 2004; Rideout, 2000).

**Sexual Abuse**

Sexual abuse has been identified as a serious concern in Inuit communities in Canada, particularly in the context of residential schooling and its intergenerational effects (Pauktuutit, 2007). Data from the 2007-2008 Inuit Health Survey indicated that 41% of adult respondents (52% of women respondents and 22% of men respondents) experienced severe sexual abuse in childhood (Galloway & Saudny, 2012). Eighteen percent of survey respondents reported experiencing some type of forced sexual activity in adulthood (27% of women and 5% of men) (Galloway & Saudny, 2012).

In one study examining determinants of health for Inuit women in Nunavut, participants identified sexual abuse and violence against women as prevalent and hidden
realities of life for some in Nunavut (Healey & Meadows, 2014). Early sexual abuse has been associated with a lower age at first intercourse, sexually transmitted infections, and substance use among women in other populations (Young & Katz, 1998). In a study of 602 American youth across 10 cities, previous experience of sexual abuse was associated with a higher probability of engaging with a high-risk sexual partner, engaging in prostitution, and choosing multiple sex partners (Cunningham, Stiffman, Dore & Earls, 1994). Violence, sexual or not, has been identified as a theme in the pattern of ill health in Inuit communities in Canada and in other Arctic communities (Bjerregaard et al., 2004; Healey, 2007).

**Alcohol and Substance Abuse**

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

Nunavut has the third highest proportion of heavy drinkers over the age of 12 when

---

15 A high risk sexual partner was defined by the authors as a sexual partner who engaged in at least one of the following behaviors: unprotected intercourse, sex with multiple partners, injectable drug use, sharing unclean needles, and prostitution.
compared to all other provinces and territories, as reported by the Canadian Community Health Survey (2003). Nunavut’s proportion of heavy drinkers was 31.0%, third only to the NWT at 39.9% and Newfoundland at 32.2% (CCHS, 2003). Substance use has been identified as a factor in youth sexual health in other reports (Healey, 2012). The question remains as to whether drinking immoderately is both the consequence and the cause of some health-related and wellness issues of people in Nunavut.

**Mental Well-Being**

One aspect of healthy sexuality relates to mental wellbeing. It can be conceptualized as a state of well-being in which the individual realizes his or her own abilities, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to his or her community (WHO, 2013). With respect to children, an emphasis is placed on the developmental aspects, for instance, having a positive sense of identity, the ability to manage thoughts, emotions, as well as to build social relationships, and the aptitude to learn and to acquire an education, ultimately enabling their full active participation in society (WHO, 2013).

In a discussion document prepared by the Assembly of First Nations for the Mental Health Working Group, mental wellness included concepts related to spiritual and cultural aspects of wellness and was defined as: “a life-long journey to achieve wellness and balance of the body, mind and spirit...[and] includes self-esteem, personal dignity, cultural identity and connectedness in the presence of a harmonious physical, emotional, mental and spiritual wellness” (Group, 2002, p. 3). A number of factors are known to influence our mental state (Stephens, Dulberg, & Joubert, 1999). Mental health and wellness includes the ability to cope effectively with challenges to both mental and
physical functioning. Such abilities or attributes can include happiness, work satisfaction, self-esteem, mastery, and a sense of ‘coherence’ (Stephens et al., 1999). Previous research has shown that mental health problems, including depression and low self-esteem, can contribute to an increase in risky sexual behaviours, such as having multiple partners or substance use. Substance use has been shown to increase risk of non-condom use and acquisition of an STD (Roberts & Cahill, 2008; Seal, Minichiello, & Omodei, 1997; Shrier, Harris, Sternberg, & Beardslee, 2001). In a study from Alaska, stressful life events linked to trauma and violence were also linked to substance abuse, which increased the risk of sexual assault among the participants in the study (Parks et al., 2001; Segal, 2001).

In an analysis of positive mental health and mental health problems among Canadians, Stephens, Dulberg, and Joubert (1999) provided evidence linking current stress, social support, life events, education, and childhood traumas to several indicators of both positive and negative mental wellbeing. The authors defined mental wellbeing as having the ability to cope effectively with challenges to both mental and physical functioning. Such abilities or attributes can include happiness, satisfaction, self-esteem, mastery and a sense of ‘coherence’ (Stephens et al., 1999). Each of these aspects of wellbeing are important in sexual decision-making (WHO, 2006).

Nunavummiut face significant mental health and wellness issues and a high rate of suicide and attempted suicide. Data from the Inuit Health Survey (2007-2008), which was the largest comprehensive study of Inuit in Nunavut to date, showed that 48% of Inuit respondents thought about suicide at some point during their lives and 29% attempted suicide at some point during their lives (Galloway & Saudny, 2012). Thirteen percent
said they felt “serious psychological distress” in the thirty days prior to participation in the survey (Galloway & Saudny, 2012). Mental health and wellness is one of the most pressing issues in Nunavut today and has been highlighted as the priority issue of community members during public engagement sessions hosted by Qaujigiartiit Health Research Centre and by Inuit organizations (Aliait Inuit-specific Mental Wellness Task Group, 2007; Healey, 2006a, 2006b, 2007; Nunavut Tunngavik Inc., 2011). In the context of Nunavut’s colonial history and the prevalence of a number of issues including violence, sexual trauma, substance use, suicide, and the sense of grief expressed by those who feel the loss of Inuit identity, achieving a sense of well-being can be a daily struggle (Healey & Meadows, 2008, 2014; Kral, 2003).

**Knowledge about Sexual Health and Relationships**

One study exploring determinants of sexually transmitted infections among Canadian Inuit adolescents stated that adolescent sexual activity is generally initiated with little knowledge of reproductive physiology (Steenbeek, 2005). Steenbeek also identified that parents and grandparents, who in the past played a dominant role in educating their children on matters pertaining to reproductive health, now no longer feel competent to teach their children the importance of reproductive physiology (Steenbeek, 2005). The reason parents no longer felt competent were not documented, however, I believe that the powerful influence of colonization and the resulting change in the role educators and knowledge holders from parents to teachers and nurses played a part. In a study of health determinants for Inuit women, participants identified knowledge (about wellness, traditions, the land, and the body) as a critical determinant of health for Inuit women (Healey, 2006i). Participants in that study raised this concern in the context of
young Inuit women, because they felt they did not have the sexual health knowledge they needed to make informed decisions (Healey, 2006i). In a study of sexual health knowledge and attitudes of high school and college-age youth in Iqaluit, NU, 33% of Inuit students and 62% of non-Inuit students felt they had received enough education about STIs (Cole, 2003), highlighting discrepancies between the knowledge young people believe they have and the knowledge the older generation believes they are missing. I believe these discrepancies are demonstrative of the confusion that has been generated by the severing of family relationships during the settlement era and the shift in the role of educator from parents to teachers/nurses/others.

Until the last few decades, commercial contraceptives were not commonly used in Inuit communities. Infant mortality rates were high, and thus it was unlikely that women would have considered limiting their fertility (Bjerregaard & Young, 1998). Additionally, there is a cultural emphasis placed upon bearing children, and it is common for young people to begin having children before they establish a separate household (Steenbeek, 2005). Children born to single mothers are generally accepted within the community and are rarely stigmatized as they are in other societies (Archibald, 2004; Bjerregaard & Young, 1998; Steenbeek, 2005).
PART C – THEORY AND METHOD

Chapter 4 - Paradigms and Perspectives

In this Chapter, the theoretical and methodological aspects of this dissertation are described, with particular focus on a research model derived from Inuit philosophical concepts related to health, wellness, and research. This model is presented as a journal manuscript.

Grounded Theory, Social Science Theory, and Indigenous Theory

Historically, research among the Inuit population in Canada has been led by anthropologists and has largely been ethnographic in nature with the intent of documenting Inuit cultural practices (Bennet & Rowley, 2004; Condon, 1987, 1990, 1995; Jenness, 1991). A small portion of this work has focused on sexual health beliefs and practices (Condon, 1987; 1990). This dissertation focuses on the study of sexual health in Inuit society and the relationships between people in society. Topics covered in this dissertation, such as family, social change or acculturation, attachment, sexuality, health behaviour, or communication have been discussed widely in the health and social science literature (Alasuutari, 1996; Becker, 1998; Berry, 1980; Berscheid & Peplau, 1983; Feeney & Noller, 1990; Hunt, Schneider, & Comer, 2004; Jamieson, 2011; Morgan, 1996, 2011; Trimble, 2005; Weiss, 2007; Wellings et al., 2006; Willis, 2007). Little of this health and social science literature has explored Indigenous views on health, society and the relationships between people therein. In the education field, however, Indigenous knowledge and research epistemologies have been the focus of discussions in Western and Indigenous research theory (Alfred & Corntassel, 2005; Barnhardt & Kawagley,
2005; Battiste, 2002; Battiste & Henderson, 2000; Deloria, 1995; Kovach, 2010; Walters, Simoni, & Evans-Campbell, 2002; Wilson, 2008). This literature contributes perspectives on the assumptions implicit in different research approaches and provides models for doing or interpreting research based on Indigenous worldviews. Although significant advances have been made to engage Indigenous communities in research, there remains a need for research models that are born from Indigenous perspectives on research, from the underlying assumptions to the research questions to how to find the answers (Kovach, 2009; Prior, 2006; Wilson, 2008).

Questions that focus on what people perceive to be important aspects of health, what variations exist, and what lived experiences mean to individuals and groups are the domain of qualitative studies (Crabtree & Miller, 2004). A qualitative approach incorporates the fact that the phenomena under study are inextricably bound within the social order and the context in which people live (Willis, 2007). In qualitative research, the researchers usually start with a problem or issue that emerges from a story or some experiential context (Borkan, 1999; Crabtree & Miller, 2004). These problems and issues give rise to research questions. What distinguishes qualitative research from quantitative approaches is that it seeks to search inductively for understanding and meaning. These aspects of qualitative research are in harmony with Indigenous methods (Kovach, 2009). This research followed a modified grounded theory approach (Charmaz, 2006), which retains most of the defined characteristics of ‘classic’ grounded theory, but takes a more subjective and reflexive stance which is more aligned with Indigenous knowledge and ways of knowing (Chilisa, 2012; Kovach, 2009; Wilson, 2008). Originally presented by Glaser and Strauss (1967), the intent of using a grounded theory approach is to generate
or discover a theory inductively from the understandings or meanings explored in the data collection (Creswell, 2013).

Indigenous ways of knowing are formulated on understandings of the world based on human interactions and go beyond to include interaction with the land, animal, and spirit worlds (Chilisa, 2012; Deloria, 1995; Wilson, 2008). In what Battiste (2002) referred to as ‘Eurocentric thought,’ Indigenous knowledge was often represented by the term ‘traditional’ knowledge, which suggested a body of relatively old data that had been handed down generation to generation relatively unchanged (Battiste, 2002). However, both Battiste (2002) and Grenier (1998) argued that Indigenous knowledge was not static but dynamic, and embodied the following characteristics:

1) Indigenous knowledge is accumulative and represents generations of experiences, careful observations, and trial and error experiments and observations;

2) It is dynamic, with new knowledge continuously added and external knowledge adapted to suit local situations and understandings;

3) All members of the community, that is elders, women, men, and children, have Indigenous knowledge;

4) The quantity and quality of Indigenous knowledge that an individual processes will vary according to age, gender, socioeconomic status, daily experiences, roles and responsibilities in the home and the community, etc.;

5) Indigenous knowledge is stored in people’s memories and activities and is expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, cultural community, laws, local language, artifacts, forms of communication, and organization.
Battiste (2002) also described Indigenous knowledge as embodying a web of relationships within a specific ecological context; as containing linguistic categories, rules, and relationships unique to each knowledge system; as having localized content and meaning; as having established customs with respect to acquiring and sharing knowledge; and implying responsibilities for possessing various types of knowledge. Knowledge is viewed as something people develop as they have experiences with each other and the world around them (Chilisa, 2012; Wilson, 2008). This is similar in many ways to social constructionism in sociological theory (Burr, 2003). Ideas are shared, changed, and improved upon through the understanding and meaning that are derived from experience (Burr, 2003; Wilson, 2008). Fundamentally, this knowledge is rooted in a relational epistemology – a foundation for knowing, which is based on the formulation of relationships among the members of the community of knowers.

A research approach that is mindful of Inuit ways of knowing

The research question about how to approach this health research study from an Inuit worldview was answered by the Piliriqatigiinniq Community Health Research Model, which is presented as a journal article. A version of this article was published in the peer-reviewed International Journal of Critical Indigenous Studies in June 2014.
Manuscript 1 - *Piliriqatiigiinniq* “Working in a Collaborative Way for the Common Good”: A Perspective on the Space Where Health Research Methodology and Inuit Epistemology Come Together

Authors: Gwen K. Healey¹, Andrew Tagak, Sr. ¹

¹ Qaujigiartiit Health Research Centre, Iqaluit, NU, Canada

Abstract

Increasing attention on the Arctic has led to an increase in research in these areas. Health research in Arctic Indigenous communities is also increasing as part of this movement. A growing segment of the research community is focused on explaining and understanding Indigenous knowledge and ways of knowing. Researchers have become increasingly aware that Indigenous knowledge must be perceived, collected, and shared in ways that are unique to, and shaped by, the communities and individuals from which this knowledge is gathered. This paper adds to this body of literature to provide Inuit perspectives on health-related research epistemologies and methodologies with the intent that it may inform health researchers with an interest in Arctic health. The Inuit concepts of *Inuuqatigiitiiarniq* (“being respectful of all people”), *Unikkaaatigiinniq* (“storytelling”), *Pittiarniq* (“being kind and good”), and *Iqqaumaqatigiinniq* (“all things coming into one”) and *Piliriqatiigiinniq* (“working together for the common good”) are woven into a responsive community health research model grounded in Inuit ways of knowing which is shared and discussed.
Key words

Inuit, epistemology, health research methods, relational knowledge, Indigenous knowledge
Introduction

There has been a significant and increasing amount of attention on the Arctic in terms of research, press, exploration, and resource development. Health research and research involving Inuit in Canada’s north has also been increasing in this movement. Community-based participatory research has been a method that has been promoted, however, even though this methodology recognizes the role of community in the research, this methodology still holds the western scientific worldview above others. Concurrently, a growing body of literature has focused on articulating Indigenous knowledge and research epistemologies, leading the way for greater discussion of western and Indigenous research approaches and contributing to more meaningful research (Alfred & Corntassel, 2005; Barnhardt & Kawagley, 2005; Battiste, 2002; Battiste & Henderson, 2000; Deloria, 1995; Kovach, 2010; Wilson, 2008). This paper adds to this body of literature by providing Inuit perspectives on health-related research epistemologies and methodologies with the intent that it may inform health research approaches in Arctic communities.

Inuit are the Indigenous inhabitants of the North American Arctic, whose homeland stretches from the Bering Strait to east Greenland, a distance of over 6000 kilometres. Inuit live in Russia, Alaska, Greenland and the Canadian Arctic, and share a common cultural heritage, language and genetic ancestry. Before contact, small groups of families traveled together to different camps and hunting grounds. In the Qikiqtaaluk\textsuperscript{16} region alone, for example, Inuit lived in small, kin-based groups in over 100 locations.

\textsuperscript{16} Qikiqtaaluk, meaning ‘big island’ is the Inuktitut word for Baffin Island.
throughout the region\textsuperscript{17} (QIA, 2010). Of the approximately 150,000 Inuit living in the circumpolar region today, 45,000 live in Canada’s North. Canadian Inuit lands are known as \textit{Inuit Nunangat} and comprise 4 regions: Nunavut Territory; Nunavik (Northern Quebec); Inuvialuit Settlement Region (northern NWT); and Nunatsiavut (northern Labrador). Comprising one fifth of Canada’s landmass, and 60% of the nation’s coastline, Nunavut occupies the largest geographical area of all the \textit{Inuit Nunangat}. When the Nunavut Act was passed in conjunction with the settlement of the Nunavut Land Claims Agreement in 1993, Nunavut became Canada’s 3\textsuperscript{rd} Territory. Nunavut’s new Territorial Government was formally established in 1999. As the authors are from Nunavut and this is the context with which we are most familiar, the majority of the references in this paper are to Inuit communities in Nunavut.

\textbf{Ways Of Knowing}

Epistemology is the theory of knowledge, questioning what knowledge is, how it is acquired, and the extent to which a given subject can be known (Thayer-Bacon, 2003). Epistemology is the investigation of what distinguishes justified belief from opinion, particularly with regard to methods, validity, and scope. It is the starting point upon which we build our theoretical assumptions. What do we know and how do we know it? Do we know it individually or collectively? Is there more than one way to know something? Do we possess knowledge or do we engage with it? Or both? Epistemology is the space in which these questions are posed and explored.

\textsuperscript{17} The \textit{Qikiqtaaluk} region is the largest of Nunavut’s 3 regions: \textit{Qitirmiut} (western Nunavut); \textit{Kivalliq} (Central Nunavut and Belcher Islands); and \textit{Qikiqtaaluk} (is the name for Baffin Island, the region also includes neighbouring communities)
Indigenous Ways Of Knowing

A growing segment of the academic community is focused on explaining and understanding Indigenous knowledge and ways of knowing. This group recognizes that such knowledge is perceived, collected, and shared in ways that are unique to these communities. Battiste (2002) states that the recognition and intellectual activation of Indigenous knowledge today is an act of empowerment by Indigenous peoples.

Indigenous peoples throughout the world have sustained unique worldviews and associated knowledge systems for millennia, even while going through social upheavals as a result of transformative forces beyond their control. Many of the core values, beliefs, and practices associated with these worldviews have survived and are beginning to be recognized as being just as valid for today’s generations as they were for generations past. The depth of indigenous knowledge rooted in the long inhabitation of a particular place offers lessons that can benefit everyone, from educator to scientist (Barnhardt & Kawagley, 2005).

In Eurocentric thought, Indigenous knowledge has often been represented by the term ‘traditional’ knowledge, which suggests a body of relatively old data that has been handed down generation to generation relatively unchanged (Battiste, 2002). Grenier (1998), offers that Indigenous knowledge embodies certain characteristics, which are not mutually exclusive, such as: 1) Indigenous knowledge is accumulative and represents generations of experiences, careful observations, and trial and error experiments; 2) Indigenous knowledge is dynamic, with new knowledge continuously added and external knowledge adapted to suit local situations; 3) All members of the community, that is elders, women, men, and children, have Indigenous knowledge. 4) The quantity and
quality of Indigenous knowledge that an individual processes will vary according to age, gender, socioeconomic status, daily experiences, roles and responsibilities in the home and the community and so on; 5) Indigenous knowledge is stored in people’s memories and activities and is expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, cultural community, laws, local language, artifacts, forms of communication, and organization; and 6) Indigenous knowledge is shared and communicated orally and by specific example and through cultural practices such as dance and rituals (Grenier, 1998). In addition, Battiste (2002) also describes Indigenous knowledge embodying a web of relationships within a specific ecological context; containing linguistic categories, rules, and relationships unique to each knowledge system; having localized content and meaning; having established customs with respect to acquiring and sharing of knowledge; and implying responsibilities for possessing various types of knowledge.

Knowledge can be viewed as something people develop as they have experiences with each other and the world around them (Thayer-Bacon, 2003). Ideas are shared, changed, and improved upon through the understanding and meaning that are derived from experience (Burr, 2003; Wilson, 2008). Fundamentally, this knowledge is rooted in a relational epistemology – a foundation for knowing that is based on the formulation of relationships among the members of the community of knowers. Through these relationships knowledge is created, shared and acted upon. A relational paradigm begins with relations as an important aspect of a research framework and employs an inclusive approach rather than rejection (Chilisa, 2012; Kovach, 2009; Wilson, 2008). A holistic, reflexive, relational perspective is integral to Inuit ways of knowing, but how is this
actualized in the research setting?

**Relational Epistemology**

Chilisa (2012) states that “Knowing is something that is socially constructed by people who have relationships and connections with each other, the living and the non-living and the environment. Knowers are seen as beings with connections to other beings, the spirits of the ancestors, and the world around them that inform what they know and how they can know it” (pp.116). A relational epistemology draws our attentions to relational forms of knowing (Thayer-Bacon, 2003). This differs from the common western practice of focusing on individual descriptions of knowing. Knowing is informed by the multiple connections of knowers with other beings and the environment, by participating in events and observing nature such as the birds, animals, rivers, and mountains (Thayer-Bacon, 2003). Wilson (2008) and Getty (2010) assert that knowledge comes from the people’s histories, stories, observations of the environment, visions and spiritual insights. Each of these relationships has implications for how research is conducted.

*Relations With People*

Relation building is an essential aspect of everyday life experience for Indigenous communities in Canada and around the world. Greeting becomes a way of building relationships and rapport among participants and researchers – and readers. From the moment of the first greeting, we are inevitably placed in a relationship through mutual friends or through knowledge, with certain landmarks and events. We become part of the circles of relations that are connected to one another and *to whom we are also*
accountable (Chilisa, 2012) (emphasis added). From a relational perspective, the development of a relationship with a colleague or research participant is part of establishing trust and accountability (Kovach, 2009; Wilson, 2008), which then feeds into the entire research method from establishing rigour to respecting an ethical indigenous knowledge framework to sharing and disseminating the results of a study.

Relations With The Land/Environment

Many Indigenous peoples have a physical, emotional and spiritual connection with the land, the environment, and the creatures that share this space. For example, a study of Inuit women’s perception of pollution found that women identified pollution of the land to be linked to mental health and wellness in the community (Egan, 1998). From the perspective of participants, changing relationships with the land carried over into changing relationships in the community and substance use, ultimately affecting the health of the community overall. The relationship with the environment/land also has implications for the way research is conducted. The construction of knowledge has to be done in a manner that builds and sustains relationships with the land/environment and is respectful of the environment (Barnhardt & Kawagley, 2005; Chilisa, 2012; Getty, 2010). In this context, knowledge is embodied in a connection with the land and the environment. When interviews are used as a technique for gathering data, it is best to conduct them in a setting that is familiar to the research participant and relevant to the topic of the research (such as their home, on the land, or a comfortable community space); this enables the researcher to make connections with the environment and the space where the construction of knowledge takes place.

Relations With The Spirits
Spirituality may include one’s personal connection to a higher being, or humanity, or the environment (Wilson, 2008). Spirituality can be viewed as a connection or exercise that builds otherworldly relationships that are ceremonial in nature. Recognizing spirituality allows researchers to explore the interconnections between sacred and practical aspects of research. Understanding comes through factual and oral history that connects to ancestral spirits (Chilisa, 2012) and/or through dreams (Wilson, 2008). Knowledge is also regarded as a sacred object, and seeking knowledge is a spiritual quest that may begin with a ceremony (Wilson, 2008). Knowing can come through prayer or dreams as a way people connect themselves with those around them, the living and the non-living, and the ancestral spirits. In this way, the mind, the body, and the spirit are involved in the gathering information and understanding of the world.

**Inuit Ways Of Knowing**

Much of the work on Indigenous research perspectives comes from First Nations, Native Americans, and Indigenous peoples in Australia and New Zealand. McGrath (2011) is the only academic work that really explores Inuit epistemology. Therefore, the work of McGrath and Aupilaarjuk (McGrath, 2011) is the focus of this section.

... I was aware that Inuktutuq epistemology – as a broad experience for me – was not the same at all as academic epistemology in my direct encounters with it. Epistemology relates to “ways of knowing” and the traditional practices within Inuit culture and within academia are quite far apart in my experience, although I have also found some common ground.
The work of McGrath (2011) is the first work that I have seen in academia that articulates an epistemology that is unique to Inuit. McGrath’s work with the well-known and respected elder, Aupilaarjuk, focused on conveying an epistemological perspective based on Inuktitut (Inuit language) (McGrath, 2011). Given the relational knowledge perspective of Inuit, revitalization of relationships was part of renewing and sustaining Inuit languages. The language in which knowledge was conveyed was critical to the understanding of the knowledge that was conveyed because of the shared relationships between people speaking the language. This is a simplified explanation of what McGrath (2011) calls Inuktitut epistemology. As fluent Inuktitut speakers, McGrath and Aupilaarjuk demonstrated a great understanding of Inuit philosophical and ideological concepts. Today, there are many Nunavummiut who speak marginal Inuktitut, or sometimes none at all. When language is a barrier to communication, one’s connections and relations may be more limited by the inability to communicate in a common language (NDH&SS, 2005). McGrath (2011) asserted that Inuktitut language renewal part of overcoming this barrier.

**Relational Methods For Health Research In An Inuit Context**

In the following section, Inuktitut conceptual ideas related to health research methods and practices are shared.

*Inuqatigiatarniq*
Inuuqatigiittiarniq is the Inuit concept of respecting others, building positive relationships and caring for others. When each person considers their relationships to people and behaves in ways that build this relationship, they build strength both in themselves and in others and together as a community (Karetak, 2013). This is foundational to Inuit ways of being (Karetak, 2013).

Intentions and Motivations

In the health research context, part of building and fostering respectful relationships is clearly articulating one’s intentions and motivations when engaging in a study. Researchers need to be reflexive and ask themselves the questions that community members will inevitably ask them: Who are you? Where are you from? Who is your family? What are you looking at? Why do you want to know about it? What are the risks and benefits of pursuing this work? Who is it being conducted for? What will happen to the knowledge that is shared? How will we learn from each other? A commitment to an approach that is mindful of and focuses on Inuit context, knowledge, questions, and perspectives is an integral part of demonstrating respect for the community at large.

Community context

Whether one is from the community in which one is working on a research project or not, an awareness for and understanding of the community context is part of acknowledging one’s respect for it. Engaging with people, place, and community in a meaningful way will not only increase one’s own understanding of the community context but will also contribute to a richer understanding of the findings. For example, whether a community has a historical connection to a residential school or is currently experiencing a flurry of resource development, the community context and response to
such events plays a role in wellness and in relational ways of knowing.

The formation of the question(s)

Having created a descriptive picture of community contexts and understandings, as well as one’s own intentions and motivations, it is easier to collectively develop the research questions on which the research will focus. Focusing a study in such a way that it will answer community health questions is part of being responsive to the needs of Inuit communities.

Developing and fostering relationships

The development and fostering of relationships has been a focus of the natural science research community in Nunavut, and some published literature has focused on this (ACUNS, 2003; Gearheard & Shirley, 2007; ITK & NRI, 2007). Research relationships are too often characterized at the outset by conflict, impatience or animosity; sometimes these barriers can be overcome to build trust, other times they simply cannot (ITK & NRI, 2007). Health research projects can build on existing relationships and/or forge new ones. Some practical considerations for health research include exploring how these relationships are initiated, maintained, and supported; what the nature of the relationship might be; and whether a power imbalance exists, and if so how to approach it with respect and consideration (Gearheard & Shirley, 2007; ITK & NRI, 2007). Practical implications include how communication is achieved, i.e. through regular meetings and in-person discussions or teleconferences if over a distance; how direction is chosen and agreements are made collaboratively; how accountability is ensured; and how the methodological approach and sharing of knowledge is agreed upon (Gearheard & Shirley, 2007; Healey, 2006p, 2007; ITK & NRI, 2007).
Engagement of community members

From a relational perspective, participants are engaged, not recruited to participate in a project. They are engaged through the formation of relationships. A snowball engagement method, for example, focuses on the establishment of trusting relationships. Individuals volunteer to participate in the study or recommend family members, friends, or colleagues they think will be willing to participate. The project can be supported by community members who then encourage others to engage in the study through casual conversations and ‘kitchen table talks’ (Price, 2007). Participants should be considered collaborators or co-researchers when the sharing of knowledge occurs mutually, as for example in photovoice research, storytelling, or narrative research, or Inuit Qaujimajatuqangit (IQ or Inuit knowledge) studies. The project is supported and promoted by community members which strengthens the response to the project, as well as contributes to greater rigour and accountability overall.

Unikkaaqatigiinniq

Unikkaaqatigiinniq is the Inuit concept related to storytelling, the power of story, and the role of story in Inuit ways of being.

Storytelling and the sharing of experiences

Kovach (2009) states that a defining characteristic of Indigenous methods is the inclusion of story and narrative by both the researcher and research participant. In an Indigenous context, story is methodologically congruent with tribal knowledge (Wilson, 2008). Inuit have a very strong oral history and oral culture. The telling of stories is a millennia-old tradition for the sharing of knowledge, values, morals, skills, histories,
legends, and artistry. It is a critical aspect of Inuit way of life and ways of knowing (Bennet & Rowley, 2004), and allows respondents to share personal experiences without breaking cultural rules related to confidentiality, gossip, or humility. Indigenous scholars Kovach (2009) and Wilson (2008) have underscored the importance of ‘story’ in a research setting. In a study of determinants of health for Inuit women in Nunavut, participants drew upon examples and stories from the community to illustrate points about important health issues, such as teenage pregnancy and custom adoption, which further highlighted aspects of the health context involving the community, society, education and cultural identity (Healey, 2006i; Healey & Meadows, 2008). Understanding this approach for sharing knowledge allows for greater insight into the data and greater understanding of the meaning of the stories. Although some knowledge or practices may be disappearing, the use of story to effectively communicate information remains part of life. It is for this reason that the recognition of the power of story is particularly important in the context of Inuit communities.

In relational epistemology, stories are shared not collected. Interviews are conversations conducted in a natural, comfortable setting. In our work, we share a tea or coffee over a conversation. Parents may (and often do) bring their children with them. Over the course of the conversation, knowledge and experiences are shared in a common space. For example, in a study exploring the perspectives of parents on discussing a particular health topic with their teen children, I (Healey) shared personal experiences about my own family and raising my children, discussed resources related to the health topic, such as local people who can provide support, and resources available to parents to facilitate conversations with their teen children on a health topic. This was a part of the
conversation and relationship-building process, and enhanced both my own experience and that of participants/collaborators while enriching the dialogue on the particular health topic being discussed. The researcher’s willingness to listen, quietly and carefully, without interrupting the story-teller is vital; listening is in itself a critical skill that many researchers need to develop and practice (Shirley, 2013).

Reflection on how stories are presented.

Ideally, stories are presented in their entirety. The presentation of the entire story allows each reader or listener to take away messages that are relevant to them. Kovach (2009) shared her experience struggling with the presentation of findings in an Indigenous research perspective. She discussed her need to present the findings in 2 different ways: 1) in a way which she associates most closely with the Indigenous methods perspective and included the presentation of the entire story exchanged between the researcher and the research participant; and 2) a coding and thematic bundling of ideas which she associated with a more Western style of data presentation. In the case of the latter, she shares her need to present the data this way to make it accessible to the academy, but feels that this contravenes with the intent of her work (and the intent of her ancestors, p. 53) by extracting experiences from the contexts of their stories. Balancing the need to articulate a point in a small allotment of text space (in the case of a journal article or presentation) and the need to be respectful of the story in its entirety is difficult to negotiate. It is our perspective that acknowledging this challenge in the presentation of findings is part of honouring the sections of the story that are omitted for the sake of time or space.

Reflections on our own interviewing experience
Stories can be shared and told by an individual and they can be created over the course of conversation by a group of people. A dialogue about a topic is shaped by collective storytelling. When interviewing, I (Healey) am often engaged in a dialogue with the person or people I am speaking with. Since I am usually making contributions to the conversation, an important step in the exploration of the dialogue is to reflect upon my own story and experiences in relation to the topic(s) discussed. Articulating how my story and experiences may have shaped or in some way contributed to the conversation allows me to tease out the experiences that are unique to the people who shared them.

*Iqqaumaqatigiinniq*

*Iqqaumaqatigiinniq* is the Inuit concept of all thoughts, or all knowing, coming into one. It often is referred to as part of the holistic Indigenous worldview.

**Finding meaning and understanding**

The goal of data analysis is to find meaning and understanding in the stories, to return to the research question, and examine the data in the context that was set at the beginning of the study. To accomplish this, often a multi-stage process is needed such as ones described by Creswell (2003). Thinking about and analyzing dialogue at the time of the conversation with a participant or collaborator is part of the process, therefore some meaning-making occurs immediately in the moment of the conversation. After transcription, transcripts are read and re-read several times and reflected upon. The recordings of interviews/conversations are listened to and transcripts are re-read to ensure the transcripts are verbatim and to fill in missing words (Creswell, 2013). After a period of time immersed in the words and stories, ideas may start to form or crystalize (Borkan,
Discussing these ideas with others, colleagues, collaborators, or participants, is a critical part of the analysis at this phase from a relational perspective (Kovach, 2009; Wilson, 2008). How are these ideas coming together? What do they offer to the Inuit community? What do they offer to the community of colleagues, collaborators, partners, and participants? Placing the ideas in the context of the literature, the experiences of others, and the experiences of the community is part of finding meaning and understanding.

**Pittiarniq**

*Pittiarniq* is the Inuit concept of ‘being good’, which can mean being 'good' in a philosophical and moral sense and also in terms of action such as ‘good behaviour’ (i.e. in the case of the behaviour of children). The historical context of health research in Nunavut is complex (Healey, 2006p, 2007; ITK, 2001; ITK & NRI, 2007; Wachowich et al., 1999). Different communities have had varying experiences with researchers coming to the North from the South. For decades, researchers have come and gone from Nunavut to conduct their research and leave (Healey, 2006p, 2007; ITK, 2001; ITK & NRI, 2007; Wachowich et al., 1999). Some had good intentions; some were ignorant of their intentions. Some conducted experiments on Inuit (Dosseter; Wachowich et al., 1999). That experience is not unique to Inuit, which is why significant efforts have been made in Canada and in other parts of the world to define how research is carried out with Indigenous peoples and how to create an ethical space in this context (Olsen, Mulvad, Pedersen, Christiansen, & Sorensen, 2003 ; Rigney, 2001; Smith, 2012; Weber-Pillwax, 2001; Wilson, 2008). A number of documents have been developed to guide researchers
in their work with Indigenous peoples in Canada including the *Tri-Council Policy Statement* with special reference to Aboriginal Canadians, and the previously used document from the Canadian Institutes for Health Research, Ethical Guidelines for Research with Aboriginal Peoples (CIHR, 2006; CIHR, NSERC, & SSHRC, 2010). At the time of the development of those documents, little work had been done to include Inuit perspectives on the philosophical concepts that are used to convey the ideas of ‘ethics’ in Inuktitut.

In the Western research model, ethics originated in the philosophical ideas of right and wrong, good and evil, beneficence and maleficence (Beauchamp & Childress, 2001; Moore, 1903). Research ethics have their root in the post World War II Nuremburg trials, in which medical researchers were held accountable for the medical experiments they conducted on prisoners of war (Code, 1949; Grodin, 1996). Research ethics have been reactive, created in response to those who have used their power over others to do harm (Flicker, 2007; Grodin, 1996; Pressel, 2003). Five of the enduring principles of medical research ethics are: beneficence, non-maleficence, truth/justice, dignity, and autonomy (Beauchamp & Childress, 2001). Since that time, ethical frameworks have been developed to further identify particular sub-categories of ethical behaviour from the perspective of different populations, for example, vulnerable populations, Indigenous populations, women, and children (Flaskerud & Winslow, 1998). In 2006, I began a project to explore how ‘ethics’ had been typically conveyed in Inuktitut to participants in other research studies. At the same time, I wanted to learn from Nunavut community members what they perceived to be ethical conduct in research. In discussions with different community members from across Nunavut, there have been two Inuktitut terms
that have been highlighted. The first, shared by McGrath (2004), is *Pittiaq*-*, which is related to ‘being good, kind, or well; doing good or rightly’. McGrath argued that the term *Pittiaq* refers to both technical and moral excellence. Without knowledge or experience of Inuit societal values, researchers from outside of the culture and epistemology interpret doing/being good (ethics) based on their own worldviews and assumptions about what ‘good’ is (McGrath, 2004). Although well-intended, those decisions can have a range of negative impacts on their particular research participants or even on Inuit society in general (McGrath, 2004). The second term, shared by another community member who declined to be named, is *Inuuqatigiittiarniq*, which, as mentioned earlier, is related to the concept of being respectful of others. Both of the terms refer to behaviour - that one’s actions are reflective of one’s intention to ‘do good’. In doing so, one will be respectful of other people and the relationships between and among the facets of the research. Above all, participant-collaborators must be treated with respect, appreciation, and dignity (Beauchamp & Childress, 2001; CIHR et al., 2010; Flicker, 2007; McGrath, 2004).

**Consent.**

Consent is typically sought in writing in research. Newer and more responsive means of ensuring a participant-collaborator is informed include the use of video to demonstrate procedures or sample collection or capturing the verbal explanation of the project and consent on audio recorder. The language in which the project is explained is very important. Consent information should be presented in English, Inuktitut, and/or Inuinnaqtun depending on the language preference of the participant or collaborator.

**The protection of the stories**
The sensitive and private nature of the experiences shared in health research studies underscores the fact that the protection of these stories is of critical importance. Considerations for protecting the story include: presenting the story in a way that honours the storyteller; articulating the intention of the storyteller when they shared the story; articulating the context in which it was shared; respecting whether or not they want it shared with others and if so, in what context; whether the storyteller wants to be identified with their story or whether they want their identity kept confidential; and reflecting on how the story might be (mis)used in the future.

Accountability.

From a relational perspective, accountability is part of the process of developing or building on relationships with each participant. The relationship is what holds us accountable. Kovach (2009) shares that for Indigenous researchers, there are often three audiences with whom we engage for transferring the knowledge of our research: (a) findings from Indigenous research must make sense to the general Indigenous community; (b) schema for arriving at our findings must be clearly articulated to the non-indigenous academy; and (c) both the means for arriving at the findings and the findings themselves must resonate with other Indigenous researchers who are in the best position to evaluate the research. Researcher responsiveness and openness (Morse, Barrett, Mayan, Olson, & Spiers, 2002); methodological coherence (Eakin, 2003; Morse et al., 2002; Morse, Swanson, & Kuzel, 2001); and reflection upon intentions, and relationships (Gearheard & Shirley, 2007; ITK & NRI, 2007; Mays & Pope, 2000; Meadows, Verdi, & Crabtree, 2003; Morse et al., 2002) are all aspects of rigor and accountability in relational research.
Piliriqatigiinniq

*Piliriqatigiinniq* is the concept for working in a collaborative way for the common good.

The Piliriqatigiinniq Model for Community Health Research.

*Piliriqatigiinniq* is the concept for working in a collaborative way for the common good. The *Qaujigiartiit*\(^{18}\) Health Research Centre has developed a model for how research should be conducted both within the centre and by the researchers with whom the centre engages. *Qaujigiartiit* developed the Piliriqatigiinniq Partnership Model for Community Health Research, shown in Figure 1, in the formative years of the Centre (G. Healey, 2008). This model was developed in response to the community-identified need for health research that explores topics of concern to Nunavummiut and is collected, analyzed and disseminated in a holistic and collaborative way. The *Piliriqatigiinniq* model is a visual representation of the web of relationships we have with each other and is built upon the principle that anyone can be involved in health research in some capacity if we are all working for the common good. Multi-disciplinary collaboration strengthens research projects; enriches data analysis with additional perspectives; and fosters greater sharing of knowledge and implementation of findings across sectors. While there may not be a representative from every sector involved in every project, the Model serves as a reminder to look beyond the scope of what is commonly defined as ‘health’ and ‘research’ to include knowledge holders and stakeholders from other disciplines and walks of life. This model was developed to provide practical

---

\(^{18}\) *Qaujigiartiit* is the Inuktitut word for ‘looking for knowledge’.  

organizational and methodological guidance, however the foundations run much deeper.

FIGURE 1: The Piliriqatigiinniq Partnership Model for Community Health Research.

The model originated from a dialogue about health and the history of health research in Nunavut communities. It was derived from the stories and voices of people across Nunavut who attended community engagement sessions held between 2006 and 2008 (Healey, 2006a, 2006p, 2007, 2008). While the model originated from a health perspective, the underlying principle is cross cutting and interdisciplinary. The model is structured on the relational
aspects of life in Nunavut communities – the relationships that are shared are the foundation from which we move forward to achieve wellness. Those relationships can be with anyone from any walk of life and with any thing from any environment. The knowledge that is shared and created in this space is helpful for everyone. The motivations with which one engages in the project are the same – coming together for the common good and the betterment of health and wellness. The group is accountable to each other, to the relationships they have formed and/or will form together, and the relationships they have with others in their community. In essence, this is a model for an Inuit epistemology in action because it is arises from the relational perspective and is built on what was known, what is known, and what will come to be known in Inuit communities. Its development is predicated on the past, present, and future experiences of Nunavummiut\(^{19}\).

From this epistemological perspective, ethics, accountability, methodology, knowledge, understanding, and our relationships with each other as human beings and our environments are part of the same space. And this is, in our opinion, the essence of an Inuit epistemological perspective.

The Qaujigiartiit Health Research Centre promotes the idea that research must be used as a tool for action - that when one understands the scope and breadth of the issue, one is better-equipped to move forward and take action on it. Multi-sectoral collaboration strengthens research projects; contributes added perspective to data analysis; and contributes to greater dissemination and implementation of findings across sectors. Therefore, this approach can be considered to be one that promotes active engagement, the sharing of knowledge, advocacy, and action.

\(^{19}\) ‘Nunavummiut’ is the Inuktitut word for ‘People of Nunavut’
It is particularly important in Inuit communities that research projects be collaborative and inclusive. The historical context of research in the North, including harmful and unethical research practices, have led to an environment of mistrust and displeasure with researchers in many communities (Healey, 2006a, 2006p, 2007, 2008). When we lead our own research projects, we are able to focus on answering our own questions and incorporate methods that are reflective of what we know about wellness, and how we know it. This view underscores the right of colonized, Indigenous peoples to construct knowledge in accordance with the self-determined definitions of what they want to know and how they want to know it.

Conclusion

It is our belief that health research should answer the questions of the people and that such research should be collaborative. We also recognize that not all projects can incorporate the methods outlined in this paper and variations exist depending on the approach incorporated in any given project. With this paper it has been our intent to share epistemological considerations for northern community health researchers. This paper is a beginning of a dialogue and we look forward to engagement with the expansion of this literature in the future.

Acknowledgements

The growth development of this model and this centre over time has been a group effort. Valuable guidance, feedback and support was provided by Shirley Tagalik, Janet Tamalik McGrath, and Jamal Shirley in the development of this paper.
Statement of Contribution by Others

In this dissertation format, I am required to identify the work contributed by others when a manuscript is jointly authored. The manuscript was discussed with Andrew Tagak Sr. and written by Gwen Healey. It is based on collaborative work with Nunavut communities over 5 years to identify the aspects of research the research process which are valued by communities to inform a model for health research that is reflective of Inuit and community perspectives on health research. This process was led by Gwen Healey. Andrew Tagak Sr. shared this vision and contributed his knowledge, expertise, and the philosophical ideas conveyed by community members, which provide the foundation for the model, and collaboratively identified the Inuktitut concepts chosen to represent those ideas.

Chapter 5 – Research Questions and Methodological Approach

In this chapter, each of the five Inuit concepts in the Piliriqatigiinniq model is discussed in the context of how they were applied for this study.

Inuuqatigiittiarniq

Intentions

My intentions were to explore the perspectives of Nunavut youth on the topic of sexual health and relationships and the sources of knowledge and guidance about sexual health and relationships that they valued. Second to that, I intended to explore the
perspectives of parents on sexual health and relationships, and their perceptions of their relationships with their children, and their perceptions of their role in, and comfort with, providing sexual health knowledge and relationship guidance to their teenage children. This changed over the course of the study, as I will describe in a later section, to a primary focus on the perspectives of parents, with a secondary focus on the perspectives of youth.

This study began with roots in relational epistemology and a commitment to an approach that focused on Inuit context, knowledge, and perspectives. The methodological approach for this research study was based on the Pilirigatigiinniq Model for Community Health Research and the relational knowledge perspective.

The formation of the questions

Having created for the reader a descriptive picture of Inuit community contexts and understandings, as well as of my own story, it is easier to understand the research questions, which were posed at the beginning of this study:

1) Given the rapid societal changes experienced in Nunavut, and the changed/changing nature of relationships at the individual, familial, and community levels that are a result of this experience, how do youth and parents of youth in Nunavut conceptualize sexual health and relationships today?

Sub questions included:

a) It is not clear among which demographic the STI burden lies among Nunavummiut who are diagnosed with sexually transmitted infections. Are the STI rates highest among Nunavut youth (15-25 years), as many in Nunavut hypothesize?
b) What and whom do Nunavut youth identify as valued sources of knowledge and guidance about sexual health and relationships?

Specific Aims

1) To determine if chlamydia and gonorrhea cases in Nunavut are highest among youth in Nunavut.

2) To explore the perspectives of youth on sexual health and relationships, as well as the valued sources of knowledge and guidance about sexual health and relationships for Nunavut youth.

3) To explore the perspectives of parents on sexual health and relationships, and their perceptions of their relationship with their children; and their perceptions of their role in, and comfort with, providing sexual health knowledge and relationship guidance to their teenage children.

In addition, an important methodological question was posed: How can this topic be studied in a way that is respectful and mindful of Inuit ways of knowing and understanding wellness?

Preparations

In preparation for this study, I made phone calls to people I knew and worked with in the communities, with whom I had relationships, and who had earlier stated to me that they were interested in this topic of sexual health and relationships. After discussions that paralleled discussions about other research projects taking place at the Qaujigiartiit Health Research Centre, I was invited to work with local community health and wellness organizations to conduct the study.
Communities

The communities of Arviat, Cambridge Bay, and Iqaluit agreed to participate in this study. The wellness centres in Arviat and Cambridge Bay were partners in the study, as were Nunavut Tunngavik Inc. and the Nunavut Department of Health and Social Services, which are located in Iqaluit and provided their support and endorsement for this study.

There are approximately 22,000 Inuit in the Nunavut Territory. Nunavut has a very young population; in 2006 53% of the Nunavut population comprised those 24 years of age and younger (StatsCan, 2011e). The target population for this study was youth aged 16-19 years of age and parents (who may or may not be related to the youth) of teens aged 13-19 living in the participating communities.

Engagement of youth and parents

From a relational perspective, participants are not ‘sampled’ for a study. They are engaged through the formation of relationships (Wilson, 2008). I believed that a snowball sampling strategy was one of the more appealing ways to engage people because of the establishment of trusting relationships and the endorsement of the research project by community members (Creswell, 2003). A primary contact at the community wellness centres in Arviat and Cambridge Bay identified one of the staff members at the centre to work with me on recruitment. This person called people in the community, told me where to place posters so that would be seen by community members, and booked the interviews when people called back or visited the wellness centre. I spent 7 to 9 days in the communities, with the exception of Iqaluit, which is my home. The research project was discussed by community members and youth primarily through word-of-mouth.
Participants volunteered to participate in the study and recommended family members, friends, or colleagues they thought would be willing to participate.

Typically a study would require 6 to 12 interviews before reaching saturation, with an iterative cycle of data collection and analysis being a critical feature of the method (Crabtree & Miller, 2004). This was true in the case of this study. Interviews were conducted until the data reached saturation, which is the point where responses repeat data previously collected, or the researcher feels no new data are emerging (Creswell, 2013; Morse et al., 2001; Strauss & Corbin, 1990). That said, no participant was turned away if they felt they had something to share or add to the study, as is appropriate from an inclusive Inuit epistemology. In the community of Arviat, Nunavut one additional parent participant was interviewed after the data were saturated because the individual came forward to tell their story. This additional interview also confirmed that data were saturated.

Unikkaaqatigiinniq

Storytelling is rich in Inuit culture and it is for this reason that the use of Indigenous methodologies, which honour the power of story, are particularly important in the context of this population, the historical context, and the research question.

Interviewing and the sharing of experiences

Stories were collected through semi-structured interviews with youth and parents in the partnering communities. In total, 37 interviews were conducted between June-September 2011. Seventeen interviews were with Inuit youth and 20 interviews were with Inuit parents.
An interview guide with 11 central questions and topics of interest was used (see Appendices). The interview guide was developed after a review of the literature, consultation with local community members with an interest in sexual health in Nunavut, and my PhD supervisory committee. The interviews were conducted in a natural, comfortable setting at the community wellness centres in Arviat and Cambridge Bay and at the Qaujigiartiit Health Research Centre in Iqaluit. Each participant shared tea or coffee with me. We often sat comfortably in armchairs in a private, quiet room in the buildings where we met. Parents often brought their children with them.

The interviews were recorded digitally with the permission of the participants. Participants were asked to comment on the contexts and issues that affect their sexual health, e.g., source of sexual health knowledge; preferred source of sexual health knowledge; source of guidance on relationships (if any); and preferred sources of relationship guidance (if any). Over the course of the interview, I shared information that I brought with me, which included a list of local people who could provide help in the form of counseling or advice about sexual health. I also provided a list of resources for youth and parents to get more information about sexual health, and I explained what each of these resources offered.

The interviews were transferred to a transcriptionist through a confidential file-sharing website. The transcriptionist was required to sign a confidentiality agreement. Once I received the transcripts, I read them while listening to the audio recording to verify the accuracy of the transcript and to provide translation where required. Inuktitut to English translations were verified by another person unrelated to the study to ensure accuracy.
Reflection on my interviewing experience

Over the course of this study, primarily with women, I have been privileged to talk to people about their lives, health, families, knowledge, love, and pain. In interviews, women described childhood rapes; experiences of violence; traumas experienced as children; hardships and delights; and their love for their families. Although my experiences interviewing men were fewer, the men I interviewed expressed many of their own hardships and shared concern for the hardships that had been experienced by their spouses. Both men and women talked about the alcohol and substance abuse they have engaged in to numb constant and unforgettable pain they experienced in their lives. As the mother of two young girls, hearing stories of child rape was very difficult. I felt a physical reaction in my gut. I felt an emotional reaction in my heart. I developed plans for self-care when the stories upset the speaker or upset myself. First, I would ask, ‘What do I need to do to make sure they are okay?’ Second, ‘What do I need to do to make sure that I am okay?’ In every case, I referred the participant to a counselor and a toll-free support line to access a professional with whom they could speak in English or Inuktitut.

Iqqaumaqatigiinniq

Finding meaning and understanding

To hear a story is sometimes enough. We listen to it, hear it for what it is, and then move on. At other times, we may realize that there is a message in the story that we take with us. And yet another time, we may interpret the story very deeply and meaningfully and see more in the story than the words that were used to convey it. I discussed the concept of Iqqaumaqatigiinniq in great deal with Andrew Tagak Sr., who is the co-author of the Piliriqatigiinniq Model (Healey & Tagak Sr., 2014). My understanding of the
concept of *Iqqaumagatigiinniq* (“all things coming into one”) is that when something is thought about deeply enough, ideas, meanings, solutions or patterns will crystalize. There is no time limit placed on this process, it can be and often is ongoing. I believe this concept to be similar in many ways to Borkan’s articulation of a qualitative analysis technique entitled “immersion and crystallization” (Borkan, 1999). Borkan (1999) asserted that the investigator must be immersed in the data, reading and rereading transcripts and thinking deeply about concepts to identify recurring themes. I engaged in a long multi-stage analysis process over several months. I listened to the interviews multiple times and read and re-read the transcripts to reflect upon each story. I also took the opportunity while listening to ensure transcriptions were verbatim and to fill in missing words in the text.

I used hyperResearch® analysis software to attempt an open coding process of large sections of the interview to assign words or phrases to stories in the transcripts. During this process very few patterns emerged. Separating segments of text and assigning them to a category felt disingenuous. I was reminded of a passage in the book *Research is Ceremony* (Wilson, 2008):

...analysis from a western perspective breaks everything down to look at it. So you are breaking it down into its smallest pieces and then looking at those small pieces. And if we are saying that an Indigenous methodology includes all of these relationships, if you are breaking things down into their smallest pieces, you are destroying all the relationships around it. (pp. 119)

This process severed the relationship between the learner and storyteller (Simonds & Christopher, 2013). So I abandoned the coding exercises and instead reflected upon the
interviews and stories in their entirety in comparison to the original research question and examined them in the context of the literature review, similar to the processes described by Kovach (2009), McGrath (2011), and Bird et al. (2009). For myself, part of the analysis process involved taking a break from the text and audio data and working on something physical. For example, I would break from the computer to exercise, walk, sew, bead, or cook. During these activities my hands or body would be busy, which left my mind free to roam and think about the stories in different ways, possibly seeing different meanings crystalizing in different ways as in the concepts of *Iqqaumaqatigiinniq* (all knowing coming into one) and immersion and crystallization (Borkan, 1999). It was during these periods that I often found the greatest clarity.

Talking with others was also a critical part of the analysis. I spoke about my findings with Shirley Tagalik, at the Arviat Community Wellness Centre, and with my PhD supervisor, Dionne Gesink. I also had long conversations with my co-worker, Jennifer Noah; with my friend, a psychologist, Melanie Stubbing; and with an old classmate from graduate school, Robin Walker. I talked about the study with my spouse as well. I also corresponded with Janet Tamalik McGrath to learn more about her PhD process and her work with Aupilaarjuk (McGrath, 2011). Each of these individuals provided their insight on the elements of the study that I was comfortable sharing with them. My relationship with each person helped me to see the inter-relationships and the bonds that formed the web of understanding in my own work. The analysis took place over a number of months. Thinking and analyzing during the interviews was part of the process. Some of the analysis took place immediately during the interviews and in the days afterwards. Soon after I finished my interviews, I gave birth to my second daughter.
The realities of motherhood meant that I stepped away from this study. Although I continued to think about this study with some part of my mind, I was not immersed in this process. When my daughter was six months old I returned to this study. As I immersed myself in the data again, a number of events occurred in our family and in our community that separated me from my study again. It was a long analytical process, however the breaks created a space for deeper thought. For this I was grateful. Such work cannot be rushed.

**Pittiarniq**

For this study, I set out to be respectful of each of the ethical guidelines set forth by the organizations that represent Inuit, the guidelines governing research in Nunavut, the guidelines of the University of Toronto, and the guidelines for Canadian research with Indigenous peoples (CIHR, NSERC, & SSHRC, 2010; CIHR, 2006). I also set out to honour the relationships I have with people in my community and in the communities I visited. This study was reviewed and approved by the Community-based HIV/AIDS Research Ethics Board at the University of Toronto in June 2011. I also applied for and was granted a research license by the Nunavut Research Institute (No. 01 097 11N-M).

**Consent**

The consent form was presented in both English and Inuktitut, as is customary in Nunavut, however the interviews took place primarily in English. All questions were asked in English, and participants primarily responded in English. In the cases where they responded in Inuktitut, I understood what was being said and I provided the translation for the transcriptionist. Consent was obtained after orally explaining the consent form,
obtaining the consent verbally, and then the participant was asked to sign the consent form.

**The protection of the stories**

Interviews were transferred to an Ottawa-based transcriptionist with whom I had worked in the past. The transcriptionist was required to sign an oath of confidentiality for his/her participation in this project. The oath of confidentiality is an agreement to not disclose or discuss any of the information that is heard during the transcription process. The digital voice recording of the interview was transferred via a password-protected web-based file-sharing program called yousendit.com. The transcript was emailed back to me in a password-protected document. All electronic copies of data are kept on a password-protected computer. At the conclusion of the project, the electronic data will be placed on an USB key, and each individual document stored on the USB will be password-protected. The USB key, paper copies of consent forms, and hand-written field notes will be stored in a locked filing cabinet, in a locked data storage room in the Qaujigiartiit Health Research Centre in Iqaluit, Nunavut for a period of seven years.

**Accountability**

From a relational perspective, building on relationships in some way with each study participant is what held me accountable and is part of addressing rigor. In this study, it is addressed in several ways including: an extensive review of the literature (Morse et al., 2001); researcher responsiveness, i.e., researcher creativity, sensitivity, flexibility, openness, and analytical skill (Morse et al., 2002); methodological coherence - congruence between the research question and the components of the method (Morse et al., 2002; Morse et al., 2001); and bracketing before the start of each interview, i.e.,
documenting and setting aside one’s own assumptions about the research topic in order to minimize personal influence on study results (Meadows et al., 2003). Field notes were taken during data collection. Results were compared with the original field notes to provide context and reflections on the interview and ensure that the underlying intent of the respondents remained intact (Meadows et al., 2003).

When a reader knows and understands the context of the research, then s/he can decide whether the findings are transferable between settings. The degree of transferability is a direct function of the similarity or fit between two contexts (Morse et al., 2001). This is accomplished by providing a substantial amount of clear and detailed information (thick description) about the topic and the setting in which the topic was discussed during the writing of the dissertation.

Above all, participants in this study were considered to be collaborators and were treated with respect, appreciation, and dignity. All participants were invited to continue their involvement in the study after the interview, if they wished to be involved in discussing the findings and disseminating the results.
PART D - RESULTS AND DISCUSSION

Chapter 6 – Results and Stories

As described at the beginning of this dissertation and in the Piliriqatigiinniq model, storytelling features prominently in this study. In this section, the research question and objectives are reviewed and discussed, followed by the presentation of the stories of the participants in the form of manuscripts.

Review of the Research Questions and the Research Process

The research questions proposed at the beginning of this study were:

1) *Given the rapid societal changes experienced in Nunavut, and the changed/changing nature of relationships at the individual, familial, and community level that are a result of this experience, how do youth and parents of youth in Nunavut conceptualize sexual health and relationships today?*

Sub-questions included:

a) It is not clear in which demographic the STI burden lies among Nunavummiut who are diagnosed with sexually transmitted infections. Are the STI rates highest among Nunavut youth (15-25 years), as many in Nunavut hypothesize?

b) What and whom do Nunavut youth identify as valued sources of knowledge and guidance about sexual health and relationships?

Specific Aims
1) To determine if chlamydia and gonorrhea cases in Nunavut are highest among youth in Nunavut.

2) To explore the perspectives of youth on sexual health and relationships, as well as the valued sources of knowledge and guidance about sexual health and relationships for Nunavut youth.

3) To explore the perspectives of parents on sexual health and relationships, their perceptions of their relationship with their children, and their perceptions of their role in, and comfort with, providing sexual health knowledge and relationship guidance to their teenage children.

In addition, an important methodological question was posed: How can this topic be studied in a way that is respectful and mindful of Inuit ways of knowing and understanding wellness?

With regards to the first aim, I requested permission from the Nunavut Department of Health and Social Services to access the data on reported infections of chlamydia and gonorrhea in Nunavut. I requested the data, which was available and complete for the most recent two-year period, 2008 and 2009. I calculated the rates and was able to confirm that the highest rate of infection was in the 15-25 year old age group. The Nunavut Department of Health takes every precaution to protect the data of Nunavummiut. For this reason, I was not permitted to publish the rates, but was permitted to use the information to guide the direction of the study. This data validated my decision to focus on the adolescent/teen age group and their parents for this study about sexual health.
With regards to the second aim, I interviewed 17 youth for this study between June and September of 2011. The youth were between 14-19 years of age. Ten were young women and seven were young men. Two of the youth reported having been suspended or having dropped out of school. The rest were in secondary or post-secondary studies but did not indicate if they were regular attenders.

With regards to the third aim, I interviewed 20 parents of youth (the children ranged in age from 14-19) between June and September of 2011. To be included, the parents must have had at least 1 teenage son or daughter between the age of 13 and 19 years. Most of the parents had more than one child (n = 19). Of the parents who volunteered to be interviewed for this study, 3 were fathers and 17 were mothers. Nineteen of twenty participants did not complete high school. Eleven were employed in part-time, seasonal or casual work, three were unemployed, and six were employed full-time. The data from the parents were very compelling and highlighted perspectives that were different from the conventional view of sexual health, which was unexpected. For this reason, their data comprise the largest segment of the results section of this dissertation.

The interviews were conducted in three geographically, regionally, and historically distinct Nunavut communities. The population of the communities ranged from 1200 to 7000. The research was conducted within an Indigenous knowledge framework and with a focus on Inuit epistemology and methodology, specifically, the Piliriqatigiinniq Partnership Community Health Research Model described in Chapter 5.

Three primary thematic areas crystallized in the data analysis:
1) **Inuit family understandings of sexual health and relationships are linked to historical and contextual factors.** Parents defined sexual health in terms of their experience of child sexual abuse. They strongly associated their abuse experiences with the residential school and settlement period of northern history, during which many Inuit families were separated and family relationships were severed.

2) **Parent-adolescent communication pathway.** Parents emphasized family communication about sexual health and healthy romantic relationships as being a critical aspect of promoting wellness among youth. They felt ill equipped to engage in communication about this topic because of previous trauma. They discussed parent-adolescent relationships, the role of elders in the community and how they might be of support, as well as other possible supports to help families revitalize Inuit knowledge sharing pathways and conversations about sexual health and relationships.

3) **The impact of childhood trauma and severed family relationships/attachments** on Inuit society, which is founded on a kinship system of relationships, and subsequent impacts on sexual health.

As articulated in Chapter 3, this is a modified grounded theory study using an Indigenous knowledge framework, and the analysis of the data led me to an examination of Attachment Theory. I examined Inuit and Western perspectives on this topic, as well as how child sexual abuse disrupted family attachments and relationships, which are core constructs in Inuit society (Arreak, 2011; Bennet & Rowley, 2004; QIA, 2010; Wachowich et al., 1999).
Reflection on How Stories Are Presented

In navigating Indigenous and Western approaches to answering questions for this study, I reflected on how I might retell or preserve narratives of an oral-based tradition in a text-based knowledge system. The intonation, gesture, and emotional qualities can be lost, and the reader can miss out on the interpretative, interactive, and relational aspects inherent in the person’s story.

Other scholars have also reflected on the need to balance Indigenous and Western ways of conveying information to be fair and respectful of the approaches while preserving the intent, meaning and words of the storyteller. In a discussion about her struggle with the presentation of findings in an Indigenous research framework, Kovach (2009) described her need to present the findings in two different ways: 1) in a way which she most closely associated with the Indigenous methods perspective and included the presentation of the entire story exchanged between the researcher and the research participant; and 2) a coding and thematic bundling of ideas, which she associated with a more Western style of data presentation in academic research. In the case of the latter, she shared her need to present the data this way to make it accessible to the academy, but felt that this contravened the intent of her work (and the intent of her ancestors) by extracting experiences from the contexts of their stories. Simonds and Christopher (2013) described a similar struggle, and ultimately a negotiation, with the process of sharing data in a way that is true to the storyteller and to the method.

In reflection upon my analytical process, I also wished to present the stories in a way that was true to the method, and to the storytellers, and in a way that was true to my thought process. Therefore, I have chosen to present the data as segments of stories from
the research participants grouped according to thematic areas, which I identified in the analysis:

1) Inuit family perspectives on sexual health and relationships;

2) Parent-adolescent communication about sexual health;

3) Perspectives on trauma, family relationships, attachments, and the implications of severed attachments in Inuit relational society.

The sensitive nature of the topic means that preserving the identity and privacy of the speaker is of utmost importance. I did not include large segments of dialogue where it made reference to people or events that would identify families. In the presentation of the perspectives of the speakers, I kept the words intact as much as possible without revealing their identity. I set out to produce four journal manuscripts as part of the preparation of this dissertation and the manuscripts are inserted into the dissertation in the methods and results sections.

This chapter is presented in three parts. In section 1, youth perspectives on sexual health and relationships are shared and briefly discussed. In section 2, the perspectives of the parents on Inuit family relationships and sexual health are shared and briefly discussed alongside two journal manuscripts prepared for publication (both have been published) on this set of data. In section 3, the implications of traumatic experiences on attachments and in Inuit relational society are presented and discussed along side a journal manuscript submitted for publication on this topic.
RESULTS SECTION 1 - YOUTH PERSPECTIVES ON SEXUAL HEALTH

Seventeen youth between the ages of 16 and 19 years, including one 14 year old who accompanied her parent to an interview, participated in this study. Two of the youth reported having been suspended or having dropped out of school. The rest were in secondary or post-secondary studies but did not indicate if they were regular attenders because the interviews took place over the summer break. The most common reasons for not attending school regularly were the need to work and the need to look after younger siblings. The youth participants reported living in a number of different home arrangements such as single- and dual-parent homes, living with grandparents, or staying with extended family.

Interview Context

The youth who volunteered to participate in this study were often quiet. The interviews took place in a comfortable meeting place with comfortable chairs and natural light. They were offered tea, coffee or water upon arrival at the meeting place. I introduced myself and told them about my family and my community in a casual conversation before we engaged in the interview. In part, I did this to help make them feel comfortable and at ease and in part to ascertain if they were truly interested in being there and talking to me. I discussed the consent form with each participant and obtained oral consent as well as written consent on the consent form. They answered the questions that I posed and were considerate, friendly, and honest.
**Stories from Inuit Youth**

The majority of the youth in this study defined sexual health using terms that they had learned in school. For example, they spoke primarily of sexual health in terms of condom use and sexually transmitted infections. Most youth reported knowing where to get condoms, how to use them, and indicated that they had learned about sexual health in ‘family life’ or ‘health’ class in school. When asked whether they would like to know more about sexual health, 14 of 17 youth indicated that they knew enough and didn’t need more information.

Only 1 out of the 17 youth interviewed indicated that they used the Internet to learn more about sexual health. One youth participant stated,

“We only use the Internet for Facebook.” – Young woman - AR

When asked from whom or how they would prefer to learn about sexual health and romantic relationships, whether it be a nurse, a teacher, the Internet, caregivers/parents or some other means, youth almost universally said caregiver/parents.

When asked about why they themselves or other young people in their community were engaging in sex, the reasons included boredom, peer-expectation, too much free time, hopelessness, desire, and love. In one community, youth participants talked about the role of poverty in their community in response to a question about how youth want to be supported to make safe sexual decisions.

“Yeah. Um, they need help sometimes…No food. All that. Yeah. Some – some are poor. Like... Some people... goes on the radio or CB to borrow milk or food. For their kids. I heard it a lot. And they have lots of kids who are hungry.” – Young woman - AR
In this community, youth shared a sense of hopelessness for their own future because they did not believe they would be able to get paid employment. The high rate of unemployment was largely because there are more people in the community than there are jobs.

**Reflection on Youth Engagement in Research**

The youth did not launch into stories when prompted in the same way that their parents did. I probed and asked open-ended questions, however this approach did not yield any greater engagement from the youth. Their body language was responsive and they were interested, but quiet. I left room for silences and time to respond. Emdal-Navne (2008) reported similar interactions with young Inuit in Greenland. I felt that the youth had something more to say, but that this interaction (sitting and talking with me) was not how they wanted to express it. I believe that the interviews with the youth were not as revealing as the interviews with the parents because the one-on-one interview format is not the way they want to share their stories.

The observation about the youth participants confirmed my understanding that other data collection methods, which are less direct, can be more appropriate for engaging youth in a dialogue on this topic. However, the cost of re-Visiting the communities to conduct a revised research project for this dissertation was prohibitive. I also did not want to ignore the compelling data from the parents in favour of pursuing a revised project to re-engage youth.

The data from the parent interviews became the primary focus for this study because they were rich with story and experience.
RESULTS SECTION 2 - PARENT PERSPECTIVES ON SEXUAL HEALTH

Summary

In 3 geographically, regionally, and historically distinct Nunavut communities, 20 interviews were conducted with Inuit parents who had at least 1 teenage son or daughter between the ages of 13 and 19 years. Parents shared stories of their own personal experiences, as well as those of family members, and observations from the community. They spoke of relationships at the individual level as well as in the larger historical and community context of the region. Parents were asked about whether they spoke to their children about ‘sexual health.’ Parents defined ‘sexual health’ in terms of the historical community and social context. For example, parents first discussed events in community history (such as settlement or residential school), then discussed specific experiences related to the events to answer the questions. Their definition of sexual health and relationships was centred around a place and time in their past. Parents shared specific experiences of childhood trauma, hardship, and sexual abuse related to these events. Parents often highlighted their desire to create a different path for their own children as a result of the traumas they had experienced. Parents also described how these events prevented them from engaging in a dialogue with their children about sexual health. The parent-child knowledge sharing pathway was severed for the parents in this study when they were separated from their parents during the settlement era. The children of that era are the parents of today’s youth generation and described the impact of the absence of that pathway on their ability to communicate about sexual health and relationships with their children.
Stories From Inuit Parents

In the following section, a series of segments of stories pertaining to the overarching concepts of Family, Elders, and Community are presented for context. To avoid redundancy in the presentation of findings, two manuscripts prepared for publication on 1) Inuit family understandings of sexual health and relationships and 2) parent-adolescent communication about sexual health and relationships are presented separately in this section. These manuscripts include segments of stories pertaining to the central themes of Settlement/Displacement, Parent-Adolescent Relationships and Communication about Sexual Health, and Perspectives on the Elder Generation, as well as analysis of the findings.

An excerpt on Family

In this excerpt, a participant describes learning from parents, and the role her parents played in talking about sexual health and relationships.

“My mother, she really got me scared one time because she really didn’t want me to get pregnant because I was too young. So back then we when we learned it – I really used to listen to what the elders said or my father said or what my mother said. And we always used to try to listen to them very much, so we really, really, really tried to listen to them and try to do whatever they told us to do. Because we had to listen to our parents. She told me if you ever kiss a boy by your lips you’re going to get pregnant. Yes. I really tried not to get my lips on a boy. Or try to touch them. I was so scared. When I turned 18 …my father said “Look. Daughter look through the window and see that boy. He’s the one you’re going to marry.” I tried to really wide open my eyes [to see him] and I didn’t even know the guy’s
name. I listened to him and we talked like - like we were friends and we kept being very close friends. Even closer and we got together. That was when I was 18 years old. And got married late [year] and it’s going to be [more than 20 years] next month. Around then we started having babies. Ah, I remember that back when we [young girls] used to talk [when we were] teenagers. We pretended to be pregnant with a big ball and we see our mothers with a big stomach. We girls always thinking of doing or trying new things. I wanted to have a baby too… The first time I had sex it was scary and all that. They told us – the other teenagers, the other girls, they done it – done it early – feel - feel it already [how it is] to touch a different person like – like skin to skin. Means that you start falling in love and making babies then be a mother and be a father. Maybe today [young people] see other same aged people – see that she got pregnant and the baby’s out and she did it good and I can do that too. Like they start getting interested – wanting to have a baby. They want a baby. Maybe today. I’m just thinking. I talk to [my children a lot]. They really understand me and it’s a good thing they listen to me and my husband. Very much. [My husband] he talks really a lot because [he] really loves the kids… Mostly today just when I’m looking out the window watching the water, watching the birds flying around on the wind or just looking at it – just feeling about it– I think today maybe the younger ones are looking at those who are older now… We, parents, now - if we say to our children we really love them, we have to explain what is good or what is not good. Including the sexual or whatever we were talking about. So that they understand... And these other parents talk with their kids and they’re understanding and trying to listen to
them and make them more safer. And they’re not being injured by someone. Because they’re looking after themselves. And try to respect their elders and all that.” - Mother

An excerpt on Elders

In this excerpt, the participant described an analogy of previous generations ‘making tracks’ in the snow, a path, which is followed by the next generation. He demonstrated that when children are not in a supportive relationship with their parents, they could go to their grandparents because the grandparents have the knowledge of the path.

“My parents. Or the grandparents. …made and followed the tracks. Generations and generations people are like that. They follow the tracks. So, my grandparents, parents, my parents’ parents, we – our parents – our kids to our parents, maybe they’re following their tracks too. Doing the same thing that our elders did when we weren’t even born. First go to grandparents, when the parents don’t listen they go to grandparents. And the grandparents have to go to the children’s parents and talk about it...” - Father

An excerpt on Poverty in the Community

In this excerpt, the participant described his view of poverty in the community and its effect on families, in response to a question about the role of families in talking to their children about sexual health.

“Um, today there’s more people with problems because of money today. More people – just today I see lots of people not working here ... most of them are on
income support. Today, I’m using it too. I’m using income support today. There’s no job and the - the number one problem in the family will be the money and ... the food. Like $400 for one person on income support is not even enough for two weeks. And we’re going to have to wait another one whole month to receive the $400 yeah. Need at least five or six hundred. We put it to the groceries account right away because we use it – the whole amount right away.” - Father

An excerpt on the Relationships Between Parents and Children

In this excerpt, a participant shares a perspective on the complexity of relationships between parents and children, how people interpret experiences differently, and his belief that all human beings follow in the footsteps of their parents.

“I’m just an Inuk – I’m just a person. When the kids are not listening to parents today maybe because the mother is so – or the father is so yelling to them. The child is too hard and it seems like they don’t want to listen to the parents anymore. Because they yell too much. That they become hard. Hard and they will forget in their mind, growing up in their childhood when they’re older ....[It’s a] different world, different families. We all have different problems. Some people [have a] very happy family. Some people are in very not good families. Some people are very scary family. Some people are really not good – not welcoming people families. Like we’re all different. ....[And] because we’re human beings, we, people, follow what our parents used to do. We follow them. For example, like I’m a mother of my teenagers children. I’m a mother. [What] if I try to kill myself with a knife... [What if ]I would maybe try to pretend to try to kill myself with a knife or I try to choke myself...For example, [if] I try to commit suicide ... and kill
myself and one of my kids would try the same thing, like. Like me, like that.. They copy their parents. Or for example, if I met up with someone and making babies and all that and children are looking – watching me ... they will do the same thing as me. Same thing. Generation to generation. So, they will always copy their parents. My grandparents got it from their parents; my parents got it from grandparents. I got it from my parents. My kids get it from me. I’m just thinking. They do what we show them [teach them].” - Father
Abstract

OBJECTIVE: To explore Inuit family understandings of sexual health and relationships in order to inform responsive public health interventions that are designed to meet the needs of Nunavummiut.

METHOD: A qualitative Indigenous knowledge approach was used for this study with a focus on Inuit epistemology and methodology as described in the Piliriqatigiinniq Community Health Research Partnership Model. Interviews were conducted with 20 parents in 3 Nunavut communities in 2011. An immersion and crystallization analytical approach was used for the data analysis and to identify groupings or themes in the data. The stories shared by parents are honored, keeping their words intact as often as possible in the presentation of results.

RESULTS: Parents in this study largely discussed sexual health in the context of historical community events related to settlement and/or residential school. Residential school and forced settlement into communities was linked to trauma, family separation, hardship, and grief. These experiences were prominent in participant understandings of sexual health and perceptions of sexual health behaviours among youth in the community.

CONCLUSION: This study highlights the complexity of the landscape of sexual health in
Nunavut and public health approaches that are inclusive of Inuit family perspectives sexual health in Nunavut are needed. Greater understanding of historical and community context can contribute to the development of meaningful evidence-based public health interventions that will meet the needs of the population.

**Introduction**

Nunavut parents of today’s youth generation (13-19 years) have highlighted that the high rates of teen pregnancy among young Nunavummiut, 119/1,000 for youth aged 15-19 (McKay, 2006), are worrisome (Healey, 2006i, 2006p, 2007). In addition Nunavut Territory consistently reports the highest rates of chlamydia and gonorrhea, both of which are sexually transmitted infections (STI), (3772/100,000 and 1,588/100,000, respectively), compared to Canadians (259/100,000 and 33/100,000, respectively) (NDH&SS, 2012). These rates have been high and remained high for many years. Public health approaches have largely focused on reducing rates of sexually transmitted infections and unwanted teen pregnancies, however the rates have not declined. The purpose of the study was to explore Inuit family perspectives on the factors that they perceive to be shaping the present-day picture of sexual health and relationships in Nunavut, with particular attention to (but not limited to) relevance to young people, in an effort to inform public health interventions in Nunavut.

**Background**

Inuit are the Indigenous inhabitants of the North American Arctic, whose homeland stretches from the Bering Strait to east Greenland, a distance of over 6000 kilometres.
Nunavut is one of the 4 Canadian *Inuit Nunangat*\(^{20}\): Nunavut; Nunavik (Northern Quebec); Inuvialuit (northern Northwest Territories); and Nunatsiavut (northern Labrador). Today, there are 25 communities in Nunavut ranging in size from a population of 110 to a population of 7000. The population of Nunavut in 2011 was 29,474, of whom approximately 85% are Inuit (StatsCan, 2011e). Nunavut has a very young population, in 2006 53% of the Nunavut population was comprised of those 24 years of age and younger (StatsCan, 2011e).

**Historical Context of Nunavut**

Before contact, small groups of Inuit families traveled together to different camps and hunting grounds, in *ilagit nunagivaktangat*\(^{21}\). In the Qikiqtaaluk (Baffin) region, for example, Inuit lived in small, kin-based groups in over 100 locations throughout the region (QIA, 2010). Today there are 12 permanent communities in the region. Before formal schooling was introduced, Inuit children learned the skills they needed to carry out their traditional roles by observation and practice (Bennet & Rowley, 2004; QIA, 2010). They acquired knowledge and skills by accompanying parents on harvesting activities (Bennet & Rowley, 2004; NCI & QIA, 2011); preparing skins and sewing clothing; and observing and assisting with childrearing, food preparation, and camp life (Briggs et al., 2000; Condon, 1987; Healey & Meadows, 2008; Wachowich et al., 1999). While specific practices differed among camps/regions in the pre-settlement period (e.g. practices related to childbirth), generally teachings related to family and reproductive health were supported equally by both men and women and embedded in every day life activities and

\(^{20}\) *Inuit Nunangat* is an Inuktitut term commonly used to refer to the lands occupied by Inuit.

\(^{21}\) Inuktitut terminology meaning, “a place used regularly or seasonally by Inuit for hunting, harvesting and/or gathering”
conversations among the family (Archibald, 2004; Briggs et al., 2000; Condon, 1987; NCI & QIA, 2011).

Relocation and Settlement

A process of relocation to more central sites began as a response by Inuit to the presence of traders, explorers, and missionaries. It took new form with systematic efforts of the government in the 1940s and 1950s to ‘resettle’ Canada’s North. At the beginning of this period, Inuit in the Central and Eastern Arctic were still actively involved in the fur trade and were living off the land. The presence of the military, resource development, and missionary activity was increasing and tuberculosis and polio epidemics took a toll among Inuit (Tester & Kulchyski, 1994). The Report of the Royal Commission on Aboriginal Peoples (1996) notes that in these years government administrators were troubled by the health and welfare reports that came to see the North as being in a state of crisis that required immediate attention (INAC, 1996i). At that time, the Canadian government implemented resettlement programs in the eastern Canadian Arctic in an effort to: 1) protect Canada’s sovereignty post-World War II; 2) facilitate the opening of trading posts by the Hudson’s Bay company; and 3) police, educate, and provide health care for remote populations (INAC, 1996i; Kirmayer et al., 2000). Inuit were not consulted about these changes, and many never knew why they were imposed on them and in such a short period of time (QIA, 2010). The agencies of the Government of Canada that were responsible for the implementation of settlement policies are still not fully aware of their own history in the Arctic or the effects of their decisions and actions (QIA, 2010). By 1956, one in seven Inuit was living in a tuberculosis sanatorium in southern Canada for treatment (Sandiford Grygier, 1994).
In the first 50 years of the twentieth century, attempts by outsiders to teach Inuit children reading, writing, and arithmetic were scattered and inconsistent. In 1951, the first government-regulated school for Inuit was opened in Chesterfield Inlet (Pauktuuitit, 2007). Inuit parents were asked to place their children in school hostels for all or a portion of the school year while parents and non-school-age siblings returned to their camps. Inuit parents who agreed to schooling did not wish to leave their children alone and often came to the settlement with their families, living in tents until housing was available. For some communities, up to three generations of Inuit children were sent away from their families to attend schools in larger communities (Pauktuuitit, 2007). This caused great anguish for both the parents and the children (QIA, 2010). Residential schools for Inuit continued to open into the 1960s and by 1963, 3,997 Inuit children were attending these schools (King, 2006). In June 1964, 75% of 6 to 15 year old Inuit children and youth were enrolled in the schools. These students are the parents and grandparents, uncles, and aunts of today.

Inuit of northern Canada, as with other Indigenous groups in Canada, have and continue to experience, a shift in a way-of-living over the last several decades. Those who were medically evacuated for tuberculosis or other medical treatment often returned to their communities up to a year or more later, if at all, and residential school students were away from their families for up to 10 months of the year (Sandiford Grygier, 1994). These individuals were disconnected from their family, culture, language, and community upon their return (Healey, 2006i; Kirmayer et al., 2000; Kirmayer & Valaskis, 2009). The reports of physical, emotional, mental and sexual abuse of children during the residential school era are well-documented (Wesley-Esquimaux & Smolewski, 2004).
The experiences of resettled Inuit continue to have an impact on many Nunavut residents to this day.

**Sexual Health**

Sexual health is a critical part of public health and is an important part of healthy living. Healthy sexuality involves acquiring the skills, knowledge and behaviours to maintain good sexual and reproductive health throughout life. Sexual health has been highlighted as a serious public health concern in Nunavut (Healey, 2006a, 2006p, 2007) by parents and community members as the territory reports the highest rates of Chlamydia and Gonorrhea infection in all of Canada (PHAC, 2008, 2010). The World Health Organization (2006) defines sexual health as, “a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.” In Nunavut, sexual health education is part of the school curriculum, and community health representatives, physicians, and nurses provide additional support when and where available.

**Methods**

This qualitative participatory research study explored a topic identified by community members through a series of consultations conducted in Nunavut between 2006-2008 (Healey, 2006a, 2007). The researcher was born and raised in Nunavut, lives and works
in the community as a health researcher, and initiated the study at the request of fellow community members. The research project was designed and implemented in partnership with community wellness or research centres in each of the 3 communities. The project was supported in principle by Nunavut Tunngavik Incorporated and the Chief Medical Officer of Health for Nunavut. Community members and community wellness committees in the 3 communities reviewed the research protocol and their feedback was provided to the Nunavut Research Institute who granted a research license. The University of Toronto Community-based HIV/AIDS Research Ethics Board granted ethical approval.

Decolonizing research is a process for conducting research with Indigenous communities that places Indigenous voices and epistemologies in the center of the research process (Simonds & Christopher, 2013). It critically examines the underlying assumptions that inform the research and challenges the widely accepted belief that Western methods and ways of knowing are the only objective, true science, which marginalizes Indigenous methods and ways of knowing. This research project was conducted within an Indigenous knowledge framework and with a focus on Inuit epistemology and methodology, specifically, the Piliriqatigiinniq Partnership Community Health Research Model (Healey & Tagak Sr., 2014). The model highlights five Inuit concepts that informed the research approach: Piliriqatigiinniq (the concept of working together for the common good); Pittiarniq (the concept of being good or kind); Inuuqatigiittiarniq (the concept of being respectful of others); Unikkaaqatigiinniq (the philosophy of storytelling and/or the power and meaning of story); and Iqqaumaqatigiinniq (the concept that ideas or thoughts may come into ‘one’). The model
calls attention to Indigenous ways of knowing and the research approaches that grow from an Indigenous worldview (Chilisa, 2012; Kovach, 2009; Wilson, 2008). With particular emphasis on relational epistemology (Thayer-Bacon, 2003) and recognizing relationships that are fostered or created as part of the research process, the Piliriqatigiinniq model emphasizes connections between people as essential pieces of the research process from the asking of the question to engaging members of the community in the project to the collective uptake and sharing of the findings. A paper outlining the theoretical and methodological aspects of this study in greater detail is published elsewhere (Healey & Tagak Sr., 2014). Participants were engaged in the study through community health and wellness centres and were offered the opportunity to be project partners if they so desired. The researcher is from Nunavut and had existing, trusting relationships with many of the organizations and individuals who volunteered to be part of the study. This added richness and depth to the dialogue. Interviews were conducted in a comfortable setting chosen by the participant, recorded with permission, and transcribed verbatim. Participants were asked open-ended questions and invited to tell stories and share experiences in English, Inuinnaqtun, or Inuktitut. Universally parents chose English, with the exception of one community where participants alternated between English and Inuktitut terminology. Translations were provided by the researcher and verified for accuracy by a 3rd party when needed. Data were analyzed through a process of immersion and crystallization (Borkan, 1999) which, from the perspective of the researcher, is a process that is analogous to the Inuit concept of Iqqumaraqtigiinniq. Through a process of reading and re-reading transcripts and highlighting stories in the text, several themes crystalized in the data. A rigorous, respectful, and mindful process
was followed for the data analysis, which included the comparison of findings to the known literature on the topic; discussion of findings with the local Nunavut-based advisors which included representatives from 2 community wellness centres\textsuperscript{22}, the Chief Medical Officer of Health for Nunavut, a Community Health Representative (CHR), and a public health nurse; member-checking with participants or collaborators when and where appropriate to develop the analysis; and honoring the stories that were shared by parents by keeping their words intact as often as possible in the presentation of results without breaching confidentiality.

**Results**

Twenty interviews were conducted in 3 geographically, regionally, and historically distinct Nunavut communities with Inuit parents who had at least 1 teenage son or daughter between the age of 13 and 19 years. The population of the communities ranged from 1200 to 7000. Of the parents who volunteered to be interviewed for this study, 3 were fathers and 17 were mothers; 19 of 20 did not complete high school; 11 were employed in part-time, seasonal or casual work, 3 were unemployed, and 6 were employed full-time. Parents shared stories of their own personal experiences, as well as those of family members and observations of the community. They spoke of relationships at the individual level as well as in the larger community and historical context of the region.

Parents were asked open-ended questions about what terms like ‘relationships’ and ‘sexual health’ mean to them, and whether they discussed these topics with their children.

\textsuperscript{22} The Arviat Community Wellness Centre and the 2\textsuperscript{nd} declined to be named.
The term ‘sexual health’ was largely defined by parents in relation to community and social context. In answering the questions, parents identified specific events in community history, then discussed personal experiences related to the events. Community events most frequently discussed in the interviews included ‘settlement’ and ‘residential school’. Parents shared specific experiences of childhood trauma, hardship, and sexual abuse related to these events. Parents often highlighted their desire to create a different path for their own children as a result of the traumas they had experienced. Themes are presented in English, as that is the language in which the stories were conveyed, mirroring the way in which parents shared experiences within a larger community issue.

Settlement and displacement

Participants associated general changes in the behaviour and attitudes of community members regarding sexual health and relationships with the settlement period. For example, before settlement, relationships or unions were primarily arranged by members of the families or camps. As a result of settlement, young people living in a community group met others in their peer group from other camps and from outside of the North. Participants in this study perceived a decline in arranged unions and an increase in short-term relationships in the community from this point in time. Commenting on the high rate of teen pregnancy in his community, which he perceived to be related to increasing short-term relationships, one father stated,

“I think [young people] think it’s normal [to have children at 14 or 15 years of age]. Because back in 1940s and 50s there was 7 to 8 different tribes...and when
they first got together, a lot of things were happening. So, from that time, it started. To having sex wherever they were [with whoever they want] – oh look at that person [or] that new person, and would start having [a relationship]. Ever since then, it’s been going on. So, it’s going to be hard to stop it like that. *snaps fingers*”

– Father

Participants associated settlement life with an increase in alcohol availability and binge drinking in the community. Participants recalled binge-drinking episodes in their communities during their childhood during which many experienced sexual abuse as children and/or adolescents. Today, alcohol remains a controlled commodity in the majority of northern communities, which has led to an underground community of bootleggers in many locations.

“And there’s a lot of bootlegging happening in the communities. And the youth will easily sneak some of that. You know and so - maybe the same throughout Nunavut. Not just in [my community].”

From the perspective of parents, the availability, and the potential use, of alcohol among their children and peers would compromise their ability to protect their children from the harm or abuse they had experienced as children.

The displacement experienced by families as a result of medical evacuations and/or residential school during and after settlement was associated with extreme hardship. For one participant, it meant engaging in sex for money to support herself and a younger sibling while their lone parent was evacuated with tuberculosis (TB).

“[my only parent] was out in [southern Canadian city]. [They] had TB. And I was wondering how come me and my [sibling] was being sent out to [residential
school]. That part I really couldn’t understand. I remember being taken away but I really can’t remember why. Growing up I was abused. A lot. Physically. Sexually abused. When I was 13 – 14 [back in the community] I started drinking. And I needed to put food on the table, I have to sell my body just to put food on the table for me and my [sibling]. We were so poor [and had no family to rely on].”

- (Mother)

The separation of families during settlement was a central theme in the interviews. This separation fractured family communication about sexuality. For the participants, the displacement of families was associated with grief, trauma, and hardship. Some parents shared that they continue to struggle to cope with the trauma they experienced as children and their relationships with their own children have been negatively impacted as a result. In these cases, parents felt they lacked the confidence, stability, or integrity, in the eyes of their children, to discuss sexual health with them even though they very much wanted to have those conversations. They worried about how and by whom their children were being influenced to make decisions to engage (or not to engage) in relationships if they weren’t able to provide guidance themselves.

Residential School

Of the participants who attended residential school, none shared a positive experience. In one community, more than one generation of many families attended residential school. One participant described the impact of the school system on her parents and her own personal family life.

“… And then while I was growing up, too, I was getting abuse from my mom. So, um, I grew up in a violent home. Very bullying and mental, physical. By my mother.
Well, she went to school in Inuvik, too. And she was trying to follow the rules of how she was brought up with us. And I didn’t like it. And then when I went to school, it was the same thing. So, I was doing that to my kids, you know, not knowing about it? I was hitting them for no reason. And then [my spouse] finally sat me down and asked me if I was abused when I was young ... I said, yep. He said, ‘Look, what you’re doing to your kids, is what [they] did to you. And you’re doing that.’ I just burst out crying and in front of my kids. And I told them I’m sorry.”

- Mother

Most participants discussed sexual health in terms of preventing child sexual abuse, including fathers who shared that their spouses had been sexually abused as children. Mothers talked about experiencing child abuse (physical, sexual, emotional, and/or mental) while attending residential school (by school staff or residence monitors), or by members of their home community who had attended residential schools. Many of the mothers in the study described how these experiences informed their discussions with their own children in an effort to protect them from such acts.

“With my kids, I’m a mother and I can teach them... I talk to them. What I have learned. And it’s been so many years since that [sexual abuse] had happened to me before ... cause I was only 8 or 9 years old when that happened. I try to protect them. I show them my love. Sometimes I have to try not to be mean, but I’m angry at the same time, I’m talking to them because I have this anger with me... I never told my mother before about that [sexual abuse]. Never told my father. So I kept it in me. [That anger] grew within me ... until I spoke to the RCMP. I never thought
I’d have a family of my own because of that anger. Scared. I was shy, scared. Now I have a family of my own. I could teach them. My children.” – Mother

Some mothers reported that sharing their experiences of child sexual abuse with their children was part of their personal healing process and gave them hope that they would be able to protect their children from the same experiences.

Discussion

The World Health Organization (2006) definition of sexual health is holistic and inclusive, however conventional public health programs largely focus on harm reduction approaches that target prevention of teen pregnancies and sexually transmitted infections (Leslie & Canadian Paediatric Society, 2008). While the present study was initiated in response to parent and community concern about teen pregnancies and high rates of STIs, the stories and experiences of the parents in this study primarily highlighted their need to protect their children from the harms of child sexual abuse. The experience of settlement changed family and community relationships in Canada’s North. The displacement of families and the hardships experienced by children during this period has been one of the most socially destructive forces of this era of Canadian history. Settlement and displacement fractured family relationships and communication about sexuality. Recognizing and moving forward from past trauma and building on cultural strengths and identity in communities that have felt such impacts, are key messages for public health practice from this area of work. The parents in this study identified a desire to teach their children about sexual health and asked for the supports to do so, which provides a clear direction for public health programming in Nunavut.
Conclusion

The results of this study indicate that sexual health understandings in Nunavut today are related to the far-reaching impact of colonial practices initiated decades ago. Nunavummiut continue to feel the impact of the power imbalances created by colonialism, as do other Northern peoples (Moffitt, 2004). The landscape of sexual health in Nunavut is complex and evidence-based public health interventions that will meet the needs of the population should be developed with an understanding of the historical and community context in which people live. Future research can expand on these findings to explore holistic, culturally relevant community-led sexual health interventions. Additional data should be sought from parents and adolescents, giving voice to their collective stories and experiences.

Acknowledgements

A heartfelt ‘qujannamiimaarialuk’ to the parents who shared their stories for this study. We learned from each other and I am grateful to have had the opportunity to share experiences as Nunavummiut. This study was acknowledged and supported in principle by Nunavut Tunngavik Inc. and the Chief Medical Officer of Health, Geraldine Osborne. Many relationships (new and existing) were fostered across multiple communities during the various stages of this project with individuals to whom I also express gratitude: Jason Akearok, Shirley Tagalik, Sarah Curley, Marie Ingram, Madeleine Cole, Theresa Koonoo, Sharon Edmunds-Potvin, Candice Lys, Jennifer Noah, Lissie Anaviapik, Ceporah Mearns, Dionne Gesink, Gillian Einstein, and Ted Myers.
Manuscript 3 - Inuit parent perspectives on sexual health communication with adolescent children in Nunavut

A version of this manuscript was published in the *International Journal of Circumpolar Health* in October 2014.

Abstract

OBJECTIVE: For Inuit, the family unit has always played a central role in life and in survival. Social changes in Inuit communities have resulted in significant transformations to economic, political, and cultural aspects of Inuit society. Where the family unit was once the setting for dialogue on family relations and sexuality, this has largely been replaced by teachings from the medical community and/or the school system. The purpose of this study was to explore Inuit parent perspectives on sharing knowledge with teenage children about sexual health and intimate relationships.

METHOD: A qualitative Indigenous knowledge approach was used for this study with a focus on Inuit ways of knowing as described in the *Piliriqatigiinniq* Community Health Research Partnership Model. Interviews were conducted with 20 individual parents in 3 Nunavut communities in 2011. Parents were asked about whether and how they talk to their children about sexual health and intimate relationships. An analytical approach building on the concept of *Iqqaumaqatigiinniq* (all knowing coming into one), ‘immersion and crystallization’ (Borkan, 1999) was used to identify story elements, groupings or themes in the data. The stories shared by parents are honored, keeping their words intact as often as possible in the presentation of results.

RESULTS: Parents shared stories of themselves, family members, and observations of
the community. Fifteen of seventeen mothers in the study reported having experienced sexual abuse as children or adolescents. Parents identified the challenges that they have and continue to experience as a result of forced settlement, family displacement, and the transition of Inuit society. They expressed a desire to teach their children about sexual health and relationships and identified the need for emotional support to do this in the wake of the trauma they have experienced. Parents highly valued elders and the knowledge they have about family relationships and childrearing.

CONCLUSION: There are powerful, unresolved healing issues in Inuit communities. The traumatic experiences of the settlement and residential school era continue to have an impact on present-day family relationships. To support parent-child dialogue on sexual health and relationships participants identified a need for culturally sensitive and responsive support to heal from trauma, as well as more opportunities for adolescents and elders to learn from one another.
Introduction

In 2009, Nunavut reported high rates of chlamydia and gonorrhea, both of which are sexually transmitted infections, (3772/100,000 and 1,588/100,000, respectively), compared to Canadians (259/100,000 and 33/100,000, respectively) (NDH&SS, 2012). Concerns about these high rates and the high rates of teen pregnancy in Nunavut (161.3/1,000 compared to 38.2/1,000 in the rest of Canada) prompted community members in Nunavut to ask questions about how parents and their children talk about sexual health (Archibald, 2004; Healey, 2006i, 2006p; Healey & Meadows, 2008). The family unit was once the setting for dialogue on family relations and sexuality, and this has largely been replaced by teachings from the medical community and/or the school system (Steenbeek et al., 2006). The purpose of this study was to explore Inuit parent perspectives on sharing knowledge with adolescent children about sexual health and partner relationships.

Family is the primary context in which a child grows, develops an identity, is socialized, is hurt and healed, and navigates physical and social development (Santisteban & Mitrani, 2005). The family is a naturally occurring unit and the context in which most behaviour-shaping experiences can occur. In recent years, increased attention has been given to the role of the family in predicting and understanding the sexual behaviour of adolescents in the literature (Lenciauskiene & Zaborskis, 2008; Meschke, Bartholomae, & Zentall, 2000; Pearson, Muller, & Frisco, 2006; Whitaker & Miller, 2000). Family factors, such as communication, availability of parents, spending time together outside the home, and engaging in activities together can have an impact on the extent to which behaviour problems or choices endure and become part of a healthy or
unhealthy lifestyle (Pearson et al., 2006; Santisteban & Mitrani, 2005; Weiss, 2007). For example, adolescents who reported positive relationships and shared activities with parents were less likely to initiate sex (Pearson et al., 2006). Parental communication about sex and condom use has been shown to directly relate to adolescent sexual behavior (Whitaker & Miller, 2000). Whitaker and Miller (2000) found that peer norms were more strongly related to sexual decision-making among adolescents who had not discussed sex or condoms with a parent. The authors suggest that results indicate that a lack of communication may cause adolescents to turn to peers and that peers may then influence their behaviour. Parental discussions have been associated with less risky sexual behavior among adolescents, less conformity to peer norms, and a greater belief that parents provide the most useful information about sex (Lenciauskiene & Zaborskis, 2008; Whitaker & Miller, 2000; Whitaker, Miller, & Clark, 2000). Research has shown that adolescents are more likely to use birth control when there is parental support to do so (Laraque, McLean, Brown-Peterside, Ashton, & Diamond, 1997). In addition, research has shown that some teens want to have discussions about sex with their parents and other caregivers, more so than others, to help them understand sexuality and to guide them in their own decision-making (Aquilina & Bragadottir, 2000). Parent-teen discussions about sexual health topics are important because they: (a) provide information to teens, (b) they reinforce parental values, and (c) they buffer teens from peer pressure (Whitaker & Miller, 2000). Parental closeness and monitoring rather than the actual specifics of parent-child communication may also play a role because parents who talk to their children about sex or condoms may have already established closer relationships with their children (Whitaker & Miller, 2000; Whitaker et al., 2000).
For Inuit, the family unit has always played a central role in life and in survival (Arnakak, 2006). Inuit kinship extends beyond familial affiliation to other non-biological affiliations including adoption, friendship, marriage or partnership, and namesake (Bennet & Rowley, 2004; Emdal-Navne, 2008; Haviland, Prins, McBride, & Walrath, 2010; Nuttall, 1992). Every person had a specific and essential role to play in making contributions toward family survival and the education of young children and adolescents (Bennet & Rowley, 2004; Briggs et al., 2000; NCI & QIA, 2011). Before contact, small groups of Inuit families traveled together to different camps and hunting grounds, in ilagiiit nunagivaktangat. Each person within a kinship group was valued for his or her contribution to the group’s well-being and success (Briggs, 1991). A child’s earliest learning occurred as they observed and made meaning from the actions of their parents and extended family in the camp (Briggs, 1991; Briggs et al., 2000; J. Karetak, 2013). Children learned valuable behaviours, such as self-restraint, patience, non-aggressiveness, generosity, and responsibility, by watching their family members lead by example (Bennet & Rowley, 2004; Condon, 1987; Healey & Meadows, 2008).

When Inuit lived in family-based nomadic camps, teaching about sexual health and relationships was part of a dialogue between children and their parents or extended family, which occurred as part of the sharing of knowledge on a variety of topics (Bennet & Rowley, 2004; NCI & QIA, 2011; QIA, 2010). Painngut Peterloosie (2011) highlighted the importance that was placed on the openness of the relationship dialogue between romantic partners in discussing, for example, menstruation, sex, or sexual satisfaction. After the settlement era in the 1950s, during which time Inuit settled into

---

23 Inuktitut terminology meaning, “a place used regularly or seasonally by Inuit for hunting, harvesting and/or gathering” (QIA, 2010)
communities, were sent to residential school, and/or were sent away to Canadian cities for medical treatment, that parent-child-extended family interaction changed significantly because many families were separated and displaced (INAC, 1996a; Kral et al., 2011; QIA, 2010). Today in Nunavut, as in many other jurisdictions, parents and family are no longer the sole source for information about sexual health knowledge and behaviours, if they are a source at all (Archibald, 2004; Condon, 1987, 1990, 1995; Steenbeek et al., 2006; Strasburger, 2008). The school system, peers, television, Internet, media, community members, teachers and others now play a role in the transmission of attitudes, knowledge and beliefs about sexual health behaviours (Archibald, 2004; Cole, 2003; Strasburger, 2008). In a study of the perspectives of 53 Inuit women on teen pregnancy, some respondents identified less parental control over young people and greater influence on behaviour from other individuals outside of the family as a worrisome trend in larger communities compared to pre-settlement times (Archibald, 2004). In a review of determinants of sexual health among Inuit adolescents, Steenbeek et al. (2006) asserted that Inuit parents and grandparents did not feel competent to instruct their own children in sexual health. Trauma experienced during and after the settlement and settlement era in the Eastern Arctic (Healey, 2014a; Kirmayer et al., 2009), and the loss of accumulated Inuit wisdom, knowledge, teachings and practices regarding the life cycle, reproductive health, and family planning that occurred as a result, (Condon, 1990; Mancini Billson & Mancini, 2007; Moffitt, 2004; QIA, 2010; Steenbeek et al., 2006), and the changing nature of northern communities (Archibald, 2004; Kral et al., 2011; Wexler, 2006), could be factors contributing to the lack of confidence reported among parents.
Methods

This qualitative participatory research study explored the topic of Inuit family communication about sexual health and relationships at the request of community members who participated in consultations conducted in Nunavut between 2006-2008 (Healey, 2006a, 2007). Their request was prompted by the high rates of sexually transmitted infections and high rate of teenage pregnancy in Nunavut communities compared to the Canadian population. The research project was designed and implemented in partnership with community wellness or research centres in each of three Nunavut communities. The researcher is from Nunavut and is familiar with community and territorial research protocols. The research was conducted within an Indigenous knowledge framework with a focus on Inuit ways of knowing, specifically, the Pilirigatigiinniq Partnership Community Health Research Model (Healey & Tagak Sr., 2014). The model highlights five Inuit concepts, which informed the research approach: Pilirigatigiinniq (the concept of working together for the common good); Pittiarniq (the concept of being good or kind); Inuuqatiitirniq (the concept of being respectful of others); Unikkaaqtigiinniq (the philosophy of storytelling and/or the power and meaning of story); and Iqaumaatigiinniq (the concept that ideas or thoughts may come into ‘one’). A paper outlining the theoretical and methodological aspects of this study in greater detail is published elsewhere (Healey & Tagak Sr., 2014). Participants were engaged in the study through community health and wellness centres and were offered the opportunity to be project partners if they so desired. Inuit parents who had at least 1 teenage son or daughter between the age of 13 and 19 years were invited to participate. Interviews were conducted in a comfortable setting chosen by the participant, recorded
with permission, and transcribed verbatim. All questions were asked in English, and participants primarily responded in English. In the cases where they responded in Inuktitut, the author provided the translation and verified the translation with a third party. Participants were asked open-ended questions about their experiences talking about sexual health and relationships with their children and invited to tell stories and share experiences. Parents were asked how they defined sexual health, where they learned about sexual health, and their perspectives on adolescent sexual decision-making. Data were analyzed through a process of immersion and crystallization (Borkan, 1999) which, from the perspective of the researcher, is a process that is analogous to the Inuit concept of *Iqqaumaqatigiinniq,* “all knowing coming into one.” Through a process of listening to interviews, reading and re-reading transcripts and stories, themes crystalized in the data. A rigorous, respectful, and mindful process was followed for the data analysis, which included: the comparison of findings to the known literature on the topic (Creswell, 2013); reflexivity and bracketing of researcher perspectives before and during the study (Mays & Pope, 2000; Meadows et al., 2003); an iterative data collection and analysis process (Morse et al., 2002); discussion of findings with the local Nunavut-based advisors which included representatives from two community wellness centres24, the Chief Medical Officer of Health for Nunavut, a Community Health Representative (CHR), and a public health nurse (Morse et al., 2002); reviewing the findings with participants or collaborators when and where appropriate (Mays & Pope, 1995); and honoring the stories, shared by parents, by keeping their words intact as often as possible in the presentation of results without breaching confidentiality (Kovach, 2009).

24 The Arviat Community Wellness Centre and the 2nd declined to be named.
Results

Twenty interviews were conducted in three Nunavut communities. The population of the communities ranged from 1200 to 7000. The respondents ranged in age between 30-58 years of age. Of the Inuit parents who volunteered to be interviewed for this study, 3 were fathers and 17 were mothers; 19 of 20 did not complete high school; 11 were employed in part-time, seasonal or casual work, 3 were unemployed, and 6 were employed full-time. When asked about whether they spoke to their children about sexual health, parents described sexual health at the individual level as well as in the larger community and historic context. In response to the question about where they learned about sexual health, most mothers in the study disclosed being sexually abused as a child or adolescent. They stated that their experiences of child sexual abuse made them feel inadequate to talk to their children about sexual health. Both mothers and fathers shared a desire to teach their children about sexual health and relationships, and identified a need for support to help them do this, possibly by including elders. There were two primary themes in the data: 1) Parent-adolescent communication: “It’s kinda hard for me to find the words.” and, 2) Bringing elders and young people together to talk about sexual health. Themes and quotes are presented in English because that is the language in which the stories were conveyed, mirroring the way in which parents shared experiences.

Parent-adolescent communication: “It’s kinda hard for me to find the words”

Parents most often spoke of parent-adolescent communication in terms of what they perceived to be a struggle ‘between worlds’. Parents in this study were among the first generation of Inuit born into permanent settlements. Their parents were often born and raised on the land in nomadic Inuit camps. The children of that era are the parents of
today’s youth generation. Participants spoke of the struggles families experienced adjusting to this ‘different world,’ meaning the world of permanent settlements and the expectations of non-Inuit institutions, such as schools, nursing stations, or the police force, in these new communities. Many of the parents in this study reported experiencing trauma, poverty, and/or hardship in their childhood during this period of transition. Parents described violence, substance use, and unresolved trauma as factors that have perpetuated fractures in family relationships and in parent-adolescent communication about sexual health.

“When the kids are not listening to parents today maybe [it’s] because the mother or the father is yelling to them. The child [becomes] too hard and it seems like they don’t want to listen to the parents anymore. Because they yell… yeah, they yell too much. That they become hard. Hard and they will forget in their mind their childhood when they’re older. So, some parents yell too much to the kids. Some parents are quiet. Some parents are keeping it [inside]. Different world now, different families. We all have different problems. Some people are [in a] very happy family. Some people are in very not good families. Some people are [in] very scary families. Some people are really not good – not welcoming people [in their] families. Like we’re all different.” – Mother (G. Healey, 2014d; Rink et al., 2014)

Parents in this study expressed a very strong desire to talk to their children about sexual health and relationships but questioned their confidence to teach their children. Fifteen of seventeen mothers in the study disclosed experiences of sexual abuse in childhood or adolescence and often described sexual health in terms of protecting their
children from sexual abuse. Parents shared the stories to provide context for explaining their desire to talk to their children about negative or traumatic childhood and adolescent experiences to prevent their children from being similarly harmed. However, parents feared that they would be judged by their children for having engaged in the same behaviours that they are trying to prevent.

“I’ve been on and off with a relationship with [my children’s] father. And when we have our ups and downs - when he comes and goes like takes off and then – my daughter knows that – she knows I’m down and then I start telling her – I said when you’re a teenager, don’t ever get a boyfriend. I said don’t ever get a boyfriend from here. Like you’ve got to find the right one and that’s not abusive and like won’t cheat on you and won’t play games. So it’s kinda hard for me to tell her more like, but I don’t know how to explain it to her. So, I always try before I say anything I sit down and I think about – think about how - how - how am I going to say it to her. So, it’s kinda hard for me to try to find the words. Yeah. And a way to say it to her.” - Mother

“Um, the way I see it – these young kids, now they’re all shacked up and ... at a young age. Like some of them are what? Thirteen – fourteen? And I’ll say to myself, I could see myself when I was that young and like it’s scary to get shacked up at a really young age and it’s.... Because they’re having kids. Are they just shacking up because they want to or...because I wonder - do they know about sexuality and life [relationships]? Do they know like once you’re with the one – once you’re with one girl or one boy you are just supposed to be together. Not to
just do a couple of one night stands and then take off and then go to another
girl... That’s the part that really scares me cause it’s like they’re getting that STI
all the time and I know how it feels cause you have to take pills for that and then
once you get treated and the next thing it happens – it goes back again. Same.

Just like that circle of violence. It’s like that. The same rotation over and over
again. And they say they won’t hurt you again. But the next thing it happens
again.” - Mother

Parents identified a need for greater emotional support to discuss sexual health
and relationships with their children. Parents indicated that they struggled with how to
talk to their children and identified a need for support for themselves and for each other
in order to foster wellness in their own lives and in the lives of their children.

“Definitely parents could be more involved [in talking to their children about
sexual health and relationships] because it will not only help [us], but kids to be
more aware of their surroundings. And what sexual preference they have and for
them to respect themselves. And others, I think it would make a big difference if
parents start talking to – they could do more talking to their children and not be
shy about it. Because every parent has a role and to have brighter, healthier
future they should talk to their kids.” – Mother

Bringing elders and young people together to discuss sexual health and relationships

In the context of parent-adolescent communication about sexual health, some
parents talked about personal relationships among their parents’ generation - those who
are now elders in the community. They spoke fondly of the elder generation and provided
stories and examples about the practices in which their parents had participated that are no longer followed today, such as arranged marriage. One participant indicated that the shift from the arranged marriage of her parents’ generation to the self-selected partners of her teen daughter’s generation was new for the family and something for which she was preparing.

“It’s changed a lot from [my parents] generation. Two parents – if there was a teenager, and the teenager was a boy and a girl...they would be set up – their relationship would be arranged. Once they reached puberty or once they get older, they would be living together. Then, even at the last minute– when they’re ready to be together, there would be a marriage set up right away, early in the morning around 7 am right out on the land. And they would get married. Just like that. Not living with parents anymore, you just have to be with him. That’s how some of them were. Our parents [generation]. That’s how they used to be. So, I just really prepare for it – like as our ancestors used to do – prepare and all that. Looks like our teenagers are deciding who they want to marry. Who they want to be with. I just know my parents got married one day when they were 20 years old.”

- Mother

These stories were shared to illustrate the rapid change in the formation of partner relationships within 3 generations in their communities. Participants talked about the value they placed on the knowledge of elders about relationships and/or sexual health, and expressed a desire to see it revived and promoted among young people in the community. Parents indicated that although some adolescents may have preferred to speak to elders or grandparents instead of their own parents, other young people might
not yet be willing to listen to elders at all because of the influence of music, the media, and popular culture. In the latter situation, parents identified that the relationship between youth and elders needed to be restored. The parents felt that elders and youth were important supports for each other and can sometimes communicate in a way parents and youth cannot:

“[Elders/grandparents] are not even trying [to talk to kids] anymore because...they won’t listen. They’re already listening to the music and the television and the Internet. And they don’t want to listen to their elders. They know this. That’s why [the older generation] shut their mouths. So, I guess what we need to develop is elders and young people together. Within the building, out there *gestures out the window*. And in the schools. Everywhere. On the land. When their friends are bothering them...or this young man or young lady wants to go out with one of my children...they don’t tell me; they don’t tell my wife. They always tell my mother (an elder). They talk to her. They are more open to them, than us as a parent.” – Father

**Discussion**

The stories shared in this study illustrated, first, how parents related their trauma history to the picture of sexual health in today’s communities in Nunavut. Parents described their childhood living in a ‘different world,’ one in which families were separated and relationships were disrupted. They felt they did not have the confidence or ‘the words’ to communicate with their children about sexual health and relationships as a
result. Their stories highlight the loss of Inuit knowledge, teachings and practices regarding sexual and reproductive health that occurred as a result of the separation of families at that time (Condon, 1990; Mancini Billson & Mancini, 2007; Moffitt, 2004; QIA, 2010; Steenbeek et al., 2006).

Second, discussions about sexual health and relationships in the families of the participants, if they did occur, focused on teaching children to protect themselves from sexual abuse or abusive relationships. Data from the 2007-2008 Inuit Health Survey indicated that 41% of adult respondents in Nunavut (52% of women respondents and 22% of men respondents) experienced severe sexual abuse in childhood (Galloway & Saudny, 2012). Physical, emotional, and psychological consequences of child sexual abuse can persist throughout the life course (Johnson, 2004). Anxiety, fear, and suicidal ideas and behavior have also been associated with a history of childhood sexual abuse (Johnson, 2004). Significant relationships exist among childhood abuse, substance abuse, and adult re-victimization, and among cumulative lifetime abuse events, substance abuse, and depression (Bohn, 2003; Segal, 2001). Shame, guilt, vulnerability, internal fragmentation, invalidation and cultural shame were some of the feelings reported by Indigenous women victims of sexual abuse in the literature that were also shared by participants in this study (McEvoy & Daniluk, 1995). Previous research has shown that talking about child sexual abuse can be part of a therapeutic healing process for women, which is supported by the perspectives of the women in this study (Phillips & Daniluk, 2004).

Third, parents highlighted the value that elders and their knowledge hold for them and in their community. They identified a desire to repair and support youth-elder
relationships to foster dialogue on family, sexual health, and intimate or personal relationships when parents are not able to be a support or resource. The parents’ vision of the role of elders in sexual health teaching reflects the Inuit kinship and family structure that was prominent before settlement. From their perspective, repairing that structure is important part of promoting sexual health among adolescents. Previous research has shown that revitalizing Indigenous family and kinship perspectives, where they have been disrupted, is an important part of supporting positive parenting (Pauktuutit, 2007; Poonwassie, 2006; Wesley-Esquimaux & Smolewski, 2004; Yellow Horse Brave Heart, 2009).

There are powerful, unresolved healing issues in Inuit communities related to the challenges Inuit have and continue to experience as a result of colonialism and the transition of Inuit society from one way of life to another (ITK, 2013; Kirmayer et al., 2009; Kirmayer & Valaskis, 2009; Kral, 2003; Pauktuutit, 2003, 2007). The traumatic experiences of the settlement and residential school era continue to have an impact on present-day family relationships and parent-child communication both in general and specifically about sexual health. Parents in this study identified a desire to move away from cycles of trauma and to be supported in engaging their children in dialogue about sexual health and intimate relationships with a focus on revitalizing parent-adolescent and elder-youth relationships.

Conclusion

The results of this study highlight the importance Inuit parents place on engaging with children in a dialogue about sexual-health and relationships. Parents described events in the greater community and temporal context of Nunavut that they perceived to
be blocking the communication pathway between parents and children on the topic of sexual health. They identified elders in the their communities as supports for young people when parents or caregivers are unable to speak to young people about this topic. This would be a positive contribution to the revitalization of Inuit kinship structure that existed before the displacement of families during settlement. The findings provide direction to public health programs, services and practitioners to expand current strategies by including greater support for parent-child and elder-youth dialogue about sexual health and relationships in Nunavut. Healing and counseling services must be made available to families as part of this process, given the significant role child sexual abuse played in the lives of the parents in this study. Future research should expand on this study to explore the perspectives of Inuit adolescents on the sources of knowledge about sexual health that they value, as well as how to support survivors of child sexual abuse to have meaningful conversations with their children about sexual health.

Acknowledgements

A heartfelt ‘qujannamiimaarialuk’ to the parents who shared their stories with me for this study. We learned from each other and I am grateful to have had the opportunity to share experiences as Nunavummiut. This study was acknowledged and supported in principle by Nunavut Tunngavik Inc. and the Chief Medical Officer of Health, Geraldine Osborne. Many relationships (new and existing) were fostered across multiple communities during the various stages of this project with individuals to whom I also express gratitude: Jason Akearok, Shirley Tagalik, Sarah Curley, Marie Ingram, Madeleine Cole, Theresa Koonoo, Sharon Edmunds-Potvin, Candice Lys, Jennifer Noah, Lissie Anaviapik, Ceporah Mearn, Dionne Gesink, Gillian Einstein, and Ted Myers.
Summary

The parents in this study described traumatic experiences of family separation during the settlement period. This was compounded for many by experiences of child sexual abuse, which occurred at approximately the same time. Parents described a lifelong struggle to cope with the trauma(s) and discussed how this had an impact on their relationship with their own children and how or whether they talked to their children about sexual health and partner relationships. Deeper analysis of the issue involved a reflection on parent-child attachments and the repercussions of severed attachments for Inuit families, such as the lost opportunity to transfer knowledge about sexual health and relationships. The stories from the parents highlighted that the impact of societal and cultural disruption at the time of settlement is still felt today. Experiences from that time largely informed how parents discussed the topic of sexual health and relationships.

In this section, a journal manuscript is presented, which focuses on the topic of childhood trauma, disrupted attachments and implications in Inuit relational society. A version of this manuscript was accepted for review to the peer-reviewed International Journal of Indigenous Health in August 2014.
Manuscript 4 – An exploration of Inuit kinship and attachment perspectives and the implications of disrupted attachments for sexual health in northern communities

Abstract

OBJECTIVE: Sexual health is a pressing concern identified by Nunavut community members, prompted by high rates of sexually transmitted infections. Few studies have explored Inuit family perspectives on sexual health, particularly in the context of a series of relocation events in the Canadian Arctic in the mid 20th century, which led to widespread disruption of Inuit families and way of life. The objectives of this paper are to: 1) Review and synthesize literature and oral histories about Inuit and Western academic perspectives on family attachments; 2) Share perspectives of Inuit parents on the topic of family relationships and sexual health, many of whom were children at the time the relocation events in the 1950s and 60s; and 3) Discuss the implications of severed family attachments on sexual health and relationships in Nunavut.

METHOD: The research was conducted within an Indigenous knowledge framework with a focus on Inuit ways of knowing, specifically, the Piliriqatigiinniq Partnership Community Health Research Model (G. Healey & Tagak Sr., 2014). With high regard for the concept of Unikkaaqatigiinniq (storytelling), this paper combines two sets of data to explore Inuit parent perspectives on attachment. First, a synthesis of multiple perspectives from peer-reviewed literature as well as historical, ethnographic, and oral data from key informants is presented on the topic of Inuit and Western perspectives on family attachments and the impact of relocation events of the 1950s and 1960s on sexual health. Second, data were collected in face-to-face interviews with Inuit parents in 3
Nunavut communities. An analytical approach building on the concept of
*Iqqaquqatigiinniq* (all knowing coming into one), ‘immersion and crystallization’
(Borkan, 1999) was used to identify story elements, groupings or themes in the data
related to kinship, family attachment, and sexual health. Knowledgeable and respected
community members verified findings.

FINDINGS: Inuit society is relational, founded on a system of kinship relations, and
these relations form the basis of a family attachment philosophy. Many Canadian Inuit
families were dispersed and separated during the period of time in which communities
were formally created in the Canadian Arctic. Parents in the study identified the
experience of forced relocation and/or attendance at residential school as traumatic events
for their families and others in their communities. Arctic settlement and separation
fragmented the very foundation of Inuit society, ways of knowing, language, and
knowledge communication. Participants in this study identified that severed family bonds
during the settlement period, and subsequent disrupted attachments, broke the chain of
Inuit knowledge transmission with regard to sexual health and deprived children of the
opportunity to develop bonds with adult figures. One participant referred to this
generation as ‘lost’. They identified the severing of family bonds during that time period
as one of the contributing factors to the sexual health picture seen today in northern
communities.

CONCLUSION: Initiatives to promote sexual health and healthy relationships in Inuit
communities should build on *Inunnguiniq*, Inuit family and attachment perspectives.
Reclaiming and revitalizing Inuit attachment perspectives, kinships, stories, and
philosophies is part of the path to overcoming the trauma that Canadian Inuit families have experienced and continue to experience.

**Introduction**

Inuit society is founded on a system of kinship relations (Kral et al., 2011; NCCAH, 2011; NCI & QIA, 2011; Pudlat, 2011; QIA, 2010; Tagalik, 2011). The kinship group was once the setting for dialogue on family relations and sexual and reproductive health (Briggs et al., 2000; Ootoova et al., 2001), which has largely been replaced by teachings from the medical community and/or the school system (Steenbeek et al., 2006). A series of relocation events in the Canadian Arctic in the mid 20th century led to widespread disruption of Inuit families and way of life. Many Canadian Inuit families were dispersed and separated during the period of time in which communities were formally created in the Canadian Arctic (INAC, 1996k). When parents were separated from their children, the settlement and separation events disrupted attachments, threatening the foundation of Inuit kinship society, ways of knowing, language, and knowledge communication. The objectives of this paper are to: 1) Review and synthesize literature and oral histories about Inuit perspectives on family attachments; 2) Share perspectives of Inuit parents on the topic of family relationships and sexual health, many of whom were children at the time of the relocation events in the 1950s and 60s; and 3) Discuss the implications of severed family attachments on sexual health and relationships in Nunavut.

**Background and Settlement History**
Inuit are the Indigenous inhabitants of the North American Arctic, whose homeland stretches from the Bering Strait to East Greenland, a distance of over 6000 kilometres. Inuit live in Russia, Alaska, Greenland, and the Canadian Arctic and share a common cultural heritage, language, and genetic ancestry. Before contact, small groups of families traveled together to different camps and hunting grounds. In the Qikiqtaaluk region of the Canadian Arctic alone, for example, Inuit lived in small, kinship-based groups in over 100 locations throughout the region (QIA, 2010). During the 1920s, 1930s, and 1940s, tuberculosis and influenza ravaged Canadian Inuit populations (ITK, 2005; Sandiford Grygier, 1994; Waldram et al., 2007). That time is well recognized in Nunavut as marking the beginning of a significant cultural shift for Canadian Inuit from a nomadic, subsistence lifestyle to working and living in communities year-round (INAC, 1996k; QIA, 2010; Tester & Kulchyski, 1994). The process of relocation to communities, which originally began as a response by Inuit to the presence of traders, explorers, and missionaries, took new form with the systematic efforts of the Canadian government in the 1950s to resettle Canada’s North. The Report of the Royal Commission on Aboriginal Peoples (1996) reported that in these years government administrators were concerned and came to see the North as being in a state of crisis, which required immediate attention (INAC, 1996a). The response was to implement resettlement programs in the eastern Canadian Arctic in an effort to: 1) protect Canada’s sovereignty post-World War II; 2) facilitate the opening of trading posts by the Hudson’s Bay company; and 3) police, educate, and provide health care for remote populations (INAC, 1996a; Kirmayer et al., 2000). As a result, Inuit were relocated to southern Canada to cut relief costs; to remote

---

25 *Qikiqtaaluk*, means ‘big island’ and is the Inuktitut word for Baffin Island.
High Arctic regions to maintain sovereignty and support the economic initiatives of the Hudson’s Bay Company; and into settlements to facilitate the provision of supplies, education, and medical care (INAC, 1996k). Increased attention was directed to reports of Inuit starvation as the number of caribou across the North declined and/or migration patterns changed, particularly in the Kivalliq region of central Nunavut (Tester & Kulchyski, 1994).

For some communities, up to three generations of Inuit children were sent away from their families to attend day schools in larger communities (Pauktuutit, 2007). Some children were sent much farther away than the nearest settlement, to residential schools in Churchill (Manitoba), Chesterfield Inlet, Yellowknife, Inuvik, and Iqaluit. Others were sent to live with Qallunaat26 families in southern cities, such as Ottawa, Edmonton and Halifax (Pauktuutit, 2007). This caused great anguish for both parents and children (Pauktuutit, 2007; QIA, 2010). Residential schools for Inuit continued to open into the 1960s and by 1963, 3,997 Inuit children were attending these schools (King, 2006). In June 1964, 75% of 6 to 15 year old Inuit children and youth were enrolled in the schools. These students are the parents and grandparents, uncles and aunts of today. The cultural shift experienced by Inuit during this time, when parents and children were separated, threatened the foundation of Inuit society, knowledge, and ways of knowing (QIA, 2010).

**Sexual Health**

Sexual health has been highlighted as a serious public health concern in Nunavut because the territory reports the highest rates of chlamydia and gonorrhea infection in all

---

26 *Qallunaat* is the Inuktitut word that is commonly used for ‘white person’ or ‘non-Inuk’.
of Canada (NDH&SS, 2012). In 2009, Nunavut reported high rates of chlamydia (3,772 cases per 100,000 people) and gonorrhea (1,588 cases per 100,000 people), both of which are sexually transmitted infections compared to Canadians (chlamydia: 259 cases per 100,000 and gonorrhea: 33 cases per 100,000 people) (NDH&SS, 2012). An outbreak of syphilis in the territory began in 2012 and has not abated (Leung, 2014; Nunatsiaq, 2014). In addition, in the year 2000, the rate of teenage pregnancy in Nunavut was 161.3 pregnancies per 1,000 women compared to 38.2 pregnancies per 1,000 women in all of Canada (Archibald, 2004).

Community questions that were raised about the issue of sexual health in a series of consultations on health research in Nunavut focused on trying to understand the causes of high rates of sexually transmitted infections and teen pregnancies in the context of the rapid pace with which Inuit settled off the land and into communities (Healey, 2006p, 2007). A recent study showed that Inuit parent understandings of sexual health were associated with experiences of settlement, displacement, and childhood trauma (Healey, 2014a). Other recent studies in Nunavut and Greenland found that parent-adolescent communication about sexual health is important to Inuit families and that parents require support to engage in family conversations on this topic (Healey, 2014d; Rink et al., 2014). Why the conversations between parents and children stopped taking place has not been explored in the literature. These studies suggest that the disruption of families during the settlement era had an enduring effect on family attachments.

**Approach and Methods**

The research was conducted within an Indigenous knowledge framework with a
focus on Inuit ways of knowing, specifically, the *Piliriqatigiinniq* Partnership Community Health Research Model (Healey & Tagak Sr., 2014). The model highlights five Inuit concepts, which informed the research approach: *Piliriqatigiinniq* (the concept of working together for the common good); *Pittiarniq* (the concept of being good or kind); *Inuuqatigiittiarniq* (the concept of being respectful of others); *Unikkaaqatigiinniq* (the philosophy of storytelling and/or the power and meaning of story); and *Iqqaumaqatigiinniq* (the concept that ideas or thoughts may come into ‘one’).

With high regard for the concept of *Unikkaaqatigiinniq* (storytelling), this paper combines two sets of data to explore Inuit parent perspectives on attachment. First, using a method similar to Wenzel (2008), a synthesis of multiple perspectives from peer-reviewed literature as well as historical, ethnographic, and oral data from key informants is presented on the topic of Inuit and Western perspectives on family attachments and the impact of relocation events of the 1950s and 1960s on sexual health. A search of the peer-reviewed literature was conducted using Google Scholar, Psych Info and PubMed databases with combinations of search terms related to Inuit, kinship, family, attachment, and sexual health. Oral histories from Nunavut, books, reports, transcripts of interviews with Nunavut elders, and historical texts were included in the synthesis (Bennet & Rowley, 2004; Briggs et al., 2000; EAC, 2010; Jenness, 1991; Karetak, 2013; Karetak, 2011; Lantis, 1946; Mancini Billson & Mancini, 2007; McGrath, 2011; Tester & Kulchyski, 1994). Two knowledgeable and respected community members in Nunavut validated the results of the synthesis.

Second, data were collected in face-to-face interviews in 3 Nunavut communities with Inuit parents who had at least 1 teenage son or daughter between the age of 13 and
19 years. Interviews were conducted in a comfortable setting chosen by the participant, recorded with permission, and transcribed verbatim. All questions were asked in English, and participants primarily responded in English. In the cases where they responded in Inuktitut, the author provided the translation and verified the translation with a person experienced in Inuktitut language translation. Participants were asked open-ended questions about their experiences talking about sexual health and relationships with their children and invited to tell stories and share experiences. Data were analyzed through a process of immersion and crystallization (Borkan, 1999) which, from the perspective of the researcher, is a process that is analogous to the Inuit concept of *Iqqaumaqtigiinniq*, “all knowing coming into one.” Through a process of listening to interviews, reading and re-reading transcripts and stories, themes crystalized in the data. A rigorous, respectful, and mindful process was followed for the data analysis, which included: the comparison of findings to the known literature on the topic (Creswell, 2013); reflexivity and bracketing of researcher perspectives before and during the study (Mays & Pope, 2000; Meadows et al., 2003); an iterative data collection and analysis process (Morse et al., 2002); and discussion of findings with participants and community advisors (Morse et al., 2002).

The synthesis of Inuit and Western Attachment perspectives is presented first followed by parent perspectives on family relationships and sexual health. Last, the impact of severed family attachments on sexual health, and implication for a kinship-based society, such as Inuit society, is discussed.

**Kinship, Relational knowledge and Inuit and Western Perspectives on Attachment**
Inuit ways of knowing and kinship relations

Inuit, as with many Indigenous peoples, hold a philosophical view of the world that is relational (Healey & Tagak Sr., 2014; Kovach, 2009; McGrath, 2011; Wilson, 2008). This differs from the common Western practice of focusing on individual descriptions of knowing (Thayer-Bacon, 2003). In a relational epistemology, knowing is informed by the multiple connections of knowers with other beings and the environment, by participating in events, and by observing nature such as the birds, animals, rivers, and mountains (Deloria, 1995). Wilson (2008) and Getty (2010) highlighted a perspective where knowledge comes from the people’s histories, stories, observations of the environment, visions and spiritual insights. Knowing is something that is socially constructed by people who have relationships and connections with each other, the living and the non-living, and the environment (Chilisa, 2012). Relation-building is an essential aspect of everyday life experience for Indigenous communities (Kovach, 2009, 2010; Wilson, 2008).

From a relational knowledge and Inuit epistemological perspective, kinship is the foundation of Inuit social organization (Briggs et al., 2000; Kral et al., 2011; McGrath, 2011). Inuit kinship extends beyond familial affiliation to other non-biological affiliations including adoption, friendship, marriage or partnership, and namesake (Bennet & Rowley, 2004; Emdal-Navne, 2008; Haviland et al., 2010; Nuttall, 1992). In one of the few oral histories of Nunavut that shares the voices of Inuit elders, it is said that Inuit believe that three essential parts make a human: body, soul, and name (Bennet & Rowley, 2004). Kinship and naming are critical aspects of the development of a human being from an Inuit perspective (Bennet & Rowley, 2004; Emdal-Navne, 2008; Nuttall, 1992). A
nameless child, for example, is not fully human; giving a child a name, whether before or after birth, makes a child whole (Bennet & Rowley, 2004). Inuit did not have family surnames before the arrival of Western practices. Instead, each person’s single name linked him or her to a deceased relative or family friend and the spirit of the deceased person lived on in the child (Bennet & Rowley, 2004). Often children carry traits of their namesake or *avvrainnuk*\(^{27}\), such as hunting or sewing skills, and are protected by the name-soul connection (Bennet & Rowley, 2004; Nuttall, 1992; Tagalik, 2011). The relationship between the child and the family of the namesake strengthened family bonds and created extended family kinship, which would support a child throughout life. The name bestowed upon a child was the first step to establish a community around an individual beyond the immediate family and provided connections to others (Bennet & Rowley, 2004; Nuttall, 1992; Tagalik, 2011). In the case of the custom adoption of a child, for example, a child would have kinship connections to their birth family, their adopted family, and the family of their namesake.

Inuit elders have spoken passionately and eloquently about the ties of kinship that united families (QIA, 2010). Each person within a kinship group was valued for his or her contribution to the group’s wellbeing and success. Excellence was highly respected, whether it was in hunting, problem-solving, leadership or sewing (Bennet & Rowley, 2004; Briggs et al., 2000; EAC, 2010; Karetak, 2013; NCI & QIA, 2011; QIA, 2010; Tagalik, 2011). At the same time, a tradition of humility dictated that gifted individuals should not boast or otherwise demonstrate pride (EAC, 2010; Kalluak, 2010; Tagalik, 2011). Although conflicts were inevitable, they were minimized or resolved as quickly as

\(^{27}\) *Avvrainnuk* is one of a number of Inuktitut terms used to refer to the ‘namesake’ relationship that two individuals may share.
possible, since they had the potential to put the survival of the kinship group at risk (QIA, 2010).

*Inuit and Western views of attachment*

If kinship relations are the lines that connect people to one another, attachments are the loving and supportive bonds that hold them together over the life course. The theory of attachment originated in the psychology literature to explain both attachment behavior, which children develop toward their parents, and enduring attachments in adulthood, which adults make to others (Bowlby, 1969). Attachment behavior is viewed by Bowlby (1982a) as any form of behavior that results in a person attaining or maintaining proximity to some other clearly identified individual who is perceived to be better able to cope with the world. The cross-cultural applicability of attachment theory as proposed by Bowlby (1969) has been debated in the literature and the need for an attachment model that is based on Indigenous values has been noted (Bowlby, 1982a; Cowan, 1997; Rothbaum, Weisz, Pott, Miyake, & Morelli, 2000; Yeo, 2003). In this section, two Inuit attachment perspectives, which articulate Inuit values related to family bonds and kinship relations, are shared alongside similar concepts from attachment theory: 1) the ‘puuq’ (pouch) and 2) the *Mannik, Ujaraq, Inuk* (Egg, Rock, Able Person).

Briggs (1995) has stated that in traditional Inuit camps, attachments governed social life. In Inuktitut, the word *Inunnguiniq* is used to describe the ‘creation of an able person’. In a discussion about the concept of *Inunnguiniq*, family relationships and childrearing from an Inuit perspective, Elders in Nunavut have described a *puuq*, a pouch, which metaphorically hangs around a child’s neck (EAC, 2010; Tagalik, 2011). As a child grows and develops, the *puuq* must be filled with positive articles such as good
words, values, love, safety, support, skills, practice, understanding, and knowledge (EAC, 2010; Kalluak, 2010; Tagalik, 2011). These values and tools contributed to the formation of the child’s personality and equipped the child with the skills and support he/she needed to engage in positive relationships with others and cope successfully in life whether it be in times of celebration, or through hardship or illness. Parents, caregivers, and extended family kin made positive contributions to the child’s life and the puuq by developing relationships, showing affection, caregiving, teaching and supporting the child (Kalluak, 2010; Tagalik, 2011). When a child experienced neglect, anger, hurt, abuse, or mistrust, the puuq remained empty, thus the child was not a whole person, and consequently, not able to develop trusting relationships or cope well with life events (Tagalik, 2011).

This perspective from Inuit elders parallels concepts in the Western academic theory of attachment (Bowlby, 1969). The knowledge that an attachment figure is available and responsive provides a strong and pervasive feeling of security, and so encourages the person to value and continue the relationship (Bowlby, 1982f). Attachment behavior can be observed throughout the life cycle (Bowlby, 1982f). Since it is seen in virtually all human beings (though in varying patterns), it is regarded as an integral part of human nature (Bowlby, 1982a). Attachment research places significant importance on the caregiver-child relationship (Bowlby, 1982a). The Inuit attachment perspective is extended beyond the caregiver-child relationship to the extended family-caregiver-child relationship(s) through kinship, the naming tradition, and the collective commitment and expectation to fill a child’s puuq (Karetak, 2013; Tagalik, 2011).

Attachment research separates children into categories of attachment. The ‘securely attached’ child/person comes to see himself or herself as worthy of others’
attention and sees others as trustworthy and responsive (Bowlby, 1982f). In contrast, the ‘insecurely attached’ child/person displays disorganized attachment patterns and comes to see himself or herself as unworthy of others’ attention and sees others as unworthy, non-responsive, and perhaps even abusive (Alexander, 1992). Similarly, the second Inuit attachment perspective I would like to discuss is explained in a story shared by Rhoda Karetak of Arviat, NU, in which she discusses the Mannik, Ujaraq, Inuk (Egg, Rock, Able Person). She shared this story in the context of describing the Inuit concept of Pilimmaksarniq, the Inuktitut term for the concept of learning skills through practice, effort, and action, in relation to childrearing, childhood development, and relationships with others in the community (Karetak, 2011). In her story, Rhoda described a child that is like a ‘fragile egg’, who was treated very gently, always careful to never crack the egg, and protected at all times. This person is not able to cope with hardships later in adulthood. She also described a child that is like a ‘hard rock’, who became shocked or stunned when he/she was scolded or traumatized. After enduring repeated scolding or abuse, the child became ‘hardened’ to it and unaffected or unemotional, and this person may become dangerous. Lastly, Rhoda described the ‘able person’ who was created from a childhood environment of patience, love, teaching, training, and understanding. In Rhoda’s story, the ‘fragile egg’ and the ‘hard rock’ can be seen to be analogous to the insecure forms of attachment and the ‘able person’ is analogous to the secure form of attachment.

**When relations or attachments are disrupted**

Disrupted attachments in infancy or childhood can have lifelong implications in adulthood (Bowlby, 1969, 1982a; Overbeek, Stattin, Vermulst, Ha, & Engels, 2007;
Scheeringa & Zeanah, 2001; Schreiber & Lyddon, 1998; Segal, 2001; Tavkar & Hansen, 2011). Overbeek et al (2007) found in a longitudinal cohort study of 212 individuals, that negative parent-child bonds were related to low-quality partner relationships and dissatisfaction in life in adulthood. Without intervention, the children continued to express disorganized attachment patterns when they reach adulthood. Furthermore, attachment research has demonstrated that when an adult has a history of disrupted attachments and/or abuse, their children also express disorganized attachment patterns as well (Lyons-Ruth & Block, 1996; Scheeringa & Zeanah, 2001). The implication of disrupted attachments in a relational society, such as Inuit society, is significant not only because of the impact of the severing of family bonds, but because the sharing of knowledge, customs and practices is dependent on relationships between people (McGrath, 2011). Inuit knowledge is communicated through action and explanation. There was no written Inuit language until efforts were made by Moravian brethren missionaries to write Inuktitut in the late 19th century (Harper, 1983). The transfer of knowledge, histories, and skills from one generation to the next was entirely dependent upon Inuit oral history and learning from others (Ajunnginiq, 2006; Kral, 2003; Mancini Billson & Mancini, 2007; NCI & QIA, 2011; QIA, 2010; Tester & McNicoll, 2004). Families became separated when relocated into settlements; children were taken from their parents and placed into residential schools; and family members were sent away for medical care, many never returned (INAC, 1996a, 1996k; QIA, 2010; Sandiford Grygier, 1994; Tester & Kulchyski, 1994). The bonds between parents and children in many Inuit families across the North were severed as a result, which left many children without a reliable, safe figure on whom they could depend or turn to for knowledge, understanding,
safety, or reassurance (INAC, 1996k; Kral et al., 2011; Kral & Minore, 1999; QIA, 2010). Family is the central structure of Inuit society, and changes to its structure have been identified in previous research as a key factor in the social problems experienced in northern communities (Arnakak, 2006; Healey, 2014d; INAC, 1996a; Kral et al., 2011).

Inuit Parent Perspectives on Family Relationships

Parents interviewed for this study shared personal stories of positive and negative family relationships in discussions about sexual health. Some parents shared personal experiences of trauma and separation, and discussed the impact of these events on their family life.

One mother, who did not attend residential school and was not separated from her family, shared her personal story of childhood relationships with elders, and how she learned about marriage and reproductive health from her parents when her marriage was arranged. She emphasized the role of family bonds in discussing sexual health, as well as personal safety, with her own children today:

“My mother, she really got me scared one time because she really didn’t want me to get pregnant because I was too young. So back then when we learned it – I really used to listen to what the elders said or my father said or what my mother said. And we always used to try to listen to them very much, so we really, really, really tried to listen to them and try to do whatever they told us to do. Because we had to listen to our parents. She told me if you ever kiss a boy by your lips you’re going to get pregnant. I really tried not to get my lips on a boy. Or try to touch them. I was so scared. When I turned 18 ...my father said “Look. Daughter look
through the window and see that boy. He’s the one you’re going to marry.” I tried to really wide open my eyes [to see him] and I didn’t even know the guy’s name. I listened to him and we talked… we were friends and we kept being very close friends. Even closer and we got together. That was when I was 18 years old. And got married late [year] and it’s going to be [more than 20 years] next month.

Around then we started having babies. Ah, I remember that back when we [young girls] used to talk [when we were] teenagers. We pretended to be pregnant with a big ball and we see our mothers with a big stomach… I wanted to have a baby too… Maybe today [young people] see other same aged people – see that she got pregnant and the baby’s out and she did it … and I can do that too. Like they start getting interested – wanting to have a baby. They want a baby. …I talk to [my children a lot]. They really understand me and it’s a good thing they listen to me and my husband. [My husband] he talks [with them] a lot because [he] really loves the kids… Mostly today just when I’m looking out the window watching the water, watching the birds flying around on the wing or just looking at it – just feeling about it – I think today maybe the younger ones are looking at those who are older now… We, parents, now - if we say to our children we really love them, we have to explain what is good or what is not good. Including the sexual [health] or whatever we [are] talking about. So that they understand… And these other parents talk with their kids and they’re understanding and trying to listen to them and make them more safer… they’re not being injured by someone. Because they’re looking after themselves.” – Mother
This parent described a direct link between family bonds, positive learning experiences with parents and elders, and the role of these experiences in her discussions about sexual health with her children. In the previous quote and in the quote that follows, parents also commented on the ways in which children today emulate both positive and negative behaviours modeled by their parents. This was discussed in the context of sexual health and in the greater context of mental health and wellness in the community.

“I'm just an Inuk – I'm just a person. ...[And] because we’re human beings, we, people, follow what our parents used to do. We follow them. For example, like I’m a mother of my teenage children. I’m a mother. [What] if I try to kill myself with a knife... [What if ] I would maybe try to pretend to try to kill myself with a knife or I try to choke myself...For example, [if] I try to commit suicide ... and kill myself and one of my kids would try the same thing... Like me, like that.. They copy their parents. Or for example, if I met up with someone and making babies and all that and children are...watching me [my actions] ... they will do the same thing as me. Same thing. Generation to generation. So, they will always copy their parents. My grandparents got it from their parents; my parents got it from grandparents. I got it from my parents. My kids get it from me. I’m just thinking. They do what we show them [teach them].” - Mother

This parent emphasized how knowledge and behaviours are transmitted from one generation to the next, and made note of the type of negative behaviours parents have modeled for their children in her community today such as suicide attempts or risky sexual activity. This parent and other participants believed that such behaviours had a
direct impact on sexual decision-making among adolescents, for example, seeking love and security from a romantic relationship (when not available from parents) or the decision to have a child as a teenage single parent. This perspective contributes to the notion that the children of adults who display disorganized attachment may also develop disorganized attachments, as well (Lyons-Ruth & Block, 1996; Main & Hesse, 1990; Scheeringa & Zeanah, 2001).

For the parents in this study, the experiences of family separation during the residential school and settlement era were traumatic. Most of the participants described childhood memories in which their families had been forced to move to a community or were forced to send them to residential school, or felt abandoned when a family member was evacuated for medical treatment. In the context of sexual health, when families were separated, the traditional lines of communication about sexuality and family relationships were lost. Knowledge about sexual health, among other topics, could not be passed on. For the parents in this study, that time marked the beginning of the formation of a gap in knowledge about sexual health. One participant referred to the children of this era as ‘the lost generation’.

“Um, for instance, young girls I know, and my personal experience with feeling neglected or abandoned, you’re looking for attention or someone to love you and that’s when they start seeking outside the family who would accept them for who they are and love them and I think it has a lot to do with sexual abuse as well...which is being ignored a lot. I know a lot of the cases are not reported because they are scared to report it... sexual abuse among youth, now, or their parents’ generation or maybe both. And before – maybe grandparents
Inuit parents also discussed the barriers that they felt prevented them from discussing sexual health with their children in the sincere way they wanted to. These barriers, which prevented meaningful conversations with children about sexual health and relationships, included trustworthiness, confidence, self-esteem, previous risky behaviours, and shame. Parents shared a desire to overcome these barriers and use their traumatic experiences as opportunities to teach their children.

**Discussion**

This study originated from community questions about high rates of STIs in the context of the rapid shift in the way of life of Inuit in the Eastern Arctic within the last 2
generations. The parents’ stories primarily focused on memories of both positive and negative relationships with parents and/or grandparents, and personal experiences of childhood trauma. For parents in this study, discussions about sexual health were enveloped in the broader context of family relationships and community wellness.

The children of the northern settlement and residential school era are the parents and grandparents of today’s youth generation. Where the family unit was once the primary setting for dialogue about sexual health, for many families this knowledge pathway was eliminated when children and parents were separated during the relocation events of the 1950s and 60s. For the many who experienced trauma as children during the relocation events, the experience of being separated from their parents was further compounded by the added experience of abuse.

The events that occurred in Canadian Inuit history over the past century altered kinship relations, attachments, and created fractures in the Inuit system for sharing knowledge (Bohn, 2003; McGrath, 2011; Tester & McNicoll, 2004). Many adults have struggled with childhood trauma experienced during the settlement and residential school eras and, in previous studies, have reported turning to substances to cope with the depression, anxiety, violence, and stress that they had experienced (Healey, 2006i; Healey, 2014; Kenny, 2006; Kirmayer et al., 2009; Kral et al., 2011; Segal, 2001; Waldram et al., 2007; Wesley-Esquimaux & Smolewski, 2004). For some, the cycle of trauma has continued into the next generation, perpetuating the rift in kinship relations, in relational society, and in the transmission of knowledge and philosophies (Kral et al., 2011; Pauktuutit, 2003, 2007; Wesley-Esquimaux & Smolewski, 2004; Yellow Horse Brave Heart, 2009). Previous research has suggested that the impact of societal, cultural,
and familial disruption at the time of settlement had a lasting impact on parents’ ability to communicate to their children about sexual health (Healey, 2014a, 2014j; Steenbeek et al., 2006).

The settlement and residential school era fractured Canadian Inuit family bonds and disrupted parent-child-extended family attachments by separating young children from their parents for extended periods of time (INAC, 1996k; QIA, 2010). Attachment theorists believe that in such instances, if children are unable to find a secure, safe, and loving attachment figure, they may develop a disorganized attachment pattern (Alexander, 1992; Bartholomew & Horowitz, 1991; Bowlby, 1969, 1982f; Feeney & Noller, 1990; Haft & Slade, 1989; Yeo, 2003). The literature states that parents with a disorganized attachment pattern behave in a way that the children may perceive as threatening, for example if their behaviour is erratic, conflicting, or unreliable, or in more extreme cases, abusive or frightening to the child (Main & Hesse, 1990). In a study in the United States, Main and Hesse (1990) found that unresolved trauma and loss in a parent’s life is the best predictor of disorganized attachment between a parent and child.

However, not all Inuit were separated from their families or attended residential school during the relocation events, and each community in Nunavut has a unique settlement history related to, for example, their location, exposure to infectious illness, access to harvesting areas, and presence of authorities or trade (INAC, 1996k; QIA, 2010; Sandiford Grygier, 1994; Tester & Kulchyski, 1994). Therefore, some important Inuit concepts, such as Inunnguiniq, the puuq, and the Mannik, Ujaraq, Inuk, remain in the collective memory of elders and community members. As part of a movement to reclaim
and share Inuit knowledge and ways of knowing, *Nunavummiut*\(^{28}\) have been working most recently to revitalize Inuit perspectives on family and attachments by sharing *Inunnguiniq* perspectives through books, DVDs, parenting support programs and resources to make the material more accessible to those who do not have access to it through the traditional oral storytelling pathway (NCCAH, 2011; QHRC, 2012). Such initiatives include camps and land-based activities that celebrate the role of the land in the holistic Inuit wellness perspective and in the sharing of Inuit skills and knowledge with both youth and adults (Ilisaqsivik, 2010a, 2010c; Kalluak, 2010; Mearns, 2013).

Increasingly works are being published that incorporate multimedia, film, information technology, and written text to share Inuit stories, philosophies, knowledge, art, practices, and humour with community members and with the next generation (Arnaquq-Baril, 2010; Bennet & Rowley, 2004; Briggs et al., 2000; Christopher, McDermott, & Flaherty, 2011b; IBC, 2013; Kalluak, 2009c; Zacharias Kunuk, 2001; NCI & QIA, 2011; Ootoova et al., 2001).

In reflection upon the relocation and settlement time period in Inuit history, Inuit have since celebrated a collective resilience in the face of such societal devastation (Ajunnginiq, 2006; Korhonen, 2008; Olofsson et al.). The resilience, strength and capability of Inuit has become the focus of community-led initiatives to reclaim family relationship perspectives, kinships, creativity, Inuit skills, harvesting, and education (Arnaquq-Baril, 2010; Canada, 2001; Communities of Arctic Bay, Nickels, Furgal, Buell, & Moquin, 2005; ITK, 2011; Kral & Minore, 1999; Kral et al., 2009; QHRC & Arviat Community Wellness Committee, 2014). Parents in this study described a connection

---

\(^{28}\) *Nunavummiut* is the Inuktitut term for ‘people of Nunavut’
between kinship relations, family attachments, community wellness, and sexual health. Public health interventions that mirror community-led initiatives to revitalize Inunnguiniq could be very effective and make a positive contribution to sexual health and relationships among young people in Nunavut, and other Inuit communities across the Arctic, by strengthening the knowledge-sharing pathway between parents and their children for the purposes of sharing sexual health and relationship knowledge (Healey, 2014).

Limitations and Considerations

This article included a select review of the literature and oral histories about Inuit attachment perspectives in Nunavut. It is not necessarily representative of the perspectives of all Inuit communities across the Arctic. Similarly, interviews were conducted with Inuit parents who volunteered to participate in 3 Nunavut communities, and their perspectives are not necessarily representative of all Inuit.

Conclusion

Sexual health is a pressing concern in Inuit communities in Nunavut. Inuit society is founded on a system of kinship relations, and these relations form the basis of a parent-child-extended family attachment philosophy. Separation and relocation during the settlement period traumatized families and disrupted the essence of Inuit ways of knowing, languages, practices, and the sharing of knowledge by separating parents and children for long periods of time (Arnakak, 2006; Dorais & Sammons, 2000; Healey, 2014d; Healey, 2014; Kirmayer et al., 2009; Kral et al., 2011). Traditional lines of communication about sexuality and family relationships were disrupted. Rebuilding
family and community relationships can make a positive contribution to sexual health by enhancing family networks and revitalizing millennia old pathways for knowledge sharing. The promotion of Inuit stories, wisdom, and practices is part of a collective movement to reclaim Inuit attachments and kinships in today’s communities, which can have a positive impact on sexual health. Future research could focus on family attachments and perspectives of youth on the topic of sexual health and relationships.

*The Egg, Rock, and Able Person*

In the previous manuscript about Inuit attachments, I referred to a passage by Rhoda Karetak, Inuit elder, in which she spoke of how relationships between parents and children are viewed from an Inuit worldview. I have shared the full passage in this section. In this passage, she highlighted the significance of these relationships for healthy child development, and the impact of positive and negative relationships on the child as he/she grows into adulthood. She articulated this perspective in her telling of the story about the Egg, Rock and Able Person²⁹:

>To help us all understand, how children are affected by their immediate environment, what ever they are exposed to can potentially have an impact on their lives...The hardened person; In the Inuit society, the concept of Pilimmaksarniq can be carried too far or not far enough, and when it is carried too far over, where an individual is exposed to extreme discipline and pressure, more than the rest of their siblings, by being told to do way much more chores, or all the chores, the child will not happy about this situation, constantly being

²⁹ ‘Able Person’ meaning a person who is self-sufficient and capable
ordered around by all those around them, and you could see this happens to some individuals in all our societies. When the parent or guardian starts to scold them, all the others around start joining in. Then the scolding starts to get bigger, and instead of just scolding, it escalates to, being yelled at and maybe even being hit. If a child gets yelled at or extremely scolded suddenly while they are too young to understand, they get shocked and stunned by this, and Inuit have a term for this situation and is called, “Quqqik” meaning the child is traumatized. At first they are stunned by this, but when they are exposed this kind of treatment over and over, they will start to become a harden person and no longer seemingly affected by the yelling. No longer having any fear, this person will become harder ... like a rock, when Inuit people recognize these symptoms, that person would be known as someone who has been hardened and may become a very dangerous person when they grow up. Once you show patience, real love, and real understanding, he or she will be able to make changes to their lives, and they become whole again.

The fragile egg person has to be treated very gently, always have to be careful not to crack the egg, protected at all times. This person becomes like this, when the guardian or parents are over-protective and keep going to the defense of the child, asking him or her questions like, “who mistreated you, were you hurt by anyone, has someone been mean to you?” In the old traditional way, this behavior towards our children and asking questions of this nature is absolutely forbidden. As a mother, as I love my children a lot, makes it extremely difficult
not to want to defend my children. But we must refrain from doing so, because
the old people always say, you cannot be there forever, and be with them
wherever they go, so it is not wise to make them think, you are going to take care
of them all the time, be there all the time. [When] a fragile person experiences
hardship for the first time, it may be too much for them and not be able to
recover from this situation and the damage done within this person will be
because of you, you who have tried to defense your son or child, when ever you
think anybody has wronged them, or tried to discipline them for thing they did
wrong, and if you are father or a mother who has created a fragile person, you
will have to worry about them all the time, for the rest of your life and their
life. ...It can become confusing for a child who has been told to often, don’t do
that, and commenting [on] every action they are doing, not being left alone to
just be themselves for a little while, not being allowed to touch anything, don’t
make any mess.

If we scold children too harshly for things; like accidentally spilling something
or punishing them for every little wrong thing they do, they will start to think
they cannot do anything right, so why bother even trying to do right thing
anymore? If we want to bring up children properly, we must not scream at them
all the time or we will shock them and totally break their heart. And if we
punish them for every little wrong thing they do when they are trying new things,
to learn, we will take away their will to try. And if we just continue to scream at
them for every wrong they ever do, we will only succeed in making them
dysfunctional, and to me, that is not the proper way to bring up children... We must seek the balance in each child, for we are all different in many ways. 

(Karetak, 2011; NCCAH, 2011)

Sananiq/Crafting – Beadwork

In this dissertation, I have discussed a number of stories shared by the participants in this study and some related to my upbringing. I have one more story to share - it is about crafting something. I share this story for two reasons. First, it is part of my reflexive account as the researcher for this study. Guillemin & Gillam (2004) state that “…reflexivity is not necessarily focused only on the production of knowledge in research (what might be called the epistemological aspect of research practice) but also on the research process as a whole. Adopting a reflexive research process means a continuous process of critical scrutiny and interpretation, not just in relation to the research methods and the data but also to the researcher, participants, and the research context.” (Guillemin & Gillam, 2004, p. 275).

This story is part of documenting my research process for the reader. Second, storytelling and crafting are strongly linked in Inuit culture, and the stories and analysis that were part of the crafting of this dissertation were also part of a parallel process to craft a beaded centerpiece for my amautik. McGrath (2011) states,

“Craft culture is not just about sewing, it is about making things of all kinds. The making of snow homes, tools, boats and so on, while more the domain of men’s expertise, require all the same cultural principles and thinking strategies that
sewing does... Epistemology is a theory or philosophy of knowledge, a way of looking at knowledge and understanding it as knowledge and knowing. What are the metaphors for knowledge, knowing, and skill, and how are those metaphors organized in Inuit culture? In my understanding the main one is sananiq – craft. Sananiq is primarily relational and social. Skills are observed, taught, acquired, refined and developed through relationships; so is knowledge. It is also practical in its essential relationality; people make things that are needed by others or themselves in the service of others. So is knowledge. What is available is used to make things, and if what is needed is not available, qanuqtuurniq (innovation) is a natural way to think. In sum, sananiq/craft for me, is a metaphor for thinking, thought and knowledge. These processes – of craft and making - are primarily relational and social and thus they are transmitted through relationships. Knowledge produced is intended to be practical and thereby facilitate community and social wellbeing. (McGrath, 2011, p. 283)

Crafting and storytelling are important aspects of life for Indigenous peoples the world over (Battiste, 2000; Cardinal et al., 2004; Kovach, 2009; Vorano, 2008; Wilson, 2008). It can be a cathartic experience to convey the reality of loss, grief, and traumatic grief or stress in Indigenous communities, for example through digital storytelling (Iseke & Moore, 2012) or re-storying (Cardinal et al., 2004; Corntassel et al., 2009) or crafting/art-making (Lavallee, 2009; Pauktuutit, 2012). It is a powerful and influential way to challenge the mind and plant new thoughts, to document history and experiences, and to transform our understanding "surprising our consciousness into a new way of seeing" (Dion Buffalo 1990, p.120).
This story begins in 2011 after I completed the data collection for this study and my second daughter was born. In an effort to get out of the house and take breaks from the baby, I joined an evening sewing group for women who wished to learn more about beading for an amautik. It was taught in the Inuktitut language, by an elder, to a small group of six women including myself. I knew all of the women in attendance through one aspect of my life or another. During our sewing sessions, I discovered a relationship between my daughter’s namesake and one of my fellow sewers, and I enjoyed listening to stories about the person. This is one of the joys that comes from sharing stories in an informal setting like a sewing group.

I had learned the basic principles of beading as a child in school. In elementary school, elders would come to the school and work on projects with us related to sewing, carving, building, or cooking. We would rotate through a schedule, which would allow us to spend time with each elder on different days of the week and develop different skills. Beading was one of the projects I remembered, but it had been over 25 years since I had tried to do it and I appreciated the opportunity to revive the skill as an adult with a group of women in my community.

Beads were introduced to Inuit by traders in the 19th century (Driscoll, 1984). Inuit in different regions of the Arctic incorporated foreign objects like beads, coins, and spoons, into clothing, jewelry, and tools in different ways (Driscoll, 1984). The artistry of Inuit beadwork is remarkable. For example, Figures A, B, and C provide examples of Inuit beadwork at different time periods.

30 An amautik is a traditional Inuit women’s parka with a pouch on the back in which the baby or toddler is carried. Amautiit (pl) are very common today and almost all Inuit, and some non-Inuit, mothers (and many fathers) have one.
FIGURE 2 - Young girl's amautik, Creator Unknown

Central Arctic Iglulingmiut (Aivilingmiut), Nunavut, 1925-1935
Caribou fur, glass beads, ivory, bone, teeth, wool braid, cotton tape and thread, stroud, sinew © McCord Museum

FIGURE 3 - Inuit woman and child, wearing beaded parka (amautik)

Southampton Island (?), Nunavut, 1925-26
John M. Kinnaird © McCord Museum
FIGURE 4 - *Beaded amautik*

Made by Ulayok Lucy Kaviok, 1970s

Winnipeg Art Gallery
Soon after I had participated in the first evening beading session, my newborn baby became very ill. After several trips to the emergency room over four days, her condition deteriorated to the point that she required admission to the hospital with a severe respiratory illness. We were very frightened. We shared a room with another newborn with the same illness that cried constantly. Hospital machinery beeps and alarms provided distressing and unceasing background noise. The entire experience was nerve-wracking and stressful. I felt upset and scared. To calm myself, I decided to work on the beading project I had started. I would sit at my daughter’s crib-side and bead and think. The repetitive action of picking up four beads on the needle, placing them in position, and then anchoring them with additional stitches was meditative and calming. I beaded a
small flower while my daughter was in the hospital. Seventy-two hours after she was admitted, she was discharged - and I had completed the flower in Figure D.

FIGURE 5 – The flower I created while my daughter was in the hospital.

Within a week of coming home from the hospital, I returned to the evening sewing group. I started planning my beading project for my amautik. My amautik was made for me when my oldest daughter was born by a long time friend of my family, who is a remarkable seamstress and now an elder in my community. My intention was that this beadwork would adorn the front of the amautik. I crafted this beaded front-piece for my amautik at the same time that I crafted this dissertation. I analyzed data and wrote the results of this study while picking up beads on the thread and placing them on the fabric. The beading was part of my reflexive process. I share this story because the crafting of the dissertation and the crafting of the front of my amautik were intertwined. The processes were linked, and the stories of the people I interviewed were in my head as I sat at the computer and wrote, and while I sat at the table and beaded.
To bead in this fashion, the beads are sewn into the fabric in groups of four. Four beads are picked up on the needle, pushed down the thread into position next to the previous row, and anchored. The grouping of four beads is then anchored again, by two additional stitches that run perpendicular to the row. If a tear develops in a thread, the
anchors keep the whole piece from unraveling. Instead of losing a series of beads, one might only lose one or two. To repair such a tear, the loose string can be re-knotted underneath and replacement beads can be sewn into the gaps in the pattern. It may not look exactly the same, but it will be strong and beautiful nonetheless.

Sitting at the table and beading led me deeper into thought about fabric - the fabric of society. When something happens to fabric to tear it or damage it, what do we do with the fabric? Do we throw it out? No. Do we repair it? Yes, because torn fabric is still beautiful, useful, and valuable.

I began to see the events of settlement, residential school, and medical evacuations as tears in Inuit relational ‘fabric.’ Kinship, extended family bonds, and attachments were like the ‘anchor’ stitches in the beadwork that had become severed through the separation and relocation of families. Intergenerational trauma and the perpetuation of colonial policies can be viewed as continuing to feed the unraveling of the threads. In this analogy, the threads must be re-anchored. To find new anchors, our community members need support to heal from trauma. The holes can be filled with other colours and other beads – such as the innovations and initiatives of the people in our communities. Such initiatives grow out of revitalized relationships between individuals, between parents and children, within and between families, and in the greater community. With time, effort, and skill, repairs can be made to the fabric. It will look different, and that is okay. What is important is that the fabric retains its beauty, strength, and story.

I share this story because the narratives woven into this dissertation are also woven into the beadwork and the process contributed to my greater understanding of the topic. Sharing this perspective on ‘craft-knowing’, as McGrath (2011) described it, is an
important part of the research process and is part of the concept of *Unikkaaqatigiinniq* (the power and meaning of story) described in the *Piliriqatigiinniq* Community Health Research Model, which was presented in Chapter 5.
Chapter 7 – Discussion and Concluding Remarks

Key Findings and Contributions to Literature

The original research question posed at the beginning of this dissertation was:

1) Given the rapid societal changes experienced in Nunavut, and the changed/changing nature of relationships at the individual, familial, and community level that are a result of this experience, how do youth and parents of youth in Nunavut conceptualize sexual health and relationships today?

In addition, a methodological question was posed: How can this topic be studied in a way that is respectful and mindful of Inuit ways of knowing and understanding wellness?

I will discuss these topics in reverse order. First, I will briefly comment on the Piliriqatigiinniq model that was used for this study. Second, I will briefly comment on the perspectives of the youth in this study. Thirdly, I will expand on the perspectives of parents in this study focusing first on the traumas that parents discussed in the context of sexual health and relationships in today’s communities. I will expand on that section with a discussion of the WHO definition of sexual health, which includes power and socio-political context, and how this study contributes to that definition and our understanding of sexual health in Nunavut. Last, I will provide a final comment on the application of these findings, the strengths and limitations of this study, and direction for future research.
A decolonizing research approach places Indigenous voices and epistemologies at the centre of the research process (Simonds & Christopher, 2013). It critically examines the underlying assumptions informing the research and challenges the widely accepted belief that Western methods and ways of knowing, which have historically marginalized Indigenous methods and ways of knowing, are the only objective, true science, (Kovach, 2009; Thaman, 2003; Wilson, 2008). This does not mean researchers should reject all Western methods and theories. I believe that to decolonize research means to embrace the different kinds of knowledge that can be shared and created in Indigenous communities when methods and theories, which reflect Indigenous worldviews, are used.

Community-based participatory research is a method, which is promoted widely, particularly among Indigenous communities as part of an empowering research process (CIHR, 2006; Herbert, 1996; Macaulay et al., 1999). Three primary features of participatory research include collaboration, mutual education, and acting on results developed from research questions that are relevant to the community (Macaulay et al., 1999). This methodology recognizes and promotes the role of the community in the research process and views community engagement as beneficial to the study (CIHR, 2006; Macaulay et al., 1999). Although the community-based participatory research approach has been beneficial in changing how communities are engaged in research, there is still some disagreement among researchers on the interpretation of what ‘community-based’ means (O'Toole, Aaron, Chin, Horowitz, & Tyson, 2003). For example, it is difficult to differentiate between ‘community-placed’ and ‘community-based’ research in the literature, the former often being misinterpreted for the latter.
O'Toole et al. (2003) pointed out that the research community must continue to strive to clarify what is and is not community-based participatory research.

Smylie et al. (2004) also noted that within a community-based research approach with an Indigenous research project, there can be tensions between Western and Indigenous knowledge systems among the research team and/or with the community. The Piliriqatigiinniq Model for Community Health Research is an important addition to the dialogue about the concepts that comprise community-based participatory research and what that means for the people engaged in the projects. A growing body of literature has focused on articulating Indigenous knowledge and research epistemologies, leading the way for greater discussion of Western and Indigenous research approaches (Alfred & Corntassel, 2005; Barnhardt & Kawagley, 2005; Battiste, 2002; Battiste & Henderson, 2000; Deloria, 1995; Kovach, 2010; Wilson, 2008). This research project has contributed to this literature by articulating and implementing an Indigenous knowledge framework with a focus on Inuit epistemology and methodology, specifically, the Piliriqatigiinniq Partnership Community Health Research Model (Healey & Tagak Sr., 2014). The model highlights five Inuit concepts, which informed the research approach: Piliriqatigiinniq (working together for the common good); Pittiarniq (being good or kind); Inuuqatigitiarniq (being respectful of others); Unikkaaqatigiinniq (the philosophy of storytelling and/or the power and meaning of story); and Iqqaumaqatigiinniq (ideas or ‘knowing’ may come into ‘one’). The model calls attention to Indigenous ways of knowing and the research approaches that grow from an Indigenous worldview (Chilisa, 2012; Kovach, 2009; Wilson, 2008). With particular emphasis on relational epistemology (Thayer-Bacon, 2003), relationships, which are fostered or created as part of the research
process, are valued. The Pilirigatigiinniq model emphasizes connections between people as essential pieces of the research process from the asking of the question to engaging members of the community in the project to the collective uptake and sharing of the findings. The response of community members, organizations, and Indigenous/Inuit studies researchers to the use of this model for this study has been very positive.

I believe this topic was studied in a way that was respectful and mindful of Inuit ways of knowing and understanding wellness to the greatest extent possible within the scope of my abilities. The use of this model permitted me to explore storytelling and analysis from an Inuit perspective, which had not been utilized in public health research in Nunavut before. As a result, I was able to achieve greater insight into relationships in families today to identify historic, temporal, and contextual understandings of sexual health, which are not currently represented in the academic literature.

**Youth Perspectives on Sexual Health and Relationships: Family dialogue and social determinants**

One of the research questions posed for this study was: “What sources of information about sexual health and relationships do Nunavut youth value?” In the results section, I described the limited amount of information youth provided in the interviews, however, there are a few findings from the analysis of those interviews that are important: 1) Parents/caregivers are the preferred source of knowledge about sexual health and relationships; 2) Youth did not use the internet for sexual health information; 3) Youth related sexual decision-making to the broader community context and
determinants of health, such as poverty; and 4) Youth discussed sexual health in terms of desire and love, which is an aspect of sexual health often omitted from the discourse. Each of these points is discussed further, below.

First, youth participants indicated their preferred sources of knowledge about sexual health and relationships were parents/caregivers, even if they had not discussed sexual health with their parents/caregivers previously. They almost universally rejected the school system, the nurse/community health representative, and the Internet as preferred sources of knowledge about sexual health and relationships. Examining these findings in the context of the perspectives shared by parents in the study, it is remarkable that parents indicated that they wanted to talk to their adolescent children about sexual health, and the youth wanted to hear from their parents, however neither group was initiating these conversations. The protective benefits of parent-adolescent communication about sexual health were noted in Manuscript 3 in the Results section of this dissertation. A more in-depth discussion about the barriers to initiating these conversations is presented later in this chapter.

Second, youth participants indicated they do not use the Internet to find information about sexual health. This is an important finding because significant financial resources have been put into the development and launch of online sexual health promotion resources for youth in Nunavut in the last 3 years. Youth participants noted that the primary reason for using the Internet was to use Facebook for entertainment and communication. Similar findings were reported in a study by Jones & Biddlecom (2011) in a study of adolescents’ use of the Internet for sexual health information. The authors found that students were more likely to rely on and had greater trust in what the
researchers described as ‘traditional sexuality education sources’ such as school, family members, and friends, and were wary of sexual health information on the Internet (Jones & Biddlecom, 2011). Many respondents indicated that they knew enough about sexual health already, which may be why they were not pursuing additional information on the Internet. Most households in Nunavut do not have private Internet access in the home, therefore youth usually access the Internet through the school or Community Access Program sites, which are public spaces with controls in place on the web browsers. The intention of these controls is to protect users from sexually exploitative content, such as pornography, and they may also block content that is meant to be educational, such as sexual health education websites.

Third, youth related their understanding of sexual health and relationships to the community context, specifically, the issue of poverty and hardship. In a discussion about supports needed to make safe sexual decisions, youth talked about hunger and the number of people in the community who require assistance to feed their families and survive day-to-day. Their responses indicated that the basic needs of families in the community must be met before youth can participate in safe sexual decision-making. This is similar to some of the ideas conveyed in Maslow’s Hierarchy of Human Needs (Koltko-Rivera, 2006; Maslow, 1943), in which Maslow described a theory of human behaviour based on a series of linear steps, the first being the meeting of physiological needs and ensuring safety of body, health, and family. Youth participants described the need for physiological requirements to be met in order to make safe sexual decisions. Youth participants also described a sense of hopelessness for their future and what they perceived to be a lack of economic or scholarly opportunities in their community in the
context of sexual decision-making among their peers. In a review of the effects of social determinants of health on adolescents, Viner et al. (2012) found the strongest determinants of adolescent health worldwide were structural factors such as national wealth, income inequality, and access to education. In addition, safe and supportive families, safe and supportive schools, together with positive and supportive peers were identified as crucial factors for helping young people develop to their full potential and attain the best health in the transition to adulthood (Viner et al., 2012). Poverty in Nunavut is a widespread issue, which has drawn a significant amount of attention since 2010 when the Nunavut Roundtable on Poverty Reduction was formed to engage communities in tackling the issue. The perspectives shared by the youth participants in the present study add to this literature on the impact of social determinants on adolescents.

Last, youth discussed sexual health and relationships in terms of feelings of desire and love for their partners, which are important components to the dialogue about sexual health relationships, which are often neglected in the literature. Fine (1988) argued that the rhetoric surrounding sex education & school-based health clinics has done little to enhance the development of healthy sexual attitudes & responsible sexual behaviour in adolescents. The author advocated for a "discourse of desire," which could contribute to the intellectual, social, & sexual empowerment of young women (Fine, 1988). Fine (1988) felt the consequences of failing to develop such a discourse included teenage pregnancy, increased dropout rates and sexual victimization. Similarly, in a more recent study, Shoveller and Johnson (2006) argued that significant public health attention has focused on the ‘problems’ of youth sexual behaviour, and empirical public health
research in this area has attempted to account for mostly negative sexual health outcomes (e.g. sexually transmitted infections and teenage pregnancies) by examining individual characteristics and risk-taking behaviour. Public health practice has followed suit, focusing primarily on modifying sexual risk behaviour and lifestyle ‘choices’ (Shoveller & Johnson, 2006). The youth participant perspectives on the role of love and desire in sexual health serve as a reminder to public health practitioners and researchers that there are other lenses with which to approach the topic of sexual health and relationships, such as positive youth sexual behaviour.

While the parent interviews were rich with story and became the focus of the analysis, the few data that were collected from youth were informative. To build on those data, I collaborated with two other northern researchers and a community member to design a pilot study to explore alternative, arts-based data collection methods with youth on the topic of sexual health and romantic relationships approximately 18-months after the present study concluded. This follow-up study focused on arts-based methods, was piloted with grade nine students in Iqaluit, Nunavut, and was very successful (Healey, 2012). The second study was funded and implemented separately and was not part of my doctoral work. I share this example to demonstrate that I have not abandoned the questions about youth sexual health and that finding the answers through other means is important.
Sexual Health, Family Attachments, the Experience of Trauma, and Disruption in Inuit Relational Society

For this research project, I asked parents about their definitions of sexual health and relationships and what these terms meant to them. I asked them for their thoughts about sexual health and relationships among their teenage children and how or whether they talked to them about this topic. The parents’ stories primarily focused on their personal experiences of childhood trauma and their goal to protect their children from having the same experiences. Overwhelmingly, the responses had less to do with the traditional public health perspective on sexual health and more to do with parent-child relationships, healing from trauma, and supporting parents to have conversations with their children about sexual health. In this section, I will first discuss the two primary ways in which parents discussed trauma, and then I will discuss the impact of trauma on attachments, Inuit relational society, and sexual health.

Trauma experienced in childhood

Fifteen of seventeen mothers in this study reported having experienced sexual abuse either as an adult or as a child. Data from the 2007-2008 Inuit Health Survey indicated that 41% of adult respondents in Nunavut (52% of women respondents and 22% of men respondents) experienced severe sexual abuse in childhood (Galloway & Saudny, 2012). Child sexual abuse is a worldwide concern. It is an insidious, persistent, and serious problem that, depending on the population studied and the definition used, affects 2—62% of women and 3—16% of men as victims globally (Johnson, 2004).

Physical, emotional, and psychological consequences of child sexual abuse can persist throughout the life course (Johnson, 2004). Associated sexually transmitted
diseases (such as HIV) and suicide attempts can be fatal. In a review of existing literature on the long-term sequelae of child sexual abuse, Beitchman et al. (1992) suggested that adult women with a history of childhood sexual abuse showed greater evidence of sexual disturbance or dysfunction, depression, and were more likely than non-abused women to be re-victimized (Beitchman et al., 1992). Anxiety, fear, and suicidal ideas and behavior have also been associated with a history of childhood sexual abuse (Johnson, 2004).

Greater long-term harm is associated with abuse involving the use of force or the threat of force, penetration, and longer duration of abuse over a period of time (Beitchman et al., 1992). There is a statistically significant association between sexual abuse and a lifetime diagnosis of anxiety disorder (OR, 3.09; 95% CI, 2.43-3.94), depression (OR, 2.66; 95% CI, 2.14-3.30), eating disorders (OR, 2.72; 95% CI, 2.04-3.63), posttraumatic stress disorder (OR, 2.34; 95% CI, 1.59-3.43), sleep disorders (OR, 16.17; 95% CI, 2.06-126.76), and suicide attempts (OR, 4.14; 95% CI, 2.98-5.76) (Chen et al., 2010).

In the present study, Inuit mothers discussed personal experiences of child sexual abuse, which informed their view on sexual health and how or whether they spoke about sexual health and relationships with their children. In a report on violent victimization of Indigenous women in the Canadian provinces, Brennan (2011) found that Indigenous women were three times more likely to report violent victimization than non-Indigenous women. In a study examining lifetime and current physical and sexual abuse among 30 Native American women, Bohn (2003) found that nearly half had experienced physical and/or sexual abuse as children, over half were sexually abused at some time in their lives, and over three-quarters were abused by a partner (Bohn, 2003). All but four women (87%) had experienced physical or sexual abuse in their lifetimes (Bohn, 2003).
Significant relationships existed among childhood abuse, substance abuse, and adult re-victimization, and among cumulative lifetime abuse events, substance abuse, and depression (Bohn, 2003). Shame, guilt, vulnerability, internal fragmentation, invalidation and cultural shame were some of the feelings reported by Indigenous women who were victims of sexual abuse (McEvoy & Daniluk, 1995), which were also discussed by women in this study.

The complex sequelae of child sexual abuse have implications for the bonds and relationships between the victims of child sexual abuse and their children later in life. In one study of the parenting characteristics of female survivors of childhood sexual abuse, various aspects of parenting were considered, including childbearing patterns, the intergenerational transmission of child sexual abuse, parenting skills and behaviours, parental violence toward children, and adjustment of survivors’ children (DiLillo & Damashek, 2003). Among the more consistent trends were findings that survivors have difficulties establishing clear generational boundaries with their children, were more permissive as parents, and were more likely to use harsh physical discipline (DiLillo & Damashek, 2003). Ultimately, very little information exists in the literature, which shares any great understanding about this topic and the variety of factors that may act as buffers, for example, if the child disclosed the experience to a supportive adult at the time, if a criminal process was followed, or if the victim participated in a therapeutic healing program (DiLillo & Damashek, 2003).

In the present study, Inuit parents identified barriers they felt prevented them from discussing sexual health with their children in the sincere way they wanted to, which they attributed to their past traumas. These barriers included trustworthiness (whether they
would be perceived as a trustworthy source of information to their child), confidence in their ability to be teachers for their children, low self-esteem, having engaged in previous risky behaviours, and shame about their past traumas. Parents shared a desire to overcome these barriers and use their traumatic experiences as opportunities to teach their children. Most importantly, they asked for help and support to accomplish this. This request is an important directive for public health professionals in Nunavut.

*Trauma experienced from severed family attachments*

For the parents in this study, the experience of family separation during the residential school and settlement era were traumatic. Most of the participants described childhood memories in which their families had been forced to move to a community or were forced to send their children to residential school, or felt abandoned when a family member was evacuated for medical treatment. In the context of sexual health, when families were separated, the traditional pathways of communication about sexuality and family relationships were lost. Knowledge about sexual health, among other topics, could not be passed on. For the parents in this study, that time marked the beginning of the formation of a gap in knowledge about sexual health. They described feeling little confidence in their ability to share the knowledge they did have with their children because of the traumas they had experienced. One participant referred to this generation as the ‘lost generation.’

In a discussion about Inuit perspectives on fostering skills in children, parenting, and childrearing, Inuit Elder, Rhoda Karetak, spoke about Inuit perspectives on attachment (Karetak, 2011). In this discussion, she described the creation of the Egg, the Rock and the Able Person, 3 personality types, which develop as a result of how children
are treated by their caregivers. The complete transcript of Rhoda’s explanation is in Appendix 4. I believe Rhoda was speaking about the need to achieve balance in childrearing because there is currently an imbalance in family dynamics caused by cultural disruption and family separation (Karetak, 2013; Karetak, 2011). Parents in this study shared stories, which highlighted this imbalance, and their struggles to communicate with their adolescent children about sexual health and relationships. For most parents in the study, the experience of childhood trauma added another layer of difficulty to their struggle to communicate with their children about this topic.

Family is the central structure of the kinship-based relational Inuit society (Arnakak, 2000; Briggs, 1991, 1994; Nuttall, 1992), and the changes to this structure have been identified in other studies as a key factor in social problems experienced in northern communities (Arnakak, 2006; Healey, 2014d; INAC, 1996a; Kral et al., 2011). The cycle of trauma has continued into the next generation, perpetuating the rift in kinship relations, in relational society, and in the transmission of knowledge and philosophies (Kral et al., 2011; Pauktuutit, 2003, 2007; Wesley-Esquimaux & Smolewski, 2004; Yellow Horse Brave Heart, 2009). The Canadian settlement and residential school era fractured family bonds among Inuit and disrupted parent-child-extended family attachments by separating young children from their parents for extended periods of time (INAC, 1996k; QIA, 2010). Attachment theorists believe that in such instances, if children are unable to find a secure, safe, and loving attachment figure, they can develop a disorganized attachment pattern (Alexander, 1992; Bartholomew & Horowitz, 1991; Bowlby, 1969, 1982f; Feeney & Noller, 1990; Haft & Slade, 1989; Yeo, 2003). The literature states that parents with a disorganized attachment pattern behave in a way that
the children may perceive as threatening, for example if their behaviour is erratic, conflicting, or unreliable, or in more extreme cases, abusive or frightening to the child (Main & Hesse, 1990). This can lead the child to also develop disorganized attachment patterns, which perpetuates the rift in relationships across generations (Alexander, 1992; Haskell & Randall, 2009; Main & Hesse, 1990).

Young people in this study valued learning about sexual health and relationships from their parents/caregivers more so than any other source, even if they did not report having a strong relationship with their parents. Parents in the study wanted to talk to their children about sexual health and relationships, but identified trauma experienced from severed family attachments and the additional trauma of child sexual abuse as barriers to engaging their children in this dialogue. In the context of the original research question about how cultural change has influenced sexual health in Nunavut, I believe that the results of this study highlight that the traumatic movement away from the fundamental kinship and extended family-parent-child relationships, which previously existed, and the established knowledge transmission pathways that this facilitated, are significant factors in understanding the changing picture of sexual health among today’s young Nunavummiut.

*Cultural disruption and power in the Indigenous colonial story and its role in the definition of sexual health*

For most Indigenous populations globally, cultural changes have been imposed or produced invariably though legislation, war, disease, and industrialization brought by a colonizing group (Trimble, 2005). It was important for me to recognize that the cultural and societal changes described by the parents in this study were part of a larger colonial
story. Kirmayer, Tait, and Simpson (2009) argue that over the past century, Canadian and American government policies have perpetuated the initial process of colonization and continue to destroy Indigenous cultures and ways of life through forced sedentarization, the creation of reserves, relocation to remote regions, residential schools, chronic underfunding, bureaucratic control, and poor resourcing of essential services such as health care and education. Waldaram, Herring, and Young (2007) examined historical healing cultures and traditions among Canadian Indigenous peoples and the impact of government policies designed to suppress them. The authors argued that colonialism and its impact on the health of Indigenous peoples was most evident in the provision of poorly designed, implemented, and funded government medical services, which inadequately addressed the needs of a population faced with epidemics and acute health distress. For Arctic peoples, loss of traditional food resources and lands; unemployment or loss of livelihood; loss of cultural practices and/or language; loss of traditional knowledge, songs and stories; and/or migration are also tied to colonial policies (Alfred & Corntassel, 2005; Moffitt, 2004; Prior, 2006; QIA, 2010).

Alfred and Corntassel (2005) pointed out:

...there is a danger in allowing colonization to be the only story of Indigenous lives. It must be recognized that colonialism is a narrative in which the Settler’s power is the fundamental reference and assumption, inherently limiting Indigenous freedom and imposing a view of the world that is but an outcome or perspective on that power (p. 601).

I believe that Alfred and Corntassel (2005) are saying that the colonial story is important to know and understand, but that it is not the only story of Indigenous peoples.
There are many stories to be told, understood, and celebrated. In the present study, parents defined sexual health in terms related to place and time in history, in the context of the colonial processes of settlement and residential school. They articulated a link between their present understanding of sexual health and the historical processes related to relocation and settlement. Understanding the processes under which today’s communities evolved can help to contextualize the relationships between people and families and the factors influencing sexual health. This can contribute to informed, evidence-based public health practice and the development and implementation of appropriate sexual health interventions.

In 2010, the World Health Organization developed a framework for action for developing sexual health programs, which built upon the original World Health Organization definition of sexual health published in 2006:

“A state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled (WHO, 2006).”

The framework for action for developing sexual health programs (WHO, 2010), noted core concepts to inform action on the issue. Two of the concepts are of particular relevance to the findings in this study:

- *Sexual health is critically influenced by gender norms, roles, expectations and*
power dynamics.

• Sexual health needs to be understood within specific social, economic and political contexts (WHO, 2010).

First, I wish to discuss the role of power in sexual health. Empowerment plays an important role in achieving the safe, respectful, and pleasurable sexual experiences described in the World Health Organization definition of sexual health. Power in sexual relationships can refer to an individual’s ability to act independently, to dominate decision making, to engage in behaviour against the other partner’s wishes, or to control a partner’s actions (Pulerwitz, Gortmaker, & DeJong, 2000). Parents in this study did not discuss power in terms of partner relationships, but in a temporal sense related to events in their lives, similar to the way in which Alfred and Corntassel (2005) discussed power in the colonial experience for Indigenous peoples. Parents in this study described feeling vulnerable to those who held power over them, separated them from their families, and abused them. They described feeling disempowered by their experiences and struggled to engage their children in dialogue about sexual health as a result. Empowerment in the sexual health context can be on the individual level, for example, feeling empowered to make decisions about safe sex and condom use. It can also be on the community-level, as highlighted by Poonwassie (2001), particularly in the context of embracing Indigenous community approaches to health and wellness. At the community level, empowerment is a process that facilitates access to personal, organizational, and community resources to have control of one’s life (Hassenfeld, 1987). Supporting families to build positive relations in an environment of acceptance is empowering and contributes to overall
positive well-being (Keyes, Ryff, & Schmotkin, 2002). I believe that the findings of this study contribute to a broad, holistic understanding of the role of power in sexual health.

Second, I wish to discuss the concept related to understanding social, economic, and political contexts. In this study, parents defined sexual health in terms of their social, economic and political reality. Their understandings of sexual health were primarily defined by experiences of childhood trauma, family upheaval, separation, and disruption, which took place in a larger northern socio-political context in the 1950s and 1960s. Recent public health approaches to address sexual health concerns in Nunavut have focused on condom availability/promotion (Arsenau, 2011), school health curriculum development (Health, 2012), and web resources (Health, 2013). These approaches have largely neglected the Nunavut socio-political and historical context described by the parents in this study. The findings from this study underscore the importance of this aspect of the World Health Organization’s approach to sexual health and how the concepts therein can inform holistic sexual health promotion strategies in northern regions.

Translating the Findings to Public Health Practice

Given that the research question originated from community concern about a public health issue, I wish to highlight the findings that are relevant to public health practice in Nunavut communities.

1) Supporting parent-adolescent communication about sexual health and relationships
Parents in this study asked for support to engage their children in dialogue about sexual health. They indicated that they don’t have the words, the knowledge or the confidence to talk about sexual health with their children. Youth identified that they preferred to learn about sexual health from their parents over any other source – even if they weren’t learning from their parents at the time. The positive role of parent-child dialogue about sexual health has already been demonstrated in the sexual behaviour literature in other populations (Lenciauskiene & Zaborskis, 2008; Meschke et al., 2000; Overbeek et al., 2007; Pearson et al., 2006; Viner et al., 2012; Whitaker & Miller, 2000). Inuit knowledge, teachings, and practices regarding the life cycle, reproductive health, and sexual health are needed (Condon, 1990; Mancini Billson & Mancini, 2007; P. M. Moffitt, 2004; QIA, 2010; Steenbeek et al., 2006). The recognition and revitalization of the Inuit knowledge translation pathways is a critical step to advancing wellness in this topic area. Public health practitioners can develop resources, programs, and education opportunities to support families to achieve this goal in Nunavut.

2) Supporting families to heal from trauma and strengthen bonds

Participants in this study largely defined sexual health in terms of childhood trauma. Most parents identified unresolved trauma and shame as the primary barriers to discussing sexual health with their adolescent children. In small, northern communities, victim and perpetrator may see each other regularly, even over the course of a lifetime. This underscores the importance of making healing resources, programs, and services available to Nunavut families. This could have a positive impact on sexual health and family relationships, as well as on general wellbeing. As part of the decolonization process, Indigenous communities have focused on developing healing models that
reconnect them to traditional beliefs and practices from a holistic perspective, incorporating the mind, body, spirit, and emotions (Lavallee & Poole, 2010; McCabe, 2007; Poonwassie, 2006). These healing models can also serve as a starting place for the development of culturally relevant and effective models in Nunavut and other jurisdictions.

3) **Approaching sexual health and relationships from a perspective of collective, as well as individual, empowerment.**

Approaching sexual health and relationships through the lens of empowerment is an important direction for public health in Nunavut. In the last few decades, Indigenous community-initiated programs and services have been developed, which facilitate empowerment of individuals, families, and entire communities. The Ilisaqsivik Centre in Clyde River, Nunavut, the Poundmaker Treatment Centre in Alberta, Community Holistic Circle Healing (CHCH) in Manitoba, and the Sacred Circle in Ontario are a few examples of initiatives that have been successful in supporting the empowerment of Indigenous families and communities in Canada by revitalizing and strengthening family relationships, and could serve as useful models. The World Health Organization promotes a community empowerment model for addressing HIV and STIs, which could serve as a useful tool for public health practitioners in Nunavut (WHO, 2014).

**Considerations, Limitations, and Methodological Insight**

*Given that any knowledge that emerges from qualitative inquiry is filtered through the eyes of the researcher, it follows that new knowledge must be interpretive. A significant contribution of qualitative research, then, has been its ability to gain*
recognition that the researcher is not a neutral instrument of the research process.

(Kovach, 2009, p. 32)

In this section, I will highlight contextual and methodological considerations for this study, including the role of the researcher in the research process, to aid the reader’s interpretation of the findings.

Mays & Pope (1995) noted that qualitative research has been viewed as,

“merely an assembly of anecdote and personal impressions, strongly subject to researcher bias... [and] lacks reproducibility-the research is so personal to the researcher that there is no guarantee that a different researcher would not come to radically different conclusions; and ... lack[s] generalizability” (Mays & Pope, 1995, p. 110).

To address some of these perceptions about qualitative research, Mays & Pope (1995) recommended a series of steps to ensure reliability and validity of qualitative research findings, which I have followed. These steps included providing details of the sampling strategy, providing an account of the data collection and analysis protocols, and describing the interpretation and presentation of the findings. In addition, the Piliriqatigiinniq Model for Community Health Research, which was the model followed for this study, highlighted the concept of Iqqaumaqatigiinniq (all knowing coming into one), which included a reflection on rigour and accountability. Researcher responsiveness and openness (Morse et al., 2002); methodological coherence (Meadows et al., 2003; Morse et al., 2002); and reflection upon intentions, process, and relationships (Eakin, 2003; Kovach, 2009; Mays & Pope, 2000; Meadows et al., 2003) are all aspects of rigor
and accountability, which were followed for this study (Healey & Tagak Sr., 2014).

In this study, the research questions, the methods, and the researcher came from the community. The stories were analyzed through my eyes only. This may be considered a weakness in the study, because it created an opportunity for bias in the findings. I addressed this weakness by presenting quotes and discussing findings with knowledgeable community members and a subset of the participants. I recognize that other researchers may interpret these data through a different lens. The findings are presented through the lens of a community member and northerner. There are many results and interpretations that may come from these data and I have focused on the ones that are respectful and mindful of the communities in which the study took place. I believe that being a community member was an asset to the study, because I was able to dig deeper into the topics of sexual health, trauma, and attachment more than any previous researcher. The fact that I was a community member permitted the participants to share more of their stories with me, because they knew that my intentions were good and the motivation for this study was to benefit our communities. In addition, my great respect for the role of story in our communities ensured that I would not take the story away, as they felt other researchers had done in the past. I have provided my own reflexive accounts in the dissertation and in the appendices to situate these findings for the reader and to eliminate possible questions of bias.

The findings in this study are not representative of the entire population on the topic of sexual health, only the participants in 3 of 25 Nunavut communities, which had a story they wanted to share. Given the historical and geographical differences between communities, there are a number of stories and perspectives on sexual health and
relationships in Nunavut that could be explored in future research.

This dissertation offers many stories. There are other stories, not yet told, which will hopefully be told to others in time. These stories will add more and deeper perspectives on trauma, attachment, families, and sexual health and relationships. The main limitation of my study is that the findings can only be generalized to similar settings or contexts. However, the broad topics of trauma, family attachments, and parent-adolescent communication about sexual health are widely discussed in the literature and the findings from this study provide new insight to that community of scholarship.

It is disappointing that the youth participants were not very responsive in the face-to-face interviews. I am inspired by the fact that in a separate follow-up study, the youth responded favorably to the opportunity to share their perspectives through arts-based methods (Healey, 2012). This provided strong, evidence-based direction for future research.

It is my hope that the present study contributes to the body of knowledge on sexual health and relationships in the North, and stimulates a continuing dialogue on important community perspectives on research methods, which are responsive to Inuit ways of knowing, and on priority focus areas for public health in the Arctic.

**Future Research Directions**

Future research should continue to focus on the collection of data with and from youth on the topic of sexual health to inform evidence-based interventions using a variety of methods. Childhood trauma and sexual abuse continue to be important health issues, which are under-researched in the North. There are powerful, unresolved healing issues
in Inuit communities, which could continue to be explored through respectful, community-led research with the goal of informing evidence-based support for families. Future research should also continue to explore the role of attachment and kinships in sexual health and relationships in the North. Studies focused on individual and collective/community empowerment for sexual health and relationships would also be an important addition to the literature in future.

In this dissertation, my goal was to answer the research questions using research methods that reflect Inuit ways of knowing. The model I have presented in this dissertation is the beginning of what I hope will be an on-going exchange of ideas and research approaches that are grounded in Indigenous epistemology. Future research on the topic of Indigenous research perspectives would be a welcome addition to the dialogue.

Each of the topics of childhood trauma, family attachments, and parent-adolescent communication, and their impact on sexual health, are relevant to other communities and populations. Further research on these topics with other populations may also provide added insight to the public health community.

**Conclusion**

High rates of the sexually transmitted infections of chlamydia and gonorrhea have generated concern among community members in Nunavut. The goal of this study was to explore the perspectives of Inuit youth and parents on the topic of sexual health. The data from the parents were very compelling and became the primary focus of the study. Inuit
society is founded on a system of kinship relations, and these relations form the basis of a parent-child-extended family attachment philosophy. A series of relocation events in the Canadian Arctic in the mid 20th century led to widespread disruption of Inuit families, kinships, and attachments by separating young children from their primary caregivers for extended periods of time. Canadian Inuit families were dispersed and separated during these relocation events. Families became separated when relocated into settlements; children were taken from their parents and placed into residential schools; and family members were sent away for medical care, many never returned. The bonds between parents and children in many Inuit families across the North were severed as a result, which left many children without a reliable, safe figure on whom they could depend or turn to for knowledge, understanding, safety, or reassurance. The implication of disrupted attachments in a relational society, such as Inuit society, is also of great significance because the sharing of knowledge, customs, and practices is dependent on relationships between people and families. Separation and relocation during the settlement period traumatized families and disrupted the essence of Inuit ways of knowing, relationships, languages, practices, and pathways for the sharing of knowledge (Arnakak, 2006; Dorais & Sammons, 2000; Healey, 2014d; Healey, 2014; Kirmayer et al., 2009; Kral et al., 2011). As a result, the traditional communication pathway about sexual health and relationships was disrupted for many families. Concurrent experiences of child sexual abuse among the parents in this study compounded the trauma of being separated from their families. Severed family attachments during the settlement period and child sexual abuse were the primary factors discussed by parents as contributing to the current state of sexual health in Nunavut.
Parents shared a desire to heal from trauma and revitalize and strengthen relationships with adolescent children to teach them about sexual health and relationships. Youth identified a desire to learn from their parents and caregivers more than any other source of information. Directions for public health include supporting parent-adolescent dialogue about sexual health; incorporating holistic individual and collective empowerment-based models for sexual health promotion; and supporting parents to heal from trauma and strengthen family relationships. Taking all of these findings into account, rebuilding and strengthening family and community relationships can make significant positive contributions to sexual health and relationships by providing supportive networks for adolescents and revitalizing millennia old pathways for knowledge sharing.
APPENDIX 1 – Nunavut Research Institute License

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

SCIENTIFIC RESEARCH LICENSE
LICENSE #  01 097 11N-M

ISSUED TO:       Gwen Healey
                 School of Public Health
                 University of Toronto
                 Box 11372
                 Iqaluit, NU
                 X0A 1H0

TEAM MEMBERS:   D. Gesink

AFFILIATION:    University of Toronto

TITLE:  An exploration of the perspectives of youth and parents on ways of knowing and learning about sexual health and relationships in Nunavut

OBJECTIVES OF RESEARCH:
The research questions include: Where does the STI burden lie in Nunavut (gender and age group)? What are types of knowledge and beliefs about sexual health and relationships are valued by youth and parents of youth in Nunavut? And what do youth and parents identify as their preferred ways to learn about and share knowledge about sexual health and relationships? I hypothesize that the rapid cultural change experienced by Inuit in this region over the last several decades has led to a displacement of responsibility for the education and guidance of young people with regards to negotiating sexual relationships and partnerships.

TERMS & CONDITIONS:

DATA COLLECTION IN NU:
DATES:     August 14, 2011-December 31, 2011
LOCATION:  Iqaluit, Arviat

Scientific Research License 01 097 11N-M expires on December 31, 2011
Issued at Iqaluit, NU on August 24, 2011

Mary Ellen Thomas
Science Advisor
APPENDIX 2 – Ethics Approval from University of Toronto

PROTOCOL REFERENCE # 26417
June 3, 2011
Dr. Dionne Gesink
Dalla Lana School of Public Health
155 College St.
Toronto, On

Ms. Gwen Healey
Dalla Lana School of Public Health
155 College St.
Toronto, On

Dear Dr. Gesink and Ms. Healey:

Re: Your research protocol entitled, “An exploration of the perspectives of youth and parents on the ways of knowing and learning about sexual health and relationships in Nunavut”

ETHICS APPROVAL

Original Approval Date: June 3, 2011
Expiry Date: June 2, 2012
Continuing Review Level: 2

We are writing to advise you that the HIV Research Ethics Board has granted approval to the above-named research study, for a period of one year. Ongoing projects must be renewed prior to the expiry date.

All your most recently submitted documents have been approved for use in this study.

Any changes to the approved protocol or consent materials must be reviewed and approved through the amendment process prior to its implementation. Any adverse or unanticipated events should be reported to the Office of Research Ethics as soon as possible.

Please ensure that you submit an Annual Renewal Form or a Study Completion Report 15 to 30 days prior to the expiry date of your study. Note that annual renewals for studies cannot be accepted more than 30 days prior to the date of expiry, as per federal and international policies.

If your research has funding attached, please contact the relevant Research Funding Officer in Research Services to ensure that your funds are released.

Best wishes for the successful completion of your project.

Yours sincerely,

Dario Kuzmanovic
Research Ethics Analyst
APPENDIX 3 - Interview guides

Interview Guide for Youth Participants (16-19 years)

INTRODUCTION
If you are comfortable, I’d like to talk about sexual health with you. There is a lot of discussion among community members and health workers about the fact that, in Nunavut, we have very high rates of sexually transmitted infections and of teenage pregnancy. I would like to learn more about when and why young people choose to have sex and about where youth are learning about sexual health and relationships. I am doing this because I want to collect information that can help provide the right teaching tools to youth, teachers, health workers, parents, and community members to help young people make planned and informed decisions about their sexual health and relationships. In this interview, it doesn’t matter if you have had sex or not.

1) First, before we get into specific questions, I was wondering if you could tell me a bit about yourself. How old are you? Do you go to school? If so, what grade are you in? If not, what do you do during the day? Do you have siblings? Are they older or younger? Have you always lived in this community?

2) Have you have learned about reproduction and pregnancy before?
   Probes:
   a. From whom? parents, school, peers, Internet, TV, CHN, CHR?
   b. What was that like? What was the
   c. Ask if learned about STIs
   d. Know anything about high rates of STIs in Nunavut?
   e. Do you think this is different from how previous generations learned about reproduction and pregnancy?

3) When you think about relationships, what do you think of?
   a. What does an unhealthy relationship look like?
   b. What does a healthy relationship look like?
      i. i.e. values/qualities
   c. Do you usually see people being in healthy or unhealthy relationships?
   d. Do you have a role model for the kind of relationship you would like to be in?

4) What you think about sexual health, what does that mean to you?
   a. Do you feel like you know enough about sexual health?
   b. Why do you feel this way?
5) When learning about sexual health, where would you like to get information from? 
   PROBE: parents, school, peers, internet, TV, other, CHN, CHR

6) As I mentioned before, it doesn’t matter whether you have had sex or not. I would just 
   like to learn about what influences you in your decision to have sex or not to have 
   sex. Can you tell me a little bit about your decisions to/not to have sex? 
   Probe: 
   a. Love, peer pressure, everyone else is doing it/not doing it, bullying, fear of 
      STI or pregnancy, drinking/drugs, parental expectations, religious beliefs, 
      other...

7) Do you think people who are the same age as you are having sex? 
   a. What do you feel influences young people in your community to have 
      sex?

8) Where would you go for advice about girls/boys or being in a relationship? Who would 
   you talk to about dealing with an argument with someone you are in a relationship 
   with? 
   1) Same about sexual health

9) What kind of guidance do you feel young people need to have for healthy 
   relationships? What do you feel you need? Where do you get this guidance?

10) Do you think that parents can or should play a role in providing guidance to their 
    children about sexual health? About relationships? 
    PROBE: 
    a. would kids listen to them?; other role models; other teachers; other 
       influences; differentiating between sexual health and relationships

11) What do you think you or other young people would need in order to make safe 
    decisions about sexual health and relationships? 
    PROBE: resources, websites, parents discussion, peer teaching, pamphlets, 
    in-school sex ed, role models, confidence, etc.
Interview Guide for Parents of Youth

Introduction:
If you are comfortable, I’d like to talk about sexual health and relationships with you. There is a lot of discussion among community members and health workers about the fact that, in Nunavut, we have very high rates of sexually transmitted infections and of teenage pregnancy. I would like to learn more about when and why young people choose to have sex and about where youth are learning about sexual health and relationships. I would also like to gather similar information from parents of young people. I am doing this because I want to collect information that can help provide the right teaching tools to youth, teachers, health workers, parents, and community members to help young people make planned and informed decisions about their sexual health and relationships.

1) First, before we get into specific questions, I was wondering if you could tell me a bit about yourself. How old are you? Can you tell me about your family? How many children do you have? Did you go to school? If so, what grade did you complete? What do you do for a living? Have you always lived in this community?

2) Where have you have learned about reproduction and pregnancy before?
   Probes:
   • From whom? parents, school, peers, Internet, TV, CHN, CHR?
   • Ask if learned about STIs
   • Know anything about high rates of STIs in Nunavut?
   • Do you think this is different from how previous generations learned about reproduction and pregnancy?

3) Now I would like to talk a little bit about relationships. There are many kinds of relationships. When you think about relationships, what do you think of?
   • What does an unhealthy relationship look like?
   • What does a healthy relationship look like?
   • Do you usually see people being in healthy or unhealthy relationships?
   • Do you have a role model for the kind of relationship you would like to be in?
   • parents relationship?

4) What you think about sexual health, what does that mean to you?
   • Do you feel like you know enough about sexual health?
   • Why do you feel this way?

5) I would like to learn about where you think young people are learning about sexual health, where do you think they get information from?
6) I would like to learn about what you think influences youth in their decision to have sex or not to have sex. Can you tell me a little bit about what you think affects their decisions to/not to have sex?

   Probe:
   • Love, peer pressure, everyone else is doing it/not doing it, bullying, fear of STI or pregnancy, drinking/drugs, parental expectations, religious beliefs, other...
   • Do you think this is different from when you were younger?

7) Do you think youth who are the same age as your child are having sex?

8) Where would you go for advice about your relationship either in the past, now, or in the future? Who would you talk to about dealing with an argument with someone you are in a relationship with?

9) What kind of guidance do you feel young people need to have for healthy relationships? What do you feel you need? Where do you get this guidance?

10) Do you think that parents can or should play a role in providing guidance to their children about sexual health? About relationships?

   PROBE:
   • would kids listen to them?; other role models; other teachers; other influences; differentiating between sexual health and relationships

11) What do you think young people would need in order to make safe decisions about sexual health and relationships?

   PROBE:
   • resources, websites, parents discussion, peer teaching, pamphlets, in-school sex ed, role models, confidence, etc.
APPENDIX 4 – Published version of article entitled Piliriqatiginniq “Working in a Collaborative Way for the Common Good”: A Perspective on the Space Where Health Research Methodology and Inuit Epistemology Come Together
International Journal of Critical Indigenous Studies

Volume 7, Number 1, 2014

PILIRIQTIGIINNIQ: 'Working in a collaborative way for the common good': A perspective on the space where health research methodology and Inuit epistemology come together

By Gwen Healey, M.Sc. and Andrew Tagak Sr.
Qaujigiartiit Health Research Centre

Abstract

Increasing attention on the Arctic has led to an increase in research in this area. Health research in Arctic Indigenous communities is also increasing as part of this movement. A growing segment of the research community is focused on explaining and understanding Indigenous knowledge and ways of knowing. Researchers have become increasingly aware that Indigenous knowledge must be perceived, collected and shared in ways that are unique to, and shaped by, the communities and individuals from which this knowledge is gathered. This paper adds to this body of literature to provide Inuit perspectives on health-related research epistemologies and methodologies, with the intent that it may inform health researchers with an interest in Arctic health. The Inuit concepts of inuuqatigiitiamik ("being respectful of all people"), unikkaaqatigiinniq (story-telling), pittiarixiq ("being kind and good"), and iqqamaqatigiinniq ("all things coming into one") and piliriquitiginniq ("working together for the common good") are woven into a responsive community health research model grounded in Inuit ways of knowing which is shared and discussed.

Acknowledgements

The growth development of this model and this centre over time has been a group effort. Valuable guidance, feedback and support has been provided by Shirley Tagaiil, Janet Tamalik McGrath and Jamal Shirley in the development of this paper.

Key words

Inuit, epistemology, health research methods, relational knowledge, Indigenous knowledge.

Introduction

There has been a significant and increasing amount of attention on the Arctic in terms of research, press, exploration and resource development. Health research and research involving Inuit in Canada’s north has also been increasing. Community-based participatory research is a method that has been promoted, however, even though this methodology recognizes the role of community in the research, it still holds the Western scientific worldview above others. Concurrently, a growing body of literature has focused on articulating Indigenous knowledge and research epistemologies, leading the way for greater discussion of Western and Indigenous research approaches, and contributing to more meaningful research (Alfred 2005; Barnhardt & Kawagley 2005; Battiste 2002; Battiste & JY 2000; Deloria 1995; Kovach 2010; Wilson 2008). This paper adds to this body of literature by providing Inuit perspectives on health-related research epistemologies and methodologies, with the intent that it may inform health research approaches in Arctic communities.
Inuit are the indigenous inhabitants of the North American Arctic, whose homeland stretches from the Bering Strait to east Greenland, a distance of over 6,000 kilometres. Inuit live in Russia, Alaska, Greenland and the Canadian Arctic and share a common cultural heritage, language and genetic ancestry. Before contact, small groups of families travelled together to different camps and hunting grounds. In the Qikiqtarualik region alone, for example, Inuit lived in small, kin-based groups in over 100 locations throughout the region (QIA, 2012). Of the approximately 150,000 Inuit living in the Circumpolar region today, 45,000 live in Canada’s north. Canadian Inuit lands are known as Inuit Nunangat and comprise four regions: Nunavut Territory; Nunavik (Northern Quebec); Inuvialuit Settlement Region (northern NWT); and Nunatsiavut (northern Labrador). Comprising one-fifth of Canada’s land mass and 60% of the nation’s coastline, Nunavut occupies the largest geographical area of all the Inuit Nunangat. When the Nunavut Act was passed in conjunction with the settlement of the Nunavut Land Claims Agreement in 1993, Nunavut became Canada’s third territory. Nunavut’s new territorial government was formally established in 1999. As the authors of this article are from Nunavut and this is the context with which we are most familiar, the majority of the references in this article are to Inuit communities in Nunavut.

Ways of Knowing

Epistemology is the theory of knowledge, questioning what knowledge is, how it is acquired, and the extent to which a given subject can be known (Thayer-Bacon, 2003, p. 18). Epistemology is also the investigation of what distinguishes justified belief from opinion, particularly with regard to methods, validity and scope. It is the starting point upon which we build our theoretical assumptions. What do we know and how do we know it? Do we know it individually or collectively? Is there more than one way to know something? Do we possess knowledge or do we engage with it? Or both? Epistemology is the space in which these questions are posed and explored.

Indigenous Ways of Knowing

A growing segment of the academic community is focused on explaining and understanding Indigenous knowledge and ways of knowing. This group recognizes that such knowledge is perceived, collected and shared in ways that are unique to these communities. Battiste (2002) states that the recognition and intellectual activation of Indigenous knowledge today is an act of empowerment by Indigenous peoples. Indigenous peoples throughout the world have sustained unique worldviews and associated knowledge systems for millennia, even while going through social upheavals as a result of transformative forces beyond their control. Many of the core values, beliefs and practices associated with these worldviews have survived and are beginning to be recognized as being just as valid for today’s generations as they were for generations past. The depth of indigenous knowledge rooted in the long inhabitation of a particular place offers lessons that can benefit everyone, from educator to scientist (Barnhardt & Kawagley, 2005).

In Eurocentric thought, Indigenous knowledge has often been represented by the term ‘traditional’ knowledge, which suggests a body of relatively old data that has been handed down generation to generation relatively unchanged (Battiste, 2002). Grenier (1998) offers a view that Indigenous knowledge embodies certain characteristics that are not mutually exclusive, such as:

1 Qikiqtaruk, meaning ‘big island’, is the Inuktitut word for Baffin Island.
2 The Qikiqtaaluk region is the largest of Nunavut’s three regions: Qikiqtaaluk (western Nunavut); Kivalliq (central Nunavut and Bélcher Islands), and Qikiqtaruk (Baffin Island, Ellesmere Island and neighbouring communities).
1. Indigenous knowledge is accumulative and represents generations of experiences, careful observations and ‘trial and error’ experiments.

2. Indigenous knowledge is dynamic, with new knowledge continuously added and external knowledge adapted to suit local situations.

3. All members of the community, that is elders, women, men and children, have Indigenous knowledge.

4. The quantity and quality of Indigenous knowledge that an individual possesses will vary according to age, gender, socioeconomic status, daily experiences, roles and responsibilities in the home and the community, and so on.

5. Indigenous knowledge is stored in people’s memories and activities. It is expressed in stories, songs, folklore, proverbs, dances, myths, cultural values, beliefs, rituals, cultural community, laws, local language, artefacts, forms of communication and organization.

6. Indigenous knowledge is shared and communicated orally, as well as by specific example and through cultural practices, such as dance and rituals (Greene 1998).

In addition, Battiste (2002) also describes Indigenous knowledge as embodying a web of relationships within a specific ecological context; containing linguistic categories, rules and relationships unique to each knowledge system; having localized content and meaning; having established customs with respect to the acquiring and sharing of knowledge; and implying responsibilities for possessing various types of knowledge.

Knowledge can be viewed as being something that people develop as they have experiences with each other and the world around them (Thayer-Bacon 2003). Ideas are shared, changed and improved upon through the development of understanding and meaning that is derived from experience. Fundamentally, this knowledge is rooted in a relational epistemology—a foundation for knowing that is based on the formulation of relationships among the members of the community of knowers (Thayer-Bacon 2003, pp. 73-98). Through these relationships, knowledge is created and shared.

Relational Epistemology

Chilisa (2012) states that

Knowing is something that is socially constructed by people who have relationships and connections with each other, the living and the non-living and the environment. Knowers are seen as beings with connections to other beings, the spirits of the ancestors, and the world around them that inform what they know and how they can know it. (p. 116)

A relational epistemology draws our attention to relational forms of knowing. This differs from the common Western practice of focusing on individual descriptions of knowing. Knowing is informed by the multiple connections of knowers with other beings and the environment, by participating in events and observing nature, such as the birds, animals, rivers and mountains (Thayer-Bacon 2003, p. 183). Wilson (2008) and Getty (2010) identify that knowledge comes from the people’s histories, stories, observations of the environment, visions and spiritual insights. Each of these relationships has implications for how research is conducted.
Relations with people

Relationship building is an essential aspect of everyday life experience for Indigenous communities in Canada and around the world. Greetings become a way of building relationships and the rapport among participants and researchers—and readers. From the moment of the first greeting, we are inevitably placed in a relationship through mutual friends or through knowledge, with certain landmarks and events. We become part of the circles of relationships that are connected to one another and to which we are also accountable (Deloria 1999) (emphasis added). From a relational perspective, establishing trust and accountability is part of the development of a relationship with a colleague or research participant (Kovach 2009; Wilson 2008), which then feeds into the entire research method, from establishing rigour to respecting an ethical Indigenous knowledge framework to sharing and disseminating the results of a study.

Relationships with the land or environment

Many Indigenous peoples have a physical, emotional and spiritual connection with the land, the environment and the creatures who share this space. For example, a study of Inuit women's perceptions of pollution found that those women identified with pollution of the land being linked to mental health and wellness in the community (Egan 1999). From the perspective of participants, changing relationships with the land carried over into changing relationships in the community and substance use, ultimately affecting the health of the community overall. The Indigenous relationship with the environment and land also has implications for the way research is conducted. The construction of knowledge has to be done in a manner that builds and sustains relationships with the land and environment, and is respectful of the environment (Barnhardt & Kawagley 2005; Chilisa 2012; Getty 2010). In this context, knowledge is embodied in a connection to the land and the environment. When interviews are used as a technique for gathering data, it is best to conduct them in a setting that is familiar to the research participant and relevant to the topic of the research (such as their home, on the land or in a comfortable community space); this enables the researcher to make connections with the environment and the space where the construction of knowledge takes place.

Relationships with the spirits

Spirituality may include one's personal connection to a higher being or humanity, or the environment (Wilson 2008). Spirituality can be viewed as a connection or exercise that builds otherworldly relationships that are ceremonial in nature. Recognizing spirituality allows researchers to explore the interconnections between the sacred and practical aspects of research. Understanding comes through factual and oral history that connects to ancestral spirits (Chilisa 2012) and/or through dreams (Wilson 2008). Knowledge is also regarded as a sacred object and seeking knowledge is a spiritual quest that may begin with a ceremony (Wilson 2008). Knowing can come through prayer or dreams, as a way that people connect themselves with those around them, the living and the non-living, and the ancestral spirits. In this way, the mind, body and spirit are all involved in gathering information and understanding of the world.

Inuit Ways of Knowing

Much of the work involving Indigenous research perspectives originates from First Nations, Native Americans and Indigenous peoples in Australia and New Zealand. Very few Inuit are in academia and no work in published literature to date has provided an Inuit perspective, except for Janet Tamalik
McGrath (2011), which is the first academic work that articulates an epistemology that is unique to Inuit. McGrath’s (2011) work with the well-known and respected elder, Aupilaarjuk, focused on conveying an epistemological perspective for Inuktut (Inuit language) knowledge renewal. Given the relational knowledge perspective of Inuit, revitalization of relationships is part of renewing and sustaining Inuit languages. The language is which knowledge is conveyed is critical to the understanding of the knowledge that is conveyed because of the shared relationships between people speaking the language. McGrath and Aupilaarjuk’s collaboration conveys a great understanding of Inuit philosophical and ideological concepts.

Relational Methods for Health Research in an Inuit Context

A relational paradigm begins with the relationships between people as an important aspect of a research framework and employs an inclusive approach, rather than rejection. A holistic, relational perspective is integral to Inuit ways of knowing, but how is this actualized in the research setting? In the following section, Inuktut conceptual ideas related to health research methods and practices are shared.

Inuuqatigìlitarniq

Inuuqatigìlitarniq is the Inuit concept of respecting others, building positive relationships and caring for others. When each person considers their relationship to people and behave in ways that build this relationship, they build strength both in themselves and in others, and together as a community (Karetak 2013). This is foundational to Inuit ways of being.

Intentions and motivations.

In the health research context, part of building and fostering respectful relationships is clearly articulating one’s intentions and motivations in engaging in a study. Researchers need to be reflexive and ask themselves the questions that community members will inevitably ask them: Who are you? Where are you from? Who is your family? What are you looking at? Why do you want to know about it? What are the risks and benefits of pursuing this work? Who is it being conducted for? What will happen to the knowledge that is shared? How will we learn from each other? A commitment to an approach that is mindful of and focuses on Inuit context, knowledge, questions and perspectives is an integral part of demonstrating respect for the community at large.

Community context.

Whether one is from the community where one is working on a research project or not, an awareness for and understanding of the community context is part of acknowledging one’s respect for it. Engaging with people, place and community in a meaningful way will not only increase one’s own understanding of the community context, but also contributes to a richer understanding of the findings. For example, whether a community has a historical connection to a residential school or is currently experiencing a flurry of resource development, the community context and response to such events plays a role in wellness and in relational ways of knowing.
The formation of the question(s).

Having created a descriptive picture of community contexts and understandings, as well as one's own intentions and motivations, it is easier, now, to collectively develop the research questions on which the research will focus. Focusing a study in such a way that it will answer community health questions is part of being responsive to the needs of Inuit communities.

Developing and fostering relationships.

The development and fostering of relationships has been a focus of the natural science research community in Nunavut, and some published literature has focused on this (ACUNS 2003; Gearheard & Shirley 2007; ITK & NRI 2007). Sadly, research relationships are too often characterized at the outset by conflict, impatience and animosity; sometimes these barriers can be overcome to build trust, other times they simply cannot. Health research projects can build on existing relationships and/or forge new ones. Some practical considerations for health research include exploring how these relationships are initiated, maintained and supported; what the nature of the relationship might be; and whether a power imbalance exists. Practical implications include how communication is achieved, i.e. through regular meetings and in-person discussions or teleconferences, if over a distance; how direction is chosen and agreements are made collaboratively; how accountability is ensured; and how the methodological approach and sharing of knowledge is agreed upon.

Engagement of community members.

From a relational perspective, participants are engaged, not recruited, to participate in a project. They are engaged through the formation of relationships. A snowball engagement method, for example, focuses on the establishment of trusting relationships. Individuals volunteer to participate in the study or recommend family members, friends or colleagues who they think will be willing to participate. The project is supported by community members, who then encourage others to engage in the study through casual conversations and ‘kitchen table talks’ (Price 2007). Participants should be considered as collaborators or co-researchers when the sharing of knowledge occurs mutually, for example, in photovoice research, story-telling or narrative research, or Inuit Qajujiatuqangit (IQ or Inuit knowledge) studies. The project is supported and promoted by community members, which strengthens the response to the project, as well as contributes to greater rigour and accountability overall.

*Unikkaaqatiginniq*

*Unikkaaqatiginniq* is the Inuit concept related to story-telling, the power of story and the role of stories in Inuit ways of being.

Story-telling and the sharing of experiences.

Kovach (2009) states that a defining characteristic of Indigenous methods is the inclusion of stories and narratives by both the researcher and research participant. In an Indigenous context, stories are methodologically congruent with tribal knowledges (Wilson 2008). The Inuit have a very strong oral history and oral culture. The telling of stories is a millennia-old tradition for the sharing of knowledge, values, morals, skills, histories, legends and artistry. It is a critical aspect of the Inuit ways of life and of knowing (Bennet & Rowley 2004), and allows respondents to share personal experiences without breaking cultural rules related to confidentiality, gossip or humility. Indigenous scholars, Kovach (2009)
and Wilson (2008), have underscored the importance of ‘story’ in a research setting. In a study of determinants of health for Inuit women in Nunavut, participants drew upon examples from the community and used stories to illustrate points about important health issues, such as teenage pregnancy and custom adoption. These stories illustrated aspects of the broader health context involving the community and society relating to education and cultural identity (Healey 2006b; Healey & Meadows 2008). Understanding this approach for sharing knowledge allows for greater insight into the data and greater understanding of the meaning of the stories. Although some knowledge or practices may be disappearing, the use of stories to effectively communicate information remains part of Inuit life. It is for this reason that the recognition of the power of story is particularly important in the context of Inuit communities.

In relational epistemology, stories are shared, not collected. Interviews are conversations conducted in a natural, comfortable setting. In our work, we share a tea or coffee over a conversation. Parents may (and often do) bring their children with them. Over the course of the conversation, knowledge and experiences are shared in a common space. For example, in a study exploring the perspectives of parents on discussing a particular health topic with their teenaged children, I (Healey) shared personal experiences about my own family and raising my children, discussed resources related to the health topic, such as local people who can provide support, and the resources available to parents to facilitate conversations with their teenaged children about a health topic. This was part of the conversation and relationship-building process, and enhanced both my own experience and that of participants/collaborators while enriching the dialogue on the particular health topic being discussed. The researcher’s willingness to listen, quietly and carefully, without interrupting the story-teller, is vital; listening is in itself a critical skill that many researchers need to develop and practice.

Reflection on how stories are presented.

Ideally, stories are presented in their entirety. The presentation of the entire story allows the reader or listener to derive the messages that are relevant to that individual. Kovach (2009) shares her experience struggling with the presentation of findings in an Indigenous research perspective. She discusses her need to present the findings in two different ways:

1. one in which she associates most closely with the Indigenous methods perspective and includes the presentation of the entire story exchanged between the researcher and the research participant; and

2. a coding and thematic bundling of ideas with which she associates a more Western style of data presentation.

In the latter case, she shares her need to present the data this way to make it accessible to the academy, but feels that this contravenes with the intent of her work (and the intent of her ancestors) (Kovach 2009: 53) by extracting experiences from the contexts of their stories. Balancing the need to articulate a point in a small allotment of text space (in the case of a journal article or presentation) and the need to be respectful of the story in its entirety, is difficult to negotiate. It is our perspective that acknowledging this challenge in the presentation of findings is part of honouring the sections of the story that are omitted for the sake of time or space.
Reflections on our own interviewing experience.

Stories can be shared and told by an individual or they can be created over the course of conversation by a group of people. A dialogue about a topic is shaped by collective story-telling. When interviewing, I (Healey) am often engaged in a dialogue with the person or people with whom I am speaking. Since I am usually making contributions to the conversation, an important step in the exploration of the dialogue is to reflect upon my own story and experiences in relation to the topic(s) discussed. Articulating how my story and experiences may have shaped or in some way contributed to the conversation, allows me to tease out the experiences that are unique to the people who shared them.

Iqaumaqtiginniq

Iqaumaqtiginniq is the Inuit concept of all thoughts, or all knowing, coming into one. It is often referred to as part of the holistic Indigenous worldview.

Finding meaning and understanding.

The goal of data analysis is to find meaning and understanding in the stories, to return to the research question and to examine the data in the context that was set at the beginning of the study. In order to accomplish this, often a multi-stage process is needed, such as those described by Creswell (Creswell 2003). Thinking about and analysing dialogue at the time of the conversation with a participant or collaborator is part of the process, therefore, some meaning-making occurs immediately in the moment of the conversation. After transcription, transcripts are read and re-read several times and reflected upon. The recordings of interviews or conversations are listened to and transcripts are re-read to ensure that transcription is verbatim and to fill in any missing words. After a period of time immersed in the words and stories, ideas may start to form or crystallize (Borkan 1999; Healey & Meadows 2008). Discussing these ideas with others, colleagues, collaborators, or participants, is a critical part of the analysis at this phase, from a relational perspective (Kovach 2008; Wilson 2008). How are these ideas coming together? What do they offer to the Inuit community? What do they offer to the community of colleagues, collaborators, partners and participants? Placing the ideas in the context of the literature, the experiences of others and the experiences of the community is part of finding meaning and understanding.

Pittiarniq

Pittiarniq is the Inuit concept of ‘being good’, which can mean being ‘good’ in a philosophical and moral sense, and also in terms of action ‘good behaviour’ (for example, in the behaviour of children). The historical context of health research in Nunavut is complex. Different communities have had varying experiences with researchers coming to the north from the south. For decades, researchers have come and gone from Nunavut to conduct their research and then leave. Some had good intentions, some were ignorant of their intentions. Some developed relationships with Inuit, others conducted experiments on Inuit (Emberley 2008; Wachowich, Awa, Katsak & Katsak 1999). That experience is not unique to Inuit, which is why significant efforts have been made in Canada and in other parts of the world to define how research is carried out with Indigenous peoples, and how to create an ethical space in this context. A number of documents have been developed to guide researchers in their work with Indigenous peoples in Canada, including the Tri-Council Policy Statement, with special reference to Aboriginal Canadians, and the previously used document from the Canadian Institutes for Health

ISSN: ISSN 1837-0144 © International Journal of Critical Indigenous Studies
Research, Ethical Guidelines for Research with Aboriginal Peoples (CIHR 2006; CIHR, NSERC & SSHRC 2010).

In the Western research model, ethics are grounded in the philosophical ideas of right and wrong, good and evil. Research ethics have their root in the post-World War II, Nuremberg trials, where medical researchers were held accountable for the medical experiments that they conducted on prisoners of war. Research ethics have been reactive; created in response to those who have used their power over others to do harm primarily in the context of medical experiments conducted during World War II (WMA 1964). Five of the enduring principles of research ethics are beneficence, non-maleficence, truth/justice, dignity and autonomy. Since that time, ethical frameworks have been developed to further identify particular sub-categories of ethical behaviour from the perspective of different populations, for example, vulnerable populations, Indigenous populations, women, and children.

In 2006, we began a project to explore how ‘ethics’ had been typically conveyed in Inuititut in previous research studies. At the same time, we wanted to learn from Nunavut community members what they perceived to be ethical conduct in research. In discussions with different community members from across Nunavut, there have been three Inuititut terms that have been highlighted. The first, shared by McGrath (2004), is Pittiavatik, which is related to ‘being good, kind or well; doing good or rightly’. McGrath (2004) argues that the term Pittiavatik refers to both technical and moral excellence. Without knowledge or experience of Inuit societal values, researchers from outside of the culture and epistemology often interpret doing/being good (ethics) based on their own worldviews and assumptions about what ‘good’ is. While well-intended, those decisions can have a range of negative impacts on their particular research participants or even on Inuit society in general (Janet Tagalik McGrath 2004). The second term, shared by another community member who declined to be named, is inuqatigiltimiq, which, as mentioned earlier, is related to the concept of being respectful of others. Thirdly, pittiajumajigimmiq uulijalimanik is the remaining Inuititut term shared by Shirley Tagalik of Arviat, NU (Tagalik 2013). Inherent in this term is the belief that there is a power greater than oneself that operates in the world. It was regarded as folly to try to set oneself up above others or in dominance of the natural world or environment. Being humble and respectful of the rights of all things helped Inuit to maintain a balance in their relationships (Tagalik 2013). All of the terms refer to behaviour; that one’s actions are reflective of one’s intention to ‘do good’. In doing so, one will be respectful of other people, the land, and the relationships between and among the facets of the research. Above all, participant-collaborators must be treated with respect, appreciation and dignity.

Consent.

In research, consent is typically sought in writing. Never and more responsive means of ensuring that a participant-collaborator is informed include the use of video to demonstrate procedures or sample collection, or capturing the verbal explanation of the project and consent on audio recorder. The language in which the project is explained is very important. Consent information should be presented in English, Inuititut and/or Inuinnaqtun depending on the language preference of the participant or collaborator.

The protection of the stories.

The sensitive and private nature of the experiences shared in health research studies underscores the fact that the protection of these stories is of critical importance. Considerations for protecting the story include: presenting the story in a way that honours the story-teller; articulating the intention of the story-
teller when they shared the story; articulating the context in which it was shared; respecting whether or not they want it shared with others and, if so, in what context; whether the story-teller wants to be identified with their story or whether they want their identity kept confidential; and reflecting on how might the story be (mis)used in the future.

Accountability.

From a relational perspective, accountability is part of the process of developing or building on relationships with each participant. The relationship is what holds us accountable. Kovach (2009) shares that, for Indigenous researchers, there are often three audiences with whom we engage for transferring the knowledge of our research:

1. Findings from Indigenous research must make sense to the general Indigenous community.
2. Schema for arriving at our findings must be clearly articulated to the non-Indigenous academy.
3. Both the means for arriving at the findings, and the findings themselves, must resonate with other Indigenous researchers, who are in the best position to evaluate the research.

Researcher responsiveness and openness (Morse, Barrett, Mayan, Olson & Spiers 2002), methodological coherence (Eakin 2003; Morse et al 2002; Morse, Swanson & Kuzel 2001), and reflection upon intentions and relationships (Gearheard & Shirley 2007; ITK & NRI 2007; Meadows, Verdi & Crabtree 2003; Morse et al 2002) are all aspects of accountability in relational research.

The Pilirnqiutiginniq Model for Community Health Research.

Pilirnqiutiginniq is the concept for working in a collaborative way for the common good. The Qaujiqartuilit³ Health Research Centre has developed a model for how research should be conducted, both within the centre and by the researchers with whom the centre engages. Qaujiqartuilit developed the Pilirnqiutiginniq Partnership Model for Community Health Research in the formative years of the centre (Healey 2008). This model was developed in response to the community-identified need for health research that explores topics of concern to Nunavummiut and is collected, analysed and disseminated in a holistic and collaborative way. The Pilirnqiutiginniq model is a visual representation of the web of relationships that we have with each other and is built upon the principle that anyone can be involved in health research in some capacity if we are all working for the common good. Multi-disciplinary collaboration strengthens research projects, enriches data analysis with additional perspectives, and fosters a greater sharing of knowledge and implementation of findings across sectors. While there may not be a representative from every sector involved in every project, the model serves as a reminder to look beyond the scope of what is commonly defined as ‘health’ and ‘research’ to include knowledge-holders and stakeholders from other disciplines and walks of life. This model was developed to provide practical organizational and methodological guidance, however, the foundations run much deeper.

³ ‘Qaujiqartuilit’ is the Inuktitut word for ‘looking for knowledge'.
The model originated from a dialogue about health and the history of health research in Nunavut communities. It was derived from the stories and voices of people across Nunavut who attended community engagement sessions held between 2006 and 2008 (Healey 2006a, 2006c, 2007, 2008). While the model originated from a health perspective, the underlying principle is cross-cutting and interdisciplinary. The model is structured on the relational aspects of life in Nunavut communities—the relationships that are shared are the foundation from which we move forward to achieve wellness. Those relationships can be with anyone from any walk of life and with anything from any environment. The knowledge that is shared and created in this space is helpful for everyone. The motivations with which one engages in the project are the same—coming together for the common good and the betterment of health and wellness. The group is accountable to each other, to the relationships they have formed and/or will form together, and the relationships they have with others in their community. In essence, this is a model for an Inuit epistemology in action because it is arises from the relational perspective and is built on what was known, what is known, and what will come to be known in Inuit communities. Its development is predicated on the past, present and future experiences of Nunavummiut.  

---

4 ‘Nunavummiut’ is the Inuktitut word for ‘People of Nunavut’.
From this epistemological perspective, ethics, accountability, methodology, knowledge, understanding and our relationships with each other as human beings, as well as our environments are part of the same space. This is, in our opinion, the essence of an Inuit epistemological perspective.

The Qaujigiartiit Health Research Centre promotes the idea that research must be used as a tool for action—that when one understands the scope and breadth of the issue, one is better-equipped to move forward and take action on it. Multi-sectoral collaboration strengthens research projects, contributes added perspective to data analysis and contributes to greater dissemination and implementation of findings across sectors. Therefore, this approach can be considered to be one that promotes active engagement, the sharing of knowledge, advocacy and action.

It is particularly important in Inuit communities that research projects be collaborative and inclusive. The historical context of research in the north, including harmful and unethical research practices, have led to an environment of mistrust and displeasure with researchers in many communities (Healey 2006a, 2006b, 2007, 2008). When we lead our own research projects, we are able to focus on answering our own questions and incorporate methods that are reflective of what we know about wellness and how we know it. This view underscores the right of colonized, Indigenous peoples to construct knowledge in accordance with the self-determined definitions of what they want to know and how they want to know it.

Conclusion

It is our belief that health research should answer the questions of the people and that such research should be collaborative. We also recognize that not all projects can incorporate the methods outlined in this paper and variations exist depending on the approach incorporated in any given project. With this paper, it has been our intention to share epistemological considerations for northern community health researchers. This paper is a beginning of a dialogue and we look forward to engagement with the expansion of this literature in the future.

References


Canadian Institutes of Health Research (CIHR). 2006. Ethical Guidelines for Health Research with Aboriginal Peoples. Ottawa, Canada: Canadian Institutes of Health Research.


Declaration of Helsinki - Ethical Principles for Medical Research Involving Human Subjects (1964).


ISSN: ISSN 1837-0144 © International Journal of Critical Indigenous Studies


APPENDIX 5 – Published version of article entitled Inuit Family Understandings of Sexual Health and Relationships in Nunavut

QUALITATIVE RESEARCH

Inuit family understandings of sexual health and relationships in Nunavut

Gwen K. Healey, MSc

ABSTRACT

OBJECTIVE: To explore Inuit family understandings of sexual health and relationships in order to inform responsive public health interventions that are designed to meet the needs of Nunavummiut.

METHOD: A qualitative indigenous knowledge approach was used for this study with a focus on Inuit epistemology and methodology, as described in the Piiriiqatigiiniit Community Health Research Partnership Model. Interviews were conducted with 20 parents in three Nunavut communities in 2011. An immersion and crystallization analytical approach was used to analyze the data and to identify groupings or themes in the data. The stories shared by parents are honoured, keeping their words intact as often as possible in the presentation of results.

RESULTS: Parents in this study largely discussed sexual health in the context of historical community events related to settlement and/or residential schools. Residential schools and forced settlement into communities were linked to trauma, family separation, hardship and grief. These experiences were prominent in participants’ understandings of sexual health and perceptions of sexual health behaviours among youth in the community.

CONCLUSION: This study highlights the complexity of the landscape of sexual health in Nunavut and the need for public health approaches that are inclusive of Inuit family perspectives on sexual health. Greater understanding of historical and community context can contribute to the development of pertinent, evidence-based public health interventions that will meet the needs of the population.

KEY WORDS: Inuit; family health; social determinants of health; indigenous population; reproductive health

Nunavut parents of today’s youth generation (13–19 years) have pointed out that the high rates of teen pregnancy among young Nunavummiut, i.e., 119/1,000 for youth aged 15–19, are worrisome. In addition, Nunavut Territory consistently reports the highest rates of chlamydia and gonorrhea (3,772/100,000 and 1,588/100,000, respectively), both of which are sexually transmitted infections (STIs), compared with Canadian rates (259/100,000 and 33/100,000, respectively). These rates have been high and have remained high for many years. Public health approaches have largely focused on reducing rates of STIs and unwanted teen pregnancies, but the rates have not declined. The purpose of the study was to explore Inuit family perspectives on the factors that they perceive to be shaping the present-day picture of sexual health and relationships in Nunavut, with particular attention to (but not limited to) relevance to young people, in an effort to inform public health interventions in Nunavut.

BACKGROUND

Inuit are the indigenous inhabitants of the North American Arctic, whose homeland stretches from the Bering Strait to east Greenland, a distance of over 6,000 kilometres. Nunavut is one of the four territories whose homeland stretches from the Bering Strait to east Greenland, Inuit being the indigenous inhabitants of the North American Arctic. Today, there are 25 communities in Nunavut ranging in size from a population of 110 to a population of 7,000. The population of Nunavut in 2011 was 29,474, of whom approximately 85% are Inuit. Nunavut has a very young population: in 2006, 53% of the population were individuals 24 years of age and younger.

Historical context of Nunavut

Before contact, small groups of Inuit families travelled together to different camps and hunting grounds, in iļļigat̓ı̨ı̨ nunaqivakt̓angat̓ (“a place used regularly or seasonally by Inuit for hunting, harvesting and/or gathering”). In the Qikiqtaaluk (Baffin) region, for example, Inuit lived in small, kin-based groups in over 100 locations throughout the region. Today there are 12 permanent communities in the region. Before formal schooling was introduced, Inuit

© Canadian Public Health Association, 2014. All rights reserved.
INUIT FAMILIES AND SEXUAL HEALTH IN NUNAVUT

children learned the skills they needed to carry out their traditional roles by observation and practice.24 They acquired knowledge and skills by accompanying parents on harvesting activities25 preparing skins and sewing clothing; and observing and assisting with child-rearing, food preparation, and camp life.26,27 While specific practices (i.e., practices related to childbirth) differed among camps/regions in the pre-settlement period, generally teachings related to family and reproductive health were supported equally by both men and women and embedded in everyday life activities and conversations in the family.28,29

Relocation and settlement

A process of relocation to more central sites began as a response by Inuit to the presence of traders, explorers and missionaries. It took new form with systematic efforts by the government in the 1940s and 1950s to “re-settle” Canada’s North. At the beginning of this period, Inuit in the Central and Eastern Arctic were still actively involved in the fur trade and were living off the land. The presence of the military, resource development and missionary activity were increasing, and tuberculosis and polo epidemics took a toll among Inuit.30 The Report of the Royal Commission on Aboriginal Peoples (1996) notes that in these years government administrators were troubled by the health and welfare reports that came to see the North as being in a state of crisis that required immediate attention.31 At that time, the Canadian government implemented resettlement programs in the eastern Canadian Arctic in an effort to 1) protect Canada’s sovereignty post-World War II; 2) facilitate the opening of trading posts by the Hudson’s Bay Company; and 3) police, educate and provide health care for remote populations.32,33 Inuit were not consulted about these changes, and many never knew why they were imposed on them and in such a short period of time.34 The agencies of the Government of Canada that were responsible for the implementation of settlement policies are still not fully aware of their own history in the Arctic or the effects of their decisions and actions.35 By 1956, one in seven Inuit was living in a tuberculosis sanatorium in southern Canada for treatment.36

Residential school

In the first 50 years of the 20th century, attempts by outsiders to teach Inuit children reading, writing and arithmetic were scattered and inconsistent. In 1951, the first government-regulated school for Inuit was opened in Chesterfield Inlet.37 Inuit parents were asked to place their children in school hostels for all or a portion of the school year while parents and non-school-age siblings returned to their camps. Inuit parents who agreed to schooling did not wish to leave their children alone and often came to the settlement with their families, living in tents until housing was available. For some communities, up to three generations of Inuit children were sent away from their families to attend schools in larger communities.38 This caused great anguish for both the parents and the children. Residential schools for Inuit continued to open into the 1960s, and by 1963, there were 3,997 Inuit children attending the schools.39 In June 1964, 73% of 6- to 15-year-old Inuit children and youth were enrolled in the schools. These students are the parents and grandparents, uncles and aunts of today.

Inuit of northern Canada, as with other indigenous groups in Canada, have and continue to experience a shift in a way of living over the last several decades. Those who were medically evacuated for tuberculosis or other medical treatment often returned to their communities up to a year or more later, if at all, and residential school students were away from their families for up to 10 months of the year.40 These individuals were disconnected from their family, culture, language and community upon their return.41,42 The reports of physical, emotional, mental and sexual abuse of children during the residential school era are well documented.43 The experiences of resettled Inuit continue to have an impact on many Nunavut residents to this day.

Sexual health

Sexual health is a critical part of public health and is an important part of healthy living. Health education and public health interventions are used to teach the skills, knowledge and behaviours to maintain good sexual and reproductive health throughout life. Sexual health has been highlighted as a serious public health concern in Nunavut44,45 by parents and community members, and the territory reports the highest rates of chlamydia and gonococcal infection in all of Canada.46,47 The World Health Organisation (2002) defines sexual health as, “a state of physical, emotional, mental and social well-being related to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled.”48 In Nunavut, sexual health education is part of the school curriculum, and community health representatives, physicians and nurses provide additional support when and where available.

METHODS

This qualitative participatory research study explored a topic identified by community members through a series of consultations conducted in Nunavut between 2006 and 2008.49 The researcher was born and raised in Nunavut, lives and works in the community as a health researcher, and initiated the study at the request of fellow community members. The research project was designed and implemented in partnership with community wellness or research centres in each of the three communities. The project was supported in principle by Nunavut Tunngavik Incorporated and the Chief Medical Officer of Health for Nunavut. The research protocol was reviewed by community members and community wellness committees in the three communities, and their feedback was provided to the Nunavut Research Institute, which had granted a research licence. Ethical approval was granted by the University of Toronto Community-Based HIV/AIDS Research Ethics Board.

Decolonizing research is a process of conducting research with indigenous communities, placing indigenous voices and epistemologies in the centre of the research process.2 It critically examines the underlying assumptions that inform the research and challenges the widely accepted belief that Western methods and ways of knowing are the only objective, true science, marginalizing indigenous methods and ways of knowing.

This research project was conducted within an indigenous knowledge framework and with a focus on Inuit epistemology and
methodology, specifically, the Pīnitaqatiginniqtigi Partnership Community Health Research Model.24 The model highlights five Inuit concepts that informed the research approach: Pīnitaqatiginniqtigi (the concept of working together for the common good); Pīlīlilmiiq (the concept of being good or kind); Iujuatiginniqtigi (the concept of being respectful of others); Unikkaaqaatiginniqtigi (the philosophy of story-telling and/or the power and meaning of story); and Igasuqaatiginniqtigi (the concept that ideas or thoughts may come into "one"). The model calls attention to indigenous ways of knowing and the research approaches that grow from an indigenous worldview.25 With particular emphasis on relational epistemology26 and recognizing relationships that are fostered or created as part of the research process, the Pīnitaqatiginniqtigi model emphasizes connections between people as essential to the research process, from asking the question, to engaging members of the community in the project, to the collective uptake and sharing of the findings. A paper outlining the theoretical and methodological aspects of this study in greater detail is published elsewhere.28

Participants were engaged in the study through community health and wellness centres and were offered the opportunity to be project partners if they so desired. The researcher is from Nunavut and had existing, trusting relationships with many of the organizations and individuals who volunteered to be part of the study. This added richness and depth to the dialogue. Interviews were conducted in a comfortable setting chosen by the participant, recorded with permission and transcribed verbatim. Participants were asked open-ended questions and invited to tell stories and share experiences in English, Inuktitut or Inuit. University, parents chose English, with the exception of one community where participants alternated between English and Inuktitut terminology. Translations were provided by the researcher and verified for accuracy by a third party when needed.

Data were analyzed through a process of immersion and crystallization29 which, from the perspective of the researcher, is a process that is analogous to the Inuit concept of Igasuqaatiginniqtigi. Through a process of reading and re-reading transcripts and highlighting stories in the text, several themes crystallized in the data. A rigorous, respectful and mindful process was followed for the data analysis, which included the comparison of findings with the known literature on the topic; discussion of findings with the local Nunavut-based advisors, who included representatives from two community wellness centres,* the Chief Medical Officer of Health for Nunavut, a community health representative and a public health nurse; member-checking with participants or collaborators when and where appropriate to develop the analysis; and honouring the stories that were shared by parents by keeping their words intact as often as possible in the presentation of results without breaching confidentiality.

RESULTS

Twenty interviews were conducted in three geographically, regionally and historically distinct Nunavut communities with Inuit parents who had at least one teenage son or daughter between the ages of 13 and 19 years. The population of the communities ranged from 1,200 to 7,000. Of the parents who volunteered to be interviewed for this study, 3 were fathers and 17 were mothers; 19 of 20 did not complete high school; 11 were employed in part-time, seasonal or casual work, 3 were unemployed, and 6 were employed full-time. Parents shared stories of their own personal experiences, as well as those of family members and observations of the community. They spoke of relationships at the individual level as well as in the larger community and the historical context of the region.

Parents were asked open-ended questions about what terms like "relationships" and "sexual health" mean to them, and whether they discussed these topics with their children. The term "sexual health" was largely defined by parents in relation to community and a social context. In answering the questions, parents identified specific events in community and residential schools. Parents shared specific experiences of childhood trauma, hardship and sexual abuse related to these events. They often highlighted their desire to create a different path for their own children as a result of the traumas they had experienced. Themes are presented in English, as that is the language in which the stories were conveyed, mirroring the way in which parents shared experiences within a larger community issue.

Settlement and displacement

Participants associated general changes in the behaviour and attitudes of community members regarding sexual health and relationships with the settlement period. For example, before settlement, relationships or unions were primarily arranged by the members of the families or camps. As a result of settlement, young people living in a community group met others in their peer group from other camps and from outside of the North. Participants in this study perceived a decline in arranged unions and an increase in short-term relationships in the community from this point in time. Commenting on the high rate of teen pregnancy in his community, which he perceived to be related to increasing short-term relationships, one father stated:

"I think [young people] think it's normal [to have children at 14 or 15 years of age]. Because back in 1940s and 50s there was 7 to 8 different tribes...and when they first got together, a lot of things were happening. So, from that time, it started. To having sex wherever they were [with whoever they want]—oh look at that person [or] that new person, and would start having [a relationship]. Ever since then, it's been going on. So, it's going to be hard to stop it like that. *wags fingers*". – Father

Participants associated settlement life with an increase in alcohol availability and binge drinking in the community. Participants recalled binge-drinking episodes in their communities during their childhood, during which many experienced sexual abuse as children and/or adolescents. Today, alcohol remains a controlled commodity in the majority of northern communities, which has led to an underground community of bootleggers in many locations.

"And there's a lot of bootlegging happening in the communities. And the youth will easily sneak some of that. You know and so - maybe the same throughout Nunavut. Not just in [my community]." – Father

From the perspective of parents, the availability and the potential use of alcohol among their children and peers would compromise their ability to protect their children from the harm or abuse they had experienced as children.

* The Avitat Community Wellness Centre and a second that declined to be named.
INUIT FAMILIES AND SEXUAL HEALTH IN NUNAVUT

The displacement experienced by families as a result of medical evacuations and/or residential school during and after settlement was associated with extreme hardship. For one participant, it meant engaging in sex for money to support herself and a younger sibling while their lone parent was evacuated with tuberculosis (TB).

("[my only parent] was out in [southern Canadian city]. [They] had TB. And I was wondering how come me and my [sibling] was being sent out to [residential school]. That part I really couldn’t understand. I remember being taken away but I really can’t remember why. Growing up I was abused. A lot. Physically. Sexually abused. When I was 13 – 14 [back in the community] I started drinking. And I needed to put food on the table, I have to sell my body just to put food on the table for me and my [sibling]. We were so poor [and had no family to rely on]."

Mother

The displacement and settlement was a central theme in the interviews. This separation frustrated family communication about sexuality. For the participants, the displacement of families was associated with grief, trauma and hardship. Some parents shared the fact that they continue to struggle to cope with the trauma they experienced as children and that their relationships with their own children have been negatively affected as a result. In these cases, parents felt they lacked the confidence, stability or integrity, in the eyes of their children, to discuss sexual health with them even though they very much wanted to have those conversations. They worried about how and by whom their children were being influenced to make decisions to engage (or not to engage) in relationships if they were not able to provide guidance themselves.

Residential school

Of the participants who attended residential school, none shared a positive experience. In one community, more than one generation of many families attended residential school. One participant described the impact of the school system on her parents and her own personal family life.

"... And then while I was growing up, too, I was getting abuse from my mom. So, um, I grew up in a violent home. Very bullying and mental, physical. By my mother. Well, she went to school in Iqaluit, too. And she was trying to follow the rules of how she was brought up with us. And I didn’t like it. And then when I went to school, it was the same thing. So, I was doing that to my kids, you know, not knowing about it? I was hitting them for no reason. And then [my spouse] finally sat me down and asked me if I was abused when I was young... I said, yep. He said, ‘Look, what you’re doing to your kids, is what [they] did to you. And you’re doing that.’ I just burst out crying and in front of my kids. And I told them I’m sorry.” – Mother

Most participants discussed sexual health in terms of preventing child sexual abuse, including fathers who shared that their spouses had been sexually abused as children. Mothers talked about experiencing child abuse (physical, sexual, emotional and/or mental) while attending residential school (by school staff or residence monitors) or by members of their home community who had attended residential schools. Many of the mothers in the study described how these experiences informed their discussions with their own children in an effort to protect them from such acts.

"With my kids, I’m a mother and I can teach them... I talk to them. What I have learned. And it’s been so many years since that [sexual abuse] had happened to me before... So I was only 8 or 9 years old when that happened. I try to protect them. I show them my love. Sometimes I have to try not to be mean, but I’m angry at the same time. I’m talking to them because I have this anger with me... I never told my mother before about that [sexual abuse]. Never told my father. So I kept it in me. [That anger] grew within me... until I spoke to the RCMP. I never thought I’d have a family of my own because of that anger. Scared. I was shy, scared. Now I have a family of my own. I could teach them. My children.” – Mother

Some mothers reported that sharing their experiences of child sexual abuse with their children was part of their personal healing process and gave them hope that they would be able to protect their children from the same experiences.

DISCUSSION

The World Health Organization definition of sexual health is holistic and inclusive; however, conventional public health programs largely focus on harm reduction approaches that target prevention of teen pregnancies and STIs. While the current study was initiated in response to parent and community concern about teen pregnancies and high rates of STIs, the stories and experiences of the parents in this study primarily highlighted their need to protect their children from the harms of child sexual abuse. The experience of settlement changed family and community relationships in Canada’s North. The displacement of families and the hardships experienced by children during this period has been one of the most socially destructive forces of this era of Canadian history. Settlement and displacement fractured family relationships and communication about sexuality. Recognizing and moving forward from past trauma and building on cultural strengths and identity in communities that have felt such impacts are key messages for public health practice from this area of work. The parents in this study identified a desire to teach their children about sexual health and asked for the supports to do so, which provides a clear direction for public health programming in Nunavut.

CONCLUSION

The results of this study indicate that sexual health understandings in Nunavut today are related to the far-reaching impact of colonial practices initiated decades ago. Nunavummuit continue to feel the impact of the power imbalances created by colonialism, as do other Northern peoples. The landscape of sexual health in Nunavut is complex, and evidence-based public health interventions that will meet the needs of the population must incorporate a greater understanding of the historical and community context in which people live. Future research should expand on these findings to explore holistic, culturally relevant, community-led sexual health interventions and access to responsive healing and trauma support services for families. Additional data should be sought from parents and adolescents, giving voice to their collective stories and experiences.

REFERENCES

INUIT FAMILIES AND SEXUAL HEALTH IN NUNAVUT

OBJECTIF : Explorer les connaissances des familles inuites en matière de santé sexuelle et de relations sexuelles afin d’éclairer la mise au point d’interventions de santé publique sensibles aux besoins de la population du Nunavut.


CONCLUSION : L’étude fait ressortir la complexité du paysage de la santé sexuelle et des relations sexuelles dans les communautés inuites, soulignant l’importance de prendre en compte les perspectives des familles inuites dans l’élaboration des stratégies de santé publique. Les résultats de cette étude confortent la nécessité de meilleures connaissances du contexte historique et communautaire pour élaborer des stratégies de santé publique pertinentes, fondées sur des données probantes, qui répondront aux besoins de la population inuite.

MOTS CLEFS : Inuits, santé de la famille, déterminants sociaux de la santé, population indienne, santé générique
APPENDIX 6 - Published version of article entitled Inuit parent perspectives on sexual health communication with adolescent children in Nunavut
Inuit parent perspectives on sexual health communication with adolescent children in Nunavut: “It’s kinda hard for me to try to find the words”

Gwen Healey*

Qaujigiartiit Health Research Centre, Iqaluit, Nunavut, Canada

**Background.** For Inuit, the family unit has always played a central role in life and in survival. Social changes in Inuit communities have resulted in significant transformations to economic, political and cultural aspects of Inuit society. Where the family unit was once the setting for dialogue on family relations and sexuality, this has largely been replaced by teachings from the medical community and/or the school system.

**Objective.** The purpose of this study was to explore Inuit parent perspectives on sharing knowledge with teenage children about sexual health and relationships.

**Method.** A qualitative Indigenous knowledge approach was used for this study with a focus on Inuit ways of knowing as described in the Piliriqattigiinniq Community Health Research Partnership Model. Interviews were conducted with 20 individual parents in 3 Nunavut communities in 2011. Parents were asked about whether and how they talk to their children about sexual health and relationships. An analytical approach building on the concept of *Iqqaumaqatigiiniq* (“all knowing coming into one”), which is similar to “immersion and crystallization,” was used to identify story elements, groupings or themes in the data. The stories shared by parents are honoured, keeping their words intact as often as possible in the presentation of results.

**Results.** Parents shared stories of themselves, family members and observations of the community. Fifteen of 17 mothers in the study reported having experienced sexual abuse as children or adolescents. Parents identified the challenges that they have and continue to experience as a result of forced settlement, family displacement and the transition of Inuit society. They expressed a desire to teach their children about sexual health and relationships and identified the need for emotional support to do this in the wake of the trauma they have experienced. Parents highly valued elders and the knowledge they have about family relationships and childrearing.

**Conclusion.** There are powerful, unresolved healing issues in Inuit communities. The traumatic experiences of the settlement and residential school era continue to have an impact on present-day family relationships. To support parent-child dialogue on sexual health and relationships, parents identified a need to repair relationships between youth and elders, and to provide culturally sensitive support to parents to heal from trauma.

**Keywords:** Inuit; sexual health; public health; adolescents

*Correspondence to: Gwen Healey, PO Box 11372, Iqaluit, Nunavut, X0A 0H0, Canada, Email: gwen.healey@qhrc.ca

Received: 30 May 2014; Revised: 22 September 2014; Accepted: 22 September 2014; Published: 21 October 2014

In 2009, Nunavut reported high rates of chlamydia and gonorrhoea, both of which are sexually transmitted infections, (3,773/100,000 and 1,588/100,000, respectively), compared to Canadians (259/100,000 and 33/100,000, respectively) (1). Concerns about these high rates and the high rates of teen pregnancy in Nunavut (161.3/1,000 compared to 38.2/1,000 in the rest of Canada) prompted community members in Nunavut to ask questions about how parents and their children talk about sexual health (2–4). The family unit was once the setting for dialogue on family relations, reproductive health and sexuality, and this has largely been replaced by teachings from the medical community and/or the school system. The purpose of this study was to explore Inuit parent perspectives on sharing knowledge with adolescent children about sexual health and partner relationships.

Family is the primary context in which a child grows, develops an identity, is socialized, is hurt and healed, and
Gwen Healey

navigates physical and social development (5). The family is a naturally occurring unit and the context in which most behaviour-shaping experiences can occur. In recent years, increased attention has been given to the role of the family in predicting and understanding the sexual behaviour of adolescents in the literature (6–9). Family factors, such as communication, availability of parents, spending time together outside the home and engaging in activities together can have an impact on the extent to which behaviour problems or choices endure and become part of a healthy or unhealthy lifestyle (5,7,10). For example, adolescents who reported positive relationships and shared activities with parents were less likely to initiate sex (7). Parental communication about sex and condom use has been shown to directly relate to adolescent sexual behaviour (8). Whitaker and Müller (8) found that peer norms were more strongly related to sexual decision making among adolescents who had not discussed sex or condoms with a parent. The authors suggest that results indicate that a lack of communication may cause adolescents to turn to peers and that peers may then influence their behaviour. Parental discussions have been associated with less risky sexual behaviour among adolescents, less conformity to peer norms and a greater belief that parents provide the most useful information about sex (6,8,11). Research has shown that adolescents are more likely to use birth control when there is parental support to do so (12). In addition, research has shown that some teens want to have discussions about sex with their parents and other caregivers, more so than others, to help them understand sexuality and to guide them in their own decision making (13). Parent–teen discussions about sexual health topics are important because they (a) provide information to teens, (b) they reinforce parental values and (c) they buffer teens from peer pressure (8). Parental closeness and monitoring, rather than the actual specifics of parent–child communication, may also play a role because parents who talk to their children about sex or condoms may have already established closer relationships with their children (8,11).

For Inuit, the family unit has always played a central role in life and in survival (14). Inuit kinship extends beyond familial affiliation to other non-biological affiliations including adoption, friendship, marriage or partnership, and namesake (15–18). Every person had a specific and essential role to play in making contributions towards family survival and the education of young children and adolescents (16,19,20). Before contact, small groups of Inuit families travelled together to different camps and hunting grounds, in ilagitt nimangiyuqatarnat. Each person within a kinship group was valued for his or her contribution to the group’s well-being and success. A child’s earliest learning occurred as they observed and made meaning from the actions of their parents and extended family in the camp (22,23). Children learned valuable behaviours, such as self-restraint, patience, non-aggressiveness, generosity and responsibility, by watching their family members lead by example (16,24,25).

When Inuit lived in family-based nomadic camps, teaching about sexual health and relationships was part of a dialogue between children and their parents or extended family, which occurred as part of the sharing of knowledge on a variety of topics. Painngut Peterllooosie (26) highlighted the importance that was placed on the openness of the relationship dialogue between romantic partners in discussing, for example, menstruation, sex or sexual satisfaction. After the settlement era in the 1950s, during which time Inuit settled into communities, were sent to residential school and/or were sent away to Canadian cities for medical treatment, parent–child–extended family interaction changed significantly because many families were separated and displaced (21,27,28).

Today in Nunavut, as in many other jurisdictions, parents and family are no longer the sole source for information about sexual health knowledge and behaviours, if they are a source at all (24,29–33). The school system, peers, television, Internet, media, community members, teachers and others now play a role in the transmission of attitudes, knowledge and beliefs about sexual health behaviours (29,33,34). In a study of the perspectives of 53 Inuit women on teen pregnancy, some respondents identified less parental control over young people and greater influence on behaviour from other individuals outside of the family as a worrisome trend in larger communities compared to pre-settlement times (29). In a review of determinants of sexual health among Inuit adolescents, Steenbeek, Tyndall (32) asserted that Inuit parents and grandparents did not feel competent to instruct their own children in sexual health. Trauma experienced during and after the settlement and settlement era in the Eastern Arctic (35,36); the loss of accumulated Inuit wisdom, knowledge, teachings and practices regarding life cycle, reproductive health and family planning that occurred as a result (21,30,32,37,38); and the changing nature of northern communities (28,29,39) could be factors contributing to the lack of confidence reported among parents.

Methods

This qualitative participatory research study explored the topic of Inuit family communication about sexual health and relationships at the request of community members who participated in consultations conducted in Nunavut between 2006 and 2008 (2,40). Their request was prompted by the high rates of sexually transmitted infections and high rate of teenage pregnancy in Nunavut communities.

1. Inuktitut terminology meaning, “a place used regularly or seasonally by Inuit for hunting, harvesting and/ or gathering” (21).
Sexual health communication with adolescent children in Nunavut

compared to the Canadian population. The research project was designed and implemented in partnership with community wellness or research centres in each of 3 Nunavut communities. The researcher is from Nunavut and familiar with community and territorial research protocols. This study followed a modified grounded theory approach (41), which retains most of the defined characteristics of “classic” grounded theory, but takes a more subjective and reflexive stance which is more aligned with Indigenous knowledge and ways of knowing (42–44). The research framework focused on Inuit ways of knowing, specifically following the Piliriaqtiginniq Partnership Community Health Research Model (45). The model highlights 5 Inuit concepts, which informed the research approach: Piliriaqtiginniq (the concept of working together for the common good); Pitsiuarngiq (the concept of being good or kind); Innaaqatiginniq (the concept of being respectful of others); Unikkaaqatiginniq (the philosophy of story-telling and/or the power and meaning of story); and Iqqumnaaqatiginniq (the concept that ideas or thoughts may come into “one”). A paper outlining the theoretical and methodological aspects of this study in greater detail is published elsewhere (45). Participants were engaged in the study through community health and wellness centres and were offered the opportunity to be project partners if they so desired. Inuit parents who had at least 1 teenage son or daughter between the age of 13 and 19 years were invited to participate. Interviews were conducted in a comfortable setting chosen by the participant, recorded with permission and transcribed verbatim. All questions were asked in English, and participants primarily responded in English. In the cases where they responded in Inuktitut, the author provided the translation and verified the translation with a third party. Parents most often spoke of parent–adolescent communication: “It’s kinda hard for me to find the words” (page number not for citation purpose) and a public health nurse (50); reviewing the findings with participants or collaborators when and where appropriate (51); and honouring the stories, shared by parents, by keeping their words intact as often as possible in the presentation of results without breaching confidentiality (42,45).

Results

Twenty interviews were conducted in 3 Nunavut communities. The population of the communities ranged from 1,200 to 7,000. The respondents were aged between 30 and 58. Of the Inuit parents who volunteered to be interviewed for this study, 3 were fathers and 17 were mothers; 19 of 20 did not complete high school; 11 were employed in part-time, seasonal or casual work, 3 were unemployed and 6 were employed full-time. When asked about whether they spoke to their children about “sexual health,” parents described sexual health at the individual level as well as in the larger community and historic context. In response to the question about where they learned about sexual health, most mothers in the study disclosed being sexually abused as a child or adolescent. They stated that their experiences of child sexual abuse made them feel inadequate to talk to their children about sexual health. Both mothers and fathers shared a desire to teach their children about sexual health and relationships, and identified a need for support to help them do this, possibly by including elders. There were 2 primary themes in the data: (a) Parent–adolescent communication: “It’s kinda hard for me to find the words” and (b) Bringing elders and young people together to talk about sexual health. Themes and quotes are presented in English, as that is the language in which the stories were conveyed, mirroring the way in which parents shared experiences.

Parent–adolescent communication: “It’s kinda hard for me to find the words”

Parents most often spoke of parent–adolescent communication in terms of what they perceived to be a struggle “between worlds” and how this struggle impacted relationships with their children. Parents in this study were among the first generation of Inuit born into permanent settlements. Their parents were often born and raised on the land in nomadic Inuit camps. The children of that era are the parents of today’s youth generation. Participants spoke of the struggles families experienced adjusting to this “different world,” meaning the world of permanent settlements and the expectations of non-Inuit institutions, such as schools, nursing stations or the police force, in these new communities. When asked to explain the perceived divide between the parent and adolescent generations and impact on communication about sexual health, one father said:

When the kids are not listening to parents today maybe [it’s] because the mother or the father is

---

1The Arviat Community Wellness Centre and the 2nd declined to be named.

Citation: Int J Circumpolar Health 2014, 73: 25070 - http://dx.doi.org/10.3402/ijch.v73.25070
yelling to them. The child becomes too hard and it seems like they don’t want to listen to the parents anymore. Because they yell . . . yeah, they yell too much. That they become hard. Hard and they will forget in their mind their childhood when they’re older. So, some parents yell too much to the kids. Some parents are quiet. Some parents are keeping it [inside]. Different world now, different families. We all have different problems. Some people are [in a] very happy family. Some people are in not very good families. Some people are [in] very scary families. Some people are really not good – not welcoming people [in their] families. Like we’re all different.

– Father

Many of the parents in this study reported experiencing trauma, poverty and/or hardship in their childhood during this period of transition. Violence, substance use and/or mental illness are part of the pattern of ill-health in today’s communities resulting from a lack of support to cope with those experiences. Parents described violence, substance use and unresolved trauma as factors that have perpetuated fractures in family relationships and in parent–adolescent communication about sexual health.

Parents in this study expressed a very strong desire to talk to their children about sexual health and relationships but questioned their confidence to teach their children. Fifteen of 17 mothers in the study disclosed experiences of sexual abuse in childhood or adolescence, and often described sexual health in terms of protecting their children from being similarly harmed. However, parents feared that they would be judged by their children for having engaged in the same behaviours that they are trying to prevent.

I’ve been on and off with a relationship with [my children’s] father. And when we have our ups and downs – when he comes and goes like takes off and then – my daughter knows that – she knows I’m down and then I start telling her – I said when you’re a teenager, don’t ever get a boyfriend. I said don’t ever get a boyfriend from here. Like you’ve got to find the right one and that’s not abusive and like won’t cheat on you and won’t play games. So it’s kinda hard for me to tell her more like, but I don’t want to hurt her. Because every parent has a role and to have brighter, healthier future they should talk to their kids.

Bringing elders and young people together to discuss sexual health

In the context of parent–adolescent communication about sexual health, some parents talked about personal relationships among their parents’ generation – those who are now elders in the community. They spoke fondly of the older generation and provided stories and examples about the practices in which their parents had participated that are no longer followed today, such as arranged marriage. One participant indicated that the shift from the arranged unions of her parents’ generation to the self-selected partners of her teen daughter’s generation was new for the family and something for which she was preparing.

It’s changed a lot from [my parents] generation. Two parents – if there was a teenager, and the teenager was a boy and a girl . . . they would be set up – their relationship would be arranged. Once they reached puberty or once they get older, they would be living together. Then, even at the last minute – when they’re ready to be together, there would be a marriage set up.
right away, early in the morning around 7 am right out on the land. And they would get married. Just like that. Not living with parents anymore, you just have to be with him. That’s how some of them were. Our parents [generation]. That’s how they used to be. So, I just really prepare for it—like as our ancestors used to do—prepare and all that. Looks like our teenagers are deciding who they want to marry. Who they want to be with. I just know my parents got married one day when they were 20 years old.

mother

These stories were shared to illustrate the rapid change in the formation of partner relationships within 3 generations in their communities. Participants talked about value they placed on the knowledge of elders about relationships and/or sexual health, and expressed a desire to see it revived and promoted among young people in the community. Parents indicated that while some adolescents may prefer to speak to elders or grandparents instead of their own parents, other young people may not yet be willing to listen to elders at all. In the latter situation, parents identified that the relationship between youth and elders needed to be restored. The parents felt that elders and youth were important supports for each other, and sometimes can communicate in a way that parents and youth cannot:

[Elders/grandparents] are not even trying [to talk to kids] anymore because. . . they won’t listen. They’re already listening to the music and the television and the Internet. And they don’t want to listen to their elders. They know this. That’s why [the older generation] shut their mouths. So, I guess what we need to develop is elders and young people together. Within the building, out there *gestures out the window*. And in the schools. Everywhere. On the land. When their friends are bothering them. . . or this young man or young lady wants to go out with one of my children. . . they don’t tell me; they don’t tell my wife. They always tell my mother (an elder). They talk to her. They are more open to them, than us as a parent.

Discussion

The stories shared in this study illustrated, first, how parents related their trauma history to their understanding of parent–adolescent communication in today’s communities in Nunavut. Parents described their childhood living in a “different world,” one in which families were separated and relationships were disrupted. They felt they did not have the confidence or “the words” to communicate with their children about sexual health and relationships as a result. Their stories highlight the loss of Inuit knowledge, teachings and practices regarding sexual and reproductive health that occurred as a result of the separation of families at that time (21,30,32,37,38).

Second, discussions about sexual health and relationships in the families of the participants, if they did occur, focused on teaching children to protect themselves from sexual abuse or abusive relationships. Data from the 2007–2008 Inuit Health Survey indicated that 41% of adult respondents in Nunavut (52% of women respondents and 22% of men respondents) experienced severe sexual abuse in childhood (52). Physical, emotional and psychological consequences of child sexual abuse can persist throughout the life course (53). Feelings of powerlessness and betrayal, anxiety, fear, post-traumatic stress disorder (PTSD) and suicidal ideas and behaviour have also been associated with a history of childhood sexual abuse (53–56). Shame, guilt, vulnerability, internal fragmentation, invalidation and cultural shame were some of the feelings reported by Indigenous women victims of sexual abuse in the literature that were also shared by participants in this study as having an impact on their ability to engage their children in a dialogue about sexual health and relationships (57). Previous research has shown that talking about child sexual abuse can be part of a therapeutic healing process for women, which is supported by the perspectives of the women in this study (58).

Third, parents highlighted the value that elders and their knowledge hold for them and in their community. They identified a desire to repair and support youth–elder relationships to foster dialogue on family, sexual health and intimate or personal relationships when parents are not able to be a support or resource. The parents’ vision of the role of elders in sexual health teaching reflects the Inuit kinship and family structure that was prominent before settlement. From their perspective, repairing that structure is an important part of promoting sexual health among adolescents. Previous research has shown that revitalizing Indigenous family and kinship perspectives, where they have been disrupted, is an important part of supporting positive, holistic parenting (59–62).

There are powerful, unresolved traumas and healing issues in Inuit communities related to the challenges Inuit have and continue to experience as a result of colonization and the transition of Inuit society from one way of life to another (36,63–67). The traumatic experiences of the settlement and residential school era continue to have an impact on present-day family relationships and parent–adolescent communication both in general and specifically about sexual health. Parents in this study identified a desire to move away from cycles of trauma and to be supported in engaging their children in dialogue about sexual health and relationships with a focus on revitalizing parent–adolescent and elder–youth relationships.

Considerations and limitations

Only the perspectives of those with an interest in sharing their stories were represented in this study. The findings in this study are not representative of the entire population.
Conclusion
The results of this study highlight the importance Inuit parents place on engaging with children in a dialogue about sexual-health and relationships. Parents described events in the greater community and temporal context of Nunavut that they perceived to be barriers to communicating with their children about sexual health. They identified elders in their communities as supports for young people. This would be a positive contribution to the revitalization of Inuit kinship structure that existed before the displacement of families during settlement. The findings provide direction to public health programmes, services and practitioners to expand current strategies by including greater support for parent-child and elder-youth dialogue about sexual health and relationships in Nunavut. Healing and counselling services must be made available to families as part of this process, given the significant role child sexual abuse played in the lives of the parents in this study.

Acknowledgements
A heartfelt qajunamaniuarvik to the parents who shared their stories with me for this study. We learned from each other and I am grateful to have had the opportunity to share experiences as Nunavummiut. This study was acknowledged and supported in principle by Nunavut Tunngavik Inc. and the Chief Medical Officer of Health, Geraldine Osborne. Many relationships (new and existing) were fostered across multiple communities during the various stages of this project with individuals to whom I also express gratitude: Jason Akeesuk, Shirley Tagalik, Sarah Curley, Marie Ingram, Madeline Cole, Theressa Koonoo, Sharon Emundus-Potvin, Candice Lys, Jennifer Noah, Lissie Anaviapik, Ceporah Marie Ingram, Madeleine Cole, Theressa Koonoo, Sharon Emundus-Potvin, Candice Lys, Jennifer Noah, Lissie Anaviapik, Ceporah Marie Ingram, Madeleine Cole, Theressa Koonoo, Sharon Emundus-Potvin, Candice Lys, Jennifer Noah, Lissie Anaviapik, Ceporah Marie Ingram, Madeleine Cole, Theressa Koonoo, Sharon Emundus-Potvin, Candice Lys, Jennifer Noah, Lissie Anaviapik

Conflict of interest and funding
A small stipend was provided by the Northern Scientific Training Program of Aboriginal Affairs and Northern Development Canada in 2011.

References


Gwen Healey
Sexual health communication with adolescent children in Nunavut

66. Pauktuutit. There is a need, so we help: services for Inuit survivors of child sexual abuse. Ottawa, ON: Pauktuutit Inuit Women’s Association; 2003.
68. Pauktuutit. A postcolonial approach to research in Inuit communities. Ottawa, ON: Pauktuutit; 2003 
75. Pauktuutit. There is a need, so we help: services for Inuit survivors of child sexual abuse. Ottawa, ON: Pauktuutit Inuit Women’s Association; 2003.

Citation: Int J Circumpolar Health 2014, 73: 25070 - http://dx.doi.org/10.3402/ijch.v73.25070
REFERENCES


CCHS. (2003). *Canadian Community Health Survey data pertaining to alcohol use in Nunavut*.


Pauktuutit. (2003). There is a Need, So We Help: Services for Inuit survivors of child sexual abuse. . Ottawa, ON: Pauktuutit Inuit Women’s Association.


