
Tuberculosis and Colonialism:

Current Tales about Tuberculosis and Colonialism in Nunavut

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ABSTRACT

The objective of this study was to examine Inuit experience and make meaning of tuberculosis (TB) and how this may relate to the prevalence of TB in Nunavut. The study was conducted through seven months of fieldwork in two Nunavut communities using ethnographic methods for data collection including interviews, observation, participant observation, and document review. The study found that Inuit participants made meaning of TB through a combination of biomedical and traditionally Inuit holistic explanations. The theme of colonialism recurred as an influence shaping the Inuit experience of TB, through socio-political effects of colonization, such as poverty and substance abuse, and through continuing colonialism, including offering public health education in culturally incongruent ways. Examples of discrimination within and outside the healthcare system were also described as effecting the Inuit experience of TB. In order to decrease the incidence of TB in Nunavut, decolonizing measures are necessary. Decolonizing measures include embracing Inuit ways and values in educational, health and political matters. In order for this to be possible and to reduce poverty, an infusion of funds from the federal government is needed. Euro Canadians working in the Nunavut healthcare system must also examine the assumptions, motivations and values that inform their work.

KEYWORDS

Inuit, Tuberculosis, Colonialism, Nunavut, Healthcare

INTRODUCTION

This study examines how Inuit in Nunavut experience and make meaning of tuberculosis (TB), what influences their experiences and how these relate to TB levels in Nunavut (Møller, 2005). How people experience a disease depends on their cultural, socio-political and historical background. It is grounded in “the networks of meanings an illness has in a particular culture,” the local theories about what causes and contributes to the disease, the pattern of care available in a given society, and the social reaction to the sufferer (Good & Delvecchio-Good, 1980, p. 176).

Europeans brought TB to the Canadian Arctic during the 1800s, but it took a century of desperate reports and

hundreds of Inuit deaths before the Canadian government addressed the issue after World War II (WWII) (Grygier, 1994; Tester & Kulchyski, 1994). At that time all Inuit who had active TB were sent south for treatment, often separated for years from loved ones who had no knowledge of their location or condition. Although the attempts at eradicating TB were deemed a success by administrators (Wherret, 1977) and many people were cured, it was a socio-cultural disaster for many Inuit (Grygier, 1994; Tester & Kulchyski, 1994; McNicoll, Tester & Kulchyski, 2001).

The handling of TB marked a general shift in healthcare from Inuit ways to Euro Canadian ones. This process, which continued throughout the twentieth century,



resulted in Inuit losing “control over their own healthcare” (Tester, McNicoll & Irniq, 2001, p. 136). While Inuit were sent away for treatment of TB and birthing, childcare was promoted according to Euro Canadian norms and values (McNicoll, Tester & Kulchyski, 1999). These changes were part of the colonization¹ of the Canadian Eastern Arctic, which after WWII also brought involuntary relocations, forced Euro Canadian schooling, an increased dependence on store-bought goods, and permanent one-room clap-board houses with no running water (Tester & Kulchyski, 1994). It also brought non-Inuit administrators, police, priests, and teachers who exercised control over Inuit and enjoyed a higher standard of living (Brody, 2000; Tester & Kulchyski, 1994).

Today the standard of living in Nunavut is still lower than the Canadian average. General health is poorer, fewer people complete high school and access to many services is worse (Statistics Canada [Stats Can], 2001, a,b). Tuberculosis treatment has improved and is mostly provided by local nursing stations. TB levels declined steadily between 1950 and 1980, but then started climbing again. In 2005 there were 30 times more active cases per capita in Nunavut than in all of Canada (Public Health Agency of Canada, 2005), with an incidence rate of 150 per 100,000. As a nurse working with TB patients in Nunavut from 1997 to 1999 and a consultant for the TB program in 2001, it was observed that people were often reluctant to be examined for TB. Some Inuit found it difficult to finish active TB treatment, and some patients abandoned their prophylactic² treatment altogether. I thought cultural differences and the protocols that governed TB surveillance and treatment might be partly responsible.

TB protocols at the time of the research were governed by a territory-wide TB manual that called for contact tracing for people with active TB³. Highly infectious individuals were sent south for isolation until they were no longer infectious, then received medication biweekly in the community. Those who were minimally infectious stayed in the community throughout their treatment, but were asked to limit their social activities during the initial infectious stage, unless outdoors. People with latent TB under the age of 35 were offered nine months of bi-weekly prophylactic treatment. All medication was taken under observation of a health professional or designated person, which made absences from the community problematic.

METHODS

The Nunavut Research Institute, Copenhagen University and the communities where the research took place

approved the research that this paper is based on. It was conducted following the *Ethical principles for the conduct of research in the North* (Association of Canadian Universities for Northern Studies, 2003). The research was ethnographic, explorative and descriptive. It was conducted through seven months of fieldwork in two Nunavut communities. Fieldwork included observation and participation in community activities, informal conversations with community members, reviewing relevant documents, and 42 formal interviews.

Participants

Twenty-nine Inuit and seven Qallunaat (non-Inuit) were interviewed between October 2003 and February 2004. Interviews took place in Iqaluit and a smaller community. As Iqaluit is a centre for education and employment, Inuit participants came from six different Nunavut communities. Participants were recruited through posters, through presentations of the study to community groups and over the local radio, and through staff at health facilities. Volunteers signed a consent form in English or Inuktitut and the author conducted all interviews. Three interviews were conducted in Inuktitut with the help of an interpreter. Of the 29 Inuit participants, there were 22 women and seven men; their ages ranged from 19 to 76 years (eight under 30, eight in their 30s, seven in their 40s, two in their 50s, and three over 60). Their experiences with TB included:

- Having active or latent TB at the time of interview (n = 4) or in the last 5 years (n = 4).
- Being closely related to someone who had TB at the time of interview (n = 11) or in the last 5 years (n = 7).
- Having TB in the distant past (n = 10).
- Having no personal or familial experience with the disease (n = 1).

The seven Qallunaat participants were healthcare professionals who had lived and worked from one to more than 15 years in the Arctic, including work with TB patients. There were six women and one man.

Interviews

Interviews usually took one to three hours. An interview guide was used, but not rigidly followed⁴. Participants were asked to share the knowledge they had about TB and talk about their experiences with the disease and how it was dealt with in their families and communities. Six Inuit took part in a shorter follow-up interview.



Observation and participant observation

Spending time in the communities observing and participating in community life and events was an important part of the research. This included socializing with other residents at the Nunavut Arctic College residence, spending time in people's homes, attending community feasts, watching debates in the legislative assembly, volunteering in a women's shelter, and accompanying a healthcare worker delivering medication. Field notes were recorded for use in the analysis of the interviews, offering resistance to and validating experiences relayed there.

Analysis

Interviews were transcribed with preliminary analysis taking place during and after an initial five months of fieldwork. Initial coding evolved into themes that represented the most recurring topics expressed by participants across communities, age, sex, and other demographic differences. Six months after the initial fieldwork, two more months were completed. Preliminary findings were presented to community members in the two communities, healthcare workers, and nursing students and their teachers. Findings were also discussed with individual community members and students attending the medical interpreting program at Nunavut Arctic College whom the author taught. Feedback from the presentations was integrated in the final analysis.

Limitations

At the time of interview, participants lived in one of the two communities in which the research took place. Although participants represent six different communities, that is less than 25 per cent of Nunavut's 28 communities. Results may not represent all regions. The sample was small and all interviewees were volunteers, which could bias the sample. During the interviews, many talked about experiences with violence and abuse in their current or childhood homes and also mentioned that discussing bad health or bad experiences is not done in their families. Interviews were usually conducted with only the interviewee and the researcher present. Privacy and knowing that their names would not be used may have attracted people who felt the need to speak about experiences of violence or abuse but were not able to do so with community or family members. This may also be why more women than men volunteered, since people "with limited power and access to public discourse will use other spaces for expression" (DeVault, 1999, p. 57). Women in Nunavut continue to experience limited power. This was a recurring theme among the

women interviewed, and has been described by others (e.g., Zellerer, 1996). Findings related to the impact of violence on Inuit experiences of TB may be exaggerated if the sample was biased by these factors.

Most Inuit participants spoke Inuktitut as their mother tongue and the interviewer's was Danish. Most interviews were conducted in English, our second language. Three interviews used an Inuktitut/English interpreter. After listening to excerpts, a professional interpreter from another community indicated that the interpretation was excellent. Still, many English concepts and words that deal with emotions, body, health, and disease are not easily translated into Inuktitut (Susan Sammons, personal communication, January, 2004). Imprecision in language may thus have affected the depth of the interviews, even when an interpreter was used.

RESULTS

Findings are presented in three themes related to how Inuit experience and make meaning of TB: 1) concepts of sickness and health; 2) knowledge and ways of knowing and learning about health and disease; and 3) colonization and continuing colonialism. Findings from the first theme are outlined only to give context for the others; focus here is on the last two. In the last part of the discussion suggestions that may help improve health and reduce the prevalence of TB in Nunavut are made.

Concepts of sickness and health

Inuit participants made meaning of TB using a combination of biomedical explanations and traditional Inuit holistic explanations. Biomedical knowledge included identifying the usual location for TB infection, TB transmission mechanisms and methods of treatment. A range of traditional ways of understanding illness and TB were described. For example, 17 of 29 Inuit interviewees and many in casual conversation said, discussing bad health or bad experiences is not done in their families, and 13 expressed fear of being stigmatized by other community members if it was known they had TB. The interpretation would be that they had brought it upon themselves by transgressing social norms and conventions. One Inuit healthcare provider who worked with people who had TB said:

I've seen people who were shy coming here to take their medication 'cause they don't want other people to know they have the disease, 'cause the people might start to



think, 'aah this person has the disease.' Some [people] aren't very pleasant.... They start to blame them [the infected] for having gotten it like it is their own fault.

Many described instances where family or community members had experienced illness or misfortune because of breaking moral codes of conduct. One example came from a woman who said that her father blames the hand tremor of a person from their community who suffers from Parkinson's disease on the person's long history of stealing. Another example came from a man whose father was the sole survivor of a big family after a TB epidemic struck his childhood community in the 1950s. He said that other community members blame the family's misfortune on "something that someone had done wrong in the family," and that today his father, because of his relations to the person who had done wrong, is blamed when misfortune happens.

Other codes of conduct that participants stressed included the obligation to welcome visitors, trusting and respecting their decisions, and autonomy and independence of others, whether adult or child. One part of an Inuit way of making meaning of TB, then, related to why someone might become sick and had a moral connotation, as disease would befall those who had transgressed social norms. It has previously been suggested that rather than being an individual matter, for Inuit, health is a holistic concept where balance needs to exist between mind, body and spirit. This is also true in interpersonal relations, and relations to animals and to the environment (Borre, 1994; Ootoova et al., 2001). How Inuit experienced TB also depended on the knowledge they had or could obtain about the disease, the availability of information about TB and the way it was presented.

Knowledge and ways of knowing and learning

Three Qallunaat nurses said that not much was done to raise awareness about TB due to short staffing and high turnover. Four other Qallunaat healthcare professionals, three of whom were administrators, said that many health promotion initiatives had taken place. These included training home care workers about the disease, making and distributing posters and pamphlets in Inuktitut, and providing information through local radio at schools and in local groups. Still, 13 of 29 Inuit interviewees had no recollection of seeing or hearing any information about TB in their community, although more than half came from communities where initiatives reportedly had been carried out.

The people who had heard or seen information about TB did not find it valuable. Five mentioned pamphlets and posters did not seem relevant because the only symptoms described were ones they themselves did not have. Eight suggested that oral rather than textual information would be preferable, and personal stories and experiences with TB told on the radio or in person could be used as a means to educate about the disease. One participant stated, "people are just leaving their stories everywhere and nobody's bothering to read them... a person talking about it is saying something to everybody, but paper is just staying there without anybody knowing about it." Another said, "Those words, just words. Coughing, fever and all that you mean – just the poster. It's just hanging on the wall. Nobody talks about it."

Historically, Inuit relied on oral transmission and passing on knowledge in authentic contexts (Brody, 2000; Stairs, 1991), and this method of learning is still preferred by many (Arnakak, 2005; Inuit Tapiriit Kanatami, 2006; Kuptana, 2006). The Inuit way of educating was embedded in the context of daily living (Nungak, 2004), and "in Inuit societies, medical knowledge never existed as an autonomous and formal body of knowledge as in modern Western societies" (Therrien & Laugrand, 2001, p. 1). For these reasons, much of the information provided by the healthcare system on TB may be seen by Inuit to be out of context and hard to integrate. For many Inuit, "pure knowledge" is never "separated from moral and practical knowledge" (Overing, cited in Bielawski, 1992), and if learning takes place most naturally in the circumstances where the knowledge is useful, then decontextualized public health messages might be expected to fail more than they succeed.

Whether health information is received is dependent not only on the form of the information but also on its source and perceived credibility or value. For knowledge to have value, it may have to originate from personal experience (Stairs, 1991). For example, a clerk-interpreter asked a man who was being tested for TB if he would consent to an interview about TB. He replied that he did not want to be interviewed because he was not and had not been sick, and therefore would just be "telling a bunch of lies." I think he felt that he would have nothing of value to say because he had not himself experienced TB⁵. Thirteen others also said they knew nothing about the disease, although their stories of the disease revealed that they know a lot. While this reticence to display knowledge may have been due in part to an Inuit tendency to be modest about knowledge and abilities (Bennett & Rowley, 2004), when asked directly many who shared knowledge of TB began with a statement



such as, “what I have heard people saying is...” It seems clear that the source of the knowledge is critical, and this finding suggests that impersonal public health messages may be less credible to some Inuit than information delivered by someone who has first-hand experience with the disease.

Many Inuit participants made meaning of TB based on their own and/or familial experiences with the disease and many connected TB to the transgression of social norms. Many participants did not feel information that was written, broadcasted or delivered orally by health professionals was relevant, or they simply did not notice it. The actions of healthcare professionals, however, still had a significant impact on Inuit participants’ experiences of TB. This will be addressed further below, but first I will discuss the effects of colonization and colonialism on Inuit lives and living.

The effects of colonization and continuing colonialism

The colonization of Nunavut has had a huge impact on Inuit culturally, economically, socially, and health-wise, which is evident in current statistics. The median income in Nunavut is 25 per cent lower than in the rest of Canada, and the income of non-Aboriginals in Nunavut is significantly higher than that of Inuit. The level of formal schooling is also much lower than in the rest of Canada (StatsCan, 2001, a,b), a fact that has been related to the Euro Canadian structure, content, pedagogy and evaluation methods of Nunavut schools, where mostly non-Aboriginal teachers are employed (Berger, 2001, 2008; Lipka, 1991). Further, the unemployment rate is much higher (StatsCan, 2001, a,b) and crowded housing is the norm (Tester, 2006). Infant mortality in Nunavut is three times the national average and morbidity rates are higher, while life expectancy is 10 years shorter (Nunavut Department of Health and Social Services, 2002), and the rate of suicide is very high (Hicks, 2007). These social conditions are reflected in an increased use of stimulants among some Inuit (Northwest Territories Bureau of Statistics, 1997) and in the criminal justice system, which reports levels of violence and sexual crimes that are many times the Canadian average (StatsCan, 2001, a,b). These experiences may affect a person’s health, which will be discussed below. Many of these social conditions were also reflected in the experiences of Inuit participants in this study.

Thirteen of 29 Inuit participants, almost half, said that due to financial strain they sometimes lacked enough money for food or sometimes needed to live with extended family and friends. Many reported struggling or having struggled with issues of drug or alcohol abuse in their families, and many of the interviewed Inuit women spoke of personal

experiences of sexual and/or physical violence. Some also noted, however, that they knew their abuser had been abused, or mentioned abusive people in their community whom they knew had been victims of abuse themselves. One woman related how it turned out that many of the aggressive men in her community were victims of sexual abuse by a Qallunaat teacher who taught in several different communities across Arctic Canada in the 1970s and 1980s. She stated, “now I understand why [they are angry and aggressive]. They have so much hurt and grief they need to get rid of.”

Life struggles seemed to overshadow the concern about TB or compound the struggle with the disease in some cases. It is important to note that social dysfunctions such as violence, suicide, alcohol abuse, and inflated levels of disease are often connected to acculturation processes, the result of colonization and colonialism (Farmer, 1999; Kulchyski, 2005; Tuhiwai-Smith, 1999; Watt-Cloutier, 2000; World Health Organization, 1999). Greater acculturation has been connected to “greater psychosocial stress, less happiness and greater use of alcohol and drugs to cope with stress” (Wolsko et al., 2007, p. 51).

When sharing their illness stories people often gave accounts of difficult life circumstances and many described historical experiences of oppression, prejudice and racism. These included past treatment for TB under inhumane conditions, forced settlement and schooling, and the shooting of sled dogs by the RCMP that kept Inuit from pursuing traditional activities. Some also said that Qallunaat sexually and physically abused children within the church, health and educational systems in the past, leading to low self-esteem and aggressive behaviour today.

Colonial experiences, however, were not only historical. When discussing the treatment of Inuit by healthcare professionals, more than half of the Inuit participants and many in casual conversations said they felt patronized, not respected, controlled, not informed, and not listened to or taken seriously. For example, three women said that they had been forced to take TB medication with little explanation. When they experienced difficulty with the treatment, attempted to avoid taking the medicine and were apprehended by police, little attempt had been made to understand why. They had all experienced side-effects that they said were not discussed, even though two of them struggled with social issues that made adhering to a treatment regimen difficult. Another woman described a false diagnosis with TB and how, after receiving treatment that made her very sick for a week, she was suddenly told she did not have TB and discharged. No one expressed regret about the mistake or offered an explanation.



In another instance, discussing healthcare with four Inuit women, one said:

Healthcare people do not treat patients with respect. It is as if they don't care to explain anything, like the patients won't understand anyway and the healthcare people know better. People are generally not told about things. They are not informed so that they can have a choice. The doctors or nurses choose for them.

Another added, "I don't go to the hospital unless I am dying. They don't care. They don't help people."

This prompted everyone to relay different examples they knew where people became very sick and even died because their initial complaint was not taken seriously.

While patients anywhere might feel disrespected, prejudicial sentiments about Inuit were in fact expressed by some of the interviewed Qallunaat health professionals. Three of seven held Inuit responsible for their falling ill with TB. Five felt that Inuit often did not take responsibility for their health and two made generalizations about Inuit gambling, not being able to manage money, drinking and using drugs. One health professional said:

You think of them [the Inuit] making all this money carving, etc, but they haven't learned how to wisely use it and they end up in these situations where they're drinking, using drugs, gambling, whatever... they all end up in these situations where it's a perfect place for it [TB] to take off.

Another healthcare professional expressed a similar sentiment about poor Inuit conduct in Ottawa, stating that when Inuit are flown there for medical reasons or to escort a patient:

They do all the things that are probably inappropriate... they drink all night, they destroy hotel rooms, they destroy boarding homes...they get into the wrong crowd, they find the drugs.... It's like teenagers running away from home.

Talking about responsibility for TB and TB treatment, one health professional said:

I do find that people tend not always to take responsibility for their health... people shouldn't have to be sort of chased and almost harassed to come in and do things for their own benefit and the benefit of their families.

From these comments it is easy to imagine how Inuit, as patients, might feel disrespected.

Negative experiences were also relayed from outside the healthcare system. Many Inuit said that Qallunaat attempt to control Inuit unnecessarily within and outside the healthcare setting. One participant said:

People from outside tell people here what to do, how to do it, what is right and what is wrong. There is racism here against Inuit... Maybe if people from the outside knew more about our values and way of thinking they would not be so condescending.

A nursing student said:

As an Inuk student I feel I have no freedom of speech. When I talk about how my people view health and disease, [Qallunaat teachers and students] tell me to prove that things are as we see them, and tell me I should be careful with what I say."

She said Inuit students withdraw from the education because they are told they are superstitious and unscientific and feel discriminated against. No teachers are Inuit and the language of instruction is English⁷.

With the advent of Nunavut, Inuit have gained a measure of self-determination, and the government of Nunavut has mandated that Inuit ways and values must guide the work of all government institutions (Government of Nunavut, 2004). Healthcare and the nursing education, however, continue to be operated as Euro Canadian institutions within the frames of a previous colonial power, following Euro Canadian norms and largely disregarding those of Inuit. This preserves and strengthens the effects of colonization (Ryan, 1992, 1989; Tuhiwai-Smith, 1999) and affirms a continued colonial rule. It is perhaps unsurprising, then, that many Inuit participants' experiences of TB were deeply affected by colonialism past and present.

DISCUSSION

The purpose of this research was to examine how Inuit experience and make meaning of TB and how this might be connected to the high levels of TB in Nunavut. The study found that the lives and experiences of many Inuit are framed by a history of colonization and continuing colonialism and that this significantly impacts Inuit experience of, and approach to, the disease and to its examination and treatment protocols. The study also



demonstrated that Inuit make meaning of TB using a combination of biomedical and traditional holistic Inuit explanations that have highly moral connotations, and that Euro Canadian health providers seldom take Inuit beliefs or learning preferences into account when creating health promotion materials – something that in itself may contribute to negative health outcomes, which I will return to below.

The difficulties of the disease, and being treated for it, was in many cases compounded by alcohol and drug abuse, violence, poverty, or inadequate housing; issues that are evident in current statistics and are effects of colonization and continuing colonialism (Farmer, 1999; Kulchyski, 2005; Tuhiwai-Smith, 1999; Watt-Cloutier, 2000). People living under such circumstances have increased likelihood of getting the disease, at the same time they may lack the energy to seek healthcare or continue prolonged TB treatment. Furthermore, because “the scale of income differences in a society is one of the most powerful determinants of health standard” (Wilkinson, 1996, p. ix), and because the average Inuit income is sharply lower than that of other Canadians and especially lower than Qallunaat living in Nunavut (StatsCan, 2001, a,b), the effects of poverty on health may be aggravated for many Inuit.

Many Inuit reported not noticing or finding relevant public health information. This may be because public health information, even when available in Inuktitut, reflects Qallunaat ways of thinking and educating rather than Inuit ones. It is usually textual rather than oral, abstract rather than personal, does not involve relationship-building between healthcare provider and client, and does not include the moral connections to health that an Inuit understanding does. Although translation is important to make messages more accessible, delivering them orally and in Inuktitut is not enough. Thus far, in terms of reducing TB levels, translating posters and pamphlets into Inuktitut, broadcasting information on the radio in Inuktitut, and using interpreters in the clinical setting, have not proved successful. The way of formulating the message also needs to be changed in order to be culturally appropriate (Inuit Tapiriit Kanatami, 2006; World Health Organization, 1999).

For example, changes could include health education in Inuit communities that is shared in family or other smaller groups in the community, and could be in the form of a person with experience telling his or her story⁶. A known health professional who was living in the community and had a relationship with community members could be present if desired to answer more biomedical questions.

This would situate the sharing of knowledge in context, rather than delivering it out of context. It would allow health professionals and community members to know each other and allow individuals the freedom to speak or ask questions if they so wished. Health education delivered in this manner would signal respect and acceptance and build trust between the healthcare system and community members by showing that the health professional is willing to invest him or herself, and has an interest in the individual community member’s well-being. Thus, it would contribute to decolonizing the healthcare system, a necessary condition if the dissatisfaction expressed by many Inuit informants is to be reversed.

Not offering culturally appropriate public health education reinforces the historical message that Inuit ways of doing things are inferior to those of Qallunaat. It also reinforces the disrespect that participants experienced in the Qallunaat-run healthcare system, which led some to not seek healthcare. There are no statistics about people not seeking healthcare or not choosing to be examined and treated for TB; however, a TB epidemic in a Nunavut community in 1998 was traced to a person suspected of having TB who, despite repeated encouragements, failed to seek healthcare until he was quite sick, very infectious and had infected several other individuals (Case & White, 1999). People’s experiences in the healthcare system do make a difference. The interviews with four Qallunaat nurses and the many Inuit who had experience with TB demonstrated that a lot of support and time is often needed to discuss the disease, its treatment, patients’ experiences of side-effects, to make phone calls and home visits, and sometimes to provide food to take with medication. This time may be difficult to spend if staffing is an issue, but is very necessary if treatment programs are to be successful and could be viewed as part of culturally appropriate healthcare.

Culturally appropriate healthcare may continue to be difficult to obtain if a colonial model of nursing education, as described, persists. It may prevent Inuit from entering or completing the program, or may further acculturate those who do graduate as nurses to Euro Canadian ways (Ryan, 1992), perpetuating the lack of local, culturally competent, healthcare professionals. Culturally specific concerns such as the inability to say no to visitors may not be understood or honoured, and may contribute to the unnecessary spread of TB resulting in continuing high rates of infection. Furthermore, general discrimination – historical and current – as reported by participants, may result in lower self-esteem (Tuhiwai-Smith, 1999) and, coupled with poverty, lower educational levels, lower employment status, and less control



over one's own work, may lead to poorer health outcomes (Wilkinson, 1999), and a greater likelihood of contracting TB.

CONCLUSION AND RECOMMENDATIONS

In order to address the high incidence of TB in Nunavut, decolonizing measures are necessary. This means measures to move toward Inuit controlling all areas important to their cultural, linguistic, political, and economic survival (Tuhivai-Smith, 1999). In Nunavut, decolonizing measures include socio-political interventions that move toward the same standard of living, health and access to healthcare, for Inuit as for the average Canadian, as well as an educational system that serves the need of Inuit in ways that Inuit deem appropriate. It is also imperative that poverty is addressed. TB and other health issues will simply not be a priority for those who live under extremely difficult social circumstances. This also speaks to the need to develop appropriate programs for community-based healing and reconciliation for abuse victims and offenders, and to develop programs that assist parents in dealing with the pain that causes them to be alcohol or drug abusers, in order to break the cycle. Doing this through traditional Inuit healing and justice may prove more beneficial than the methods most often employed by the healthcare and justice system today (Pauktuutit Inuit Women of Canada, 2006).

Decolonizing measures also include delivering public health education in a culturally acceptable manner, preferably by Inuit. This is one reason why the education of Inuit in healthcare professions must be politically promoted and supported, albeit with the form, content, and pedagogy decided upon by Inuit stakeholders. The education of Inuit healthcare professionals will speed the transition to Inuit deciding on the form public health education should take, which might be based on an Inuit understanding of health and sickness and western biomedical knowledge.

Because individuals within, as well as between communities, are different, healthcare professionals must discuss the terms of treatment with individual families and find out what they are most comfortable with, including where medication should be delivered. Observed medication should be given by Inuktitut speaking healthcare workers who are known and trusted in the community, and who ask whether the treatment causes side-effects every time medication is delivered. This would help to address other factors that may complicate treatment, such as the lack of food available to some clients. Creative solutions to problems may be found working together from a basis

of respect. Respectful relationships are only possible if healthcare personnel are able to develop a personable relationship with their clients. This demands stability of personnel, which is another reason why the education of Inuit within the health sciences must be politically promoted and supported.

Culturally congruent education of Inuit healthcare professionals and public health education that respects, acknowledges and privileges Inuit ways and knowledge would signal an urgently needed shift towards decolonization, work towards agency and empowerment (Ryan, 1992), and help decrease what Duran and Duran (2002) call the "acute and... chronic reaction to colonialism" (p. 99) that is evident in current statistics and in the findings of the study.

Nunavut's colonial history and continuing colonialism impact Inuit culturally, socially and in health, increasing the likelihood of people becoming infected with TB while decreasing their energy and willingness to be examined and treated for the disease. Colonialism thus contributes to the number of undiagnosed and untreated individuals and to the continuing high levels of TB in Nunavut. In order to address these high levels, decolonizing measures are necessary.

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END NOTES

1. The Canadian Oxford Dictionary defines colonization as establishing a colony in an area, or when one country or society imposes its culture upon another (Barber, 2004, p. 302). I use colonization here in the second sense. The policies and actions initiated in the Arctic by the Canadian government, partly a result of Canada's struggles for sovereignty that started in the early part of the 1900s, were colonial. Euro Canadians forced their culture, values and religion on the Inuit and institutions structured and controlled by Euro Canadians became the norm (Tester & Kulchyski, 1994).
2. Prophylactic treatment is offered to people who have latent TB, that is, they have been infected with TB but the disease is not active. Without treatment there is a 10 per cent probability that a person with latent TB will develop active TB (Canadian Lung Association, 2000). Prophylactic treatment usually lasts nine months.
3. Contact tracing means that the person with active TB, in cooperation with a nurse or healthcare worker, makes a list of the people (family, friends, co-workers, etc.) he or she has close contact with. These people are then screened for TB. This helps to stop further spread of TB by finding, examining and offering treatment to those who may have been infected.



4. The list of questions in the interview guide is available as an appendix in Møller (2005). It can be accessed through the author (helle@ualberta.ca), the Lakehead University Library, the Department of Anthropology, Copenhagen University, or through the Royal Copenhagen Library.
5. Other Inuit have noted that “true” knowledge comes from experience. For example, Pauloosie Angmarlik, who was interviewed for the book *In the words of the elders*, said: “I never say what I have heard, I only tell what I have experienced, because I do not want to lie” (Angmarlik, 1999, p. 272).
6. In a project about knowledge translation in an Inuit community, Smylie and McShane (2008) noted that “informal networks of family and community were the most important sources of health information and the best means of information dissemination.”
7. It should be added that in currently ongoing Ph.D. research on the experiences of Canadian and Greenlandic Inuit being educated and practicing in western (Euro Canadian and Danish) education and health care settings no nurses or students have expressed sentiments similar to the student quoted above (Møller, 2009).

