Developing an Inuit-Specific Framework for Culturally Relevant Health Indicators Incorporating Gender-Based Analysis

Pauktuutit Inuit Women of Canada

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ABSTRACT

At the request of the Bureau of Women's Health and Gender Analysis (BWHGA) at Health Canada, Pauktuutit Inuit Women of Canada (Pauktuutit) developed a framework for an Inuit-specific culturally relevant gender-based analysis (GBA) of health determinants. The Inuit-specific framework and follow-up health determinants report show that Inuit-specific health data needs to be separated from other data. The framework also proposes a thematic listing of culturally relevant health determinants for Inuit. The framework and health report show some of the gaps in gender-based analysis of Inuit health indicators and determinants that should be addressed. The framework was well received by Inuit in its first trial use in 2008.

KEYWORDS

Inuit, health indicators, framework, gender-based analysis

INTRODUCTION

There are almost no health indicator frameworks in use in Canada that reflect Inuit concerns (Jeffery, Abonyi, Labonte, & Duncan, 2006). This is despite a 2005 recommendation from the United Nations Permanent Forum on Indigenous Issues that all nations separate Indigenous economic and social data from national figures.[1] What should an Inuit health indicator framework look like? At a minimum, an Inuit health indicator framework should separate Inuit health data from other non-Indigenous and Indigenous Canadian health data. Additionally, it should use gender-based analysis (GBA) and culturally relevant indicators that reflect an Inuit view of health determinants, unlike current frameworks that assess the well-being of Indigenous groups using a non-Indigenous yardstick.

"Until Inuit values, approaches and perspectives are incorporated into health services," warn researchers Archibald and Grey (2004), "it is difficult to imagine the system enhancing the mental health and well-being of Inuit individuals

and communities." Jeffery, Abonyi, Labonte, and Duncan (2006) agree that there is a "need for indicators under different categories that reflect Inuit life," including "traditional food as part of a definition of economic health in the North, wildlife availability as a measure for the physical environment and traditional knowledge as an important marker of education and community well-being" (pp. 48-9). Recognizing this, the Bureau of Women's Health and Gender Analysis (BWHGA) at Health Canada asked Pauktuutit Inuit Women of Canada to develop a framework for an Inuit-specific culturally relevant gender-based analysis of health indicators. This paper summarizes the research done by Pauktuutit to create an indicator framework that addresses three separate issues: gender-based analysis, cultural relevance, and Inuit focus.

METHODS

Building on a literature review and key informant interviews, Pauktuutit developed an Inuit-specific culturally relevant GBA health indicators framework in 2007. The framework was reviewed by the BWHGA before being evaluated and revised by Inuit delegates[2] at a national Inuit GBA health indicators conference funded by Status of Women Canada and hosted by Pauktuutit in 2008.

RESULTS

The Inuit-specific GBA health indicators framework (IGHIF) shows that Inuit-specific health data needs to be separated from other data. Feedback from Inuit stakeholders was remarkably consistent with the findings of the literature review in suggesting central themes for the first ever Inuit culturally relevant indicators framework. These themes make up the core of the Inuit-specific GBA health indicators framework, which uses a gender-based analysis of Inuit health data and indicators to show gaps in conventional indicators. The framework was well received by Inuit in its first trial use in 2008.

While researching the cultural relevance of certain health indicators, it became apparent that some new indicators were necessary to capture aspects of Inuit life not detected in non-Indigenous health frameworks. Three new indicators—country food (availability, acquisition, and consumption), multigenerational proximity, and Elders' wisdom—are proposed below.

DISCUSSION

Separating Inuit health data from Canadian data

Inuit live in four different geographic regions in Canada: Nunatsiavut (Labrador), Nunavik (Northern Quebec), the Nunavut Territory, and the Inuvialuit settlement region within the Northwest Territories (NWT).[3] One goal of an Inuit-specific gender-based health analysis should be to document the wide variation of health and social service delivery as well as the different medical health issues in these different regions. Currently, health information on Inuit in the four regions is generally gathered by the territorial or provincial governments, who do not separate Inuit data from other data. Inuvialuit health information, for example, is rolled into the NWT Health Status Report. Except for data from the Nunatsiavut Department of Health, Education, Social and Economic Development, the Nunavik Regional Board of Health and Social Services, and occasional Inuit-specific sampling at the community level, there is "little regional or ethno-specific data" for Inuit in Canada (Smylie, 2001, p. 3). Canada's Department of Foreign Affairs offers training in "intercultural competence" in 42 foreign languages (and both of Canada's official languages). It is reasonable to expect the government to invest a similar level of resources in developing analytical tools and intercultural competence in relation to the four Inuit groups whose homelands cover a quarter of the land mass in Canada.

The Nunavut government collects health data for the entire population including the 15 per cent that are non-Inuit. The overall health picture is most likely skewed by non-Inuit who generally live in the territory for less than 2 years and make an average income almost four times as much as the average Inuit income in the territory.[4] Nunavut has about 3,000 migrant workers, who generally live in staff and private housing and are likely to experience fewer health challenges than the region's 30,000 resident Inuit, 13,000 of whom live in decaying and overcrowded social housing enduring the "worst housing crisis in Canada" (Callaghan, Farha, & Porter, 2002).

Separating Inuit data from First Nations data

Nunavut's overcrowding rate of 54 per cent is much higher than the average overcrowding rates for First Nations at 19

per cent and the non-Indigenous Canadian population at 5 per cent (Nunavut Tunngavik Inc., 2008, p. 8). Without Inuit-specific comparable data gathered from Inuit in all regions, it is difficult to notice trends, diagnose problems, or recommend action. In a 2001 presentation to the Standing Senate Committee on Social Affairs, Science and Technology, Pauktuutit reported that "Inuit-specific health data is spotty at best and often extrapolated from larger pools of Aboriginal data collected mainly in southern Canada" (Nunavut Tunngavik Inc., 2008, p. 8).

There is a drawback to relying on southern data; only 14 per cent of Inuit live in southern Canada, in contrast to 96 per cent of non-Indigenous Canadians and 30 per cent of First Nations populations. Most of Canada's 55,000 Inuit live in the Arctic in 53 communities—all but two are located along the Arctic coastline. Thus, Inuit can be described as a northern sea-oriented people, in contrast to most First Nations and non-Indigenous Canadians. In agreement with Smylie's research, only "20 per cent of First Nations communities do not have year round road access, while almost all northern Inuit communities are remote and do not have year round road access." Most Inuit live in remote communities with the "nearest hospitals usually hundreds of kilometers away, while major referral centres may be thousands of kilometers away. For example, the distance from Iqaluit to Ottawa, the major tertiary care referral site for Iqaluit, is 2,055km" (Smylie, 2000, pp. 8–9).

Disease rates differ between Inuit and First Nations peoples, with some diseases being more severe and common among Inuit and others being more severe among First Nations. The incidence of diabetes, although on the rise for Inuit, has not reached the epidemic proportions that it has reached in First Nations communities.[5] This suggests that intervention now, including education on how to maintain a healthy diet and prevent and resist diabetes would have a greater impact on Inuit populations. On the other hand, Inuit are at "extremely high risk for several cancers that are very rare in other populations: nasopharyngeal, salivary gland, and esophageal cancers," the so-called "traditional Inuit cancers" (Waldram, Herring, & Young, 2006). Tuberculosis (TB) may be the most common disease in Inuit communities. According to 2008 figures by the Public Health Agency of Canada and reported by the Inuit Circumpolar Council, "Canada's four main Inuit regions had a TB incidence in 2008 of 157.5 for every 100,000 people," making TB 185 times more common among Inuit than among non-Aboriginal Canadians (Inuit Circumpolar Council, 2010). The severity of the TB epidemic was previously unknown "because it has been very difficult to obtain clear statistics on TB rates among the Inuit population" (Curry, 2010). A 2004 Public Health Surveillance Report by Elliott and Macaulay (2004) on Inuit of the four regions concluded with a warning:

> A final general limitation of the surveillance activities and information available from the four regions is a frequent lack of available Inuit identifier or Inuit-specific information on the particular health issue under surveillance. …[T]here clearly are differences in the relative importance for certain public health issues in the Inuit, as compared to the general Canadian population and also as compared to other Aboriginal populations, even within the same region. Availability of Inuit-specific public health surveillance information would be beneficial for design, implementation and evaluation of public health planning at local, regional and national levels. (p. 48)

While isolating Inuit health indicators is important, so is noting and respecting diversity amongst Indigenous groups, such as how Inuit and First Nations values and beliefs about health may differ. Different Indigenous peoples use different philosophical approaches to healing.[6] For example, Inuit philosophy does not include the "Medicine Wheel" or the "Healing Circle," which are common to some First Nations. "The 'Sacred Hoop' and 'Circle of Life' concepts are also not applicable to Inuit, who have their own rich and unique cultural heritage" (Smylie, 2000, p. 5).

A 2008 report on Nunavut's health system highlights the Ilisaqsivik Society of Clyde River, "a community-based organization that is an excellent example of healing and wellness programs delivered in accordance with Inuit culture and values." Ilisaqsivik's Inuit Societal Values project strives to "empower Elders to participate and help guide organizations that are addressing social problems in the community" (Nunavut Tunngavik Inc., 2008, p. 29). Along with shedding light on traditional medical knowledge, the Inuit perspective brought forth by Elders includes knowledge on "how to develop a strong mind and a resilient body" (Nunavut Tunngavik Inc., 2008, p. 34). As Inuk Elder Mary Adams cautioned doctors and nurses at the 2007 Big Land Health Conference in Labrador, "I need you guys here, yes, if I have pneumonia or something else, but don't push your values and your ideas and your way of life on another culture… . It's not fair" (CBC News, 2007).

Using a gender-based analysis of Inuit health determinants

Women and girls have specific health issues and needs based on their unique social, cultural, and environmental situations, which may vary greatly from the health and social issues facing men and boys (Colman, 2003; Yalnizyan, 2006). The main approach used by policy-makers and government to uncover and explain these differences is called gender-based analysis (GBA).[7] Gender-based analysis is an analytical tool that integrates a gender perspective into the development of policies, programs, and legislation. GBA includes both sex (the biological differences between men and women) and gender (the culturally specific set of characteristics that identify the social behaviour, roles, and relationships of men and women). However, without clear cultural reference points, GBA may tend to ignore or mask differences between Inuit men and women, and it may also obscure the differences among Inuit women.

For example, a gender-based analysis shows that country food consumption rates vary widely between men and women. Studies of Qikiqtani Inuit[8] show that Inuit men (aged 13–60) consume larger amounts of country food than Inuit women, however, Inuit girls consume more country food than Inuit boys, and Inuit women over 60 years old consume slightly more country food than men. Consumption rates and related effects of country food for males and females at different ages clearly show the relevance and necessity of gender-based analysis.

An Inuit culturally relevant GBA could also focus attention, for example, on sex-related differences in income, an important determinant of health. Archibald and Grey (2004) highlight a case in Nunavik, where "non-Inuit, who make up 10 per cent of the population (and are not permanent residents of the region) hold over one third of the full-time jobs." A GBA approach, however, would also highlight that difference in income is more extreme between non-Inuit men ($41,997) and non-Inuit women ($29,326) than between Inuit men ($17,426) and Inuit women ($14,562) (Archibald & Grey, 2004). The overall income difference between Inuit and non-Inuit in Nunavik is still quite large. This gap is even larger in Nunavut, where the average Inuit income is $13,090 and the average non-Inuit income is $50,128—a gap of $37,038 (Nunavut Tunngavik Inc., 2005). These statistics show the importance of separating data by sex and ethnicity.

One of the striking observations from Pauktuutit's research is that although there is some separation of data by sex,[9] there is little or no research on gender—the social and cultural roles of Inuit women and men and how these might impact health.

Developing culturally relevant indicators for Inuit

The Development Dictionary warns that "the Westernization of the world…has imposed the concept of 'standard of living' as the dominant category for perceiving social reality," leading most societies to measure only the "Westernized portions of their socio-economic reality" (Latouche, 1997). In a report on measurements of Inuit well-being, Duhaime, Searles, Usher, Myers, and Frechette (2002) also advise caution:

> Whereas standard indicators like per capita income and Gross National Product, average life expectancy and infant mortality rates, may reveal something about the state of a national economy and the overall health of its population, they do not reveal what some consider to be the more important indicators of development and social well-being. (p. 300)

The UN Permanent Forum on Indigenous Issues (2005) has warned that since "Indigenous peoples' concepts of development, poverty and education, for example, greatly differ from Western constructions," increases in Western-style development, for example, "could, in some cases, have a negative impact on Indigenous and tribal peoples while national indicators apparently improve."

This caution from the UN Permanent Forum indicates that it is not enough to separate Inuit-specific data from systems designed only to measure health or well-being in Western non-Indigenous terms; important parts of Inuit life may not be captured by standard non-Indigenous indicators. While standard health determinants such as wage-employment and income are important to Inuit, they also value other indicators not recognized by southern Canadians. As the 2007 Survey of Living Conditions in the Arctic (SLiCA) reported, "despite historical efforts by national governments to assimilate native peoples and encourage them to give up native traditions in favor of wage labor, nine out of ten Inuit continue to think traditional activities are important to their identity." Hunting and using local country food are still important values to Inuit, and they are "willing to use their earnings in the cash economy to support those ways of life" (National Science Foundation, 2007).

Non-Indigenous health indicator frameworks,

which tend to focus on income, life expectancy, and academic education, overlook measurements of well-being that are important to Inuit but are non-remarkable in Euro-Canadian culture. We found five such indicators during our research: proficiency in the Inuit language; multigenerational proximity; frequency of contact with Elders; intergenerational transfer of knowledge; and availability, acquisition and consumption of country food.

To avoid giving greater importance to "westernized portions of socio-economic reality," the Inuit-specific framework minimizes the use of the modern versus traditional when describing determinants of health. The modern/traditional model tends to categorize Inuit land-based activities and Elders' wisdom as traditional and contrast them with wage-economy activities and academic education, which are labelled as modern.[10] The Inuit perspective includes Inuit adaptation to, resistance to, and absorption and integration of Euro-Canadian economic, government, regulatory, and institutional pressures (Pauktuutit Inuit Women of Canada, 2006). Although much of the historical wisdom and skill of Inuit women and men is used in new ways today, continuity with and learning from the past is not only used by Inuit. A non-Indigenous Canadian will go kayaking or vote in a democratic election without viewing these activities as traditional, despite their origin as either ancient technologies—the kayak—or ancient customs—the concept of "one person one vote" democracy, which came in part from ancient Greece and in part from the Iroquois confederacy (Weatherford, 1988, pp. 136, 145). Much of non-Indigenous life owes its design, origins, or guiding principles to 'tradition,' yet southern Canadians may refer to their practices as 'modern' in contrast with 'traditional' Inuit practices—a misleading label which can encompass associations like 'backwards' or 'old-fashioned' (Scollon & Scollon, 1995, p. 145). As Kaliss (1997) put it, "The modern-traditional contrast plays the same analytical role in academic literature presently as the 'civilized-primitive' contrast the literature was forced to drop around

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1960."

> (W)e perceive things like snowmobiles, television, and government-supplied houses as proof that Inuit traditional culture has been uprooted. … Today, southern understanding of Inuit is built on that kind of ethnocentric 'understanding.' Absent from it is the recognition that traditional Inuit culture is more than dog teams and harpoons. We recognize that our own cultural traditions are founded on philosophical values, not cars and skyscrapers, yet we fail to make that leap in our appreciation of Inuit culture… Cross-cultural interpretation goes astray because we view Inuit and other aboriginal traditional culture as being exotic, but also 'simple.' (Wenzel, 1994, p. 57)

The Inuit-specific gender-based analysis health framework

A framework is a conceptual model "that sets out a particular way of looking at health and the factors that affect it. It is important to remember that a framework does not represent the 'truth' but can be a useful tool to organize information for intended users."[11] While southern Canadian health indicators tend to involve wage, employment, income, formal education attainment, mortality, and disease—which Inuit are also interested in—Inuit also hold to additional values that reflect their holistic approach to health and their concern for balance between negative and positive approaches to health (disease versus wellness).[12] The Canadian Institutes of Health Research (2001) reported that "Inuit feel that it is detrimental to the health of individuals to continually tell them that they are at the highest risk for disease… . People are interested in research on…concepts of wellness, and wellness indicators" (p. 12).

Pauktuutit's Inuit GBA framework arises out of the need to focus on Inuit health and gender in a way that is less problem-based and more reflective of the Inuit focus on wellness. As one veteran researcher, Kuhnlein (2004), comments, "Health promotion and health education would get so much further with the people involved if there would be more 'good news' and reinforcement of the positive sides of health that exist within the local culture" (p. 6). The literature review, key respondent interviews, and feedback from Inuit delegates at the GBA national conference emphasized the following themes, which became the focus of an Inuit culturally-specific framework. These themes were grouped under three headings:

1) Elders, culture, language, family, community, and spirituality
2) Land, weather, animals, and country food
3) Euro-Canadian economy, institutions, and government

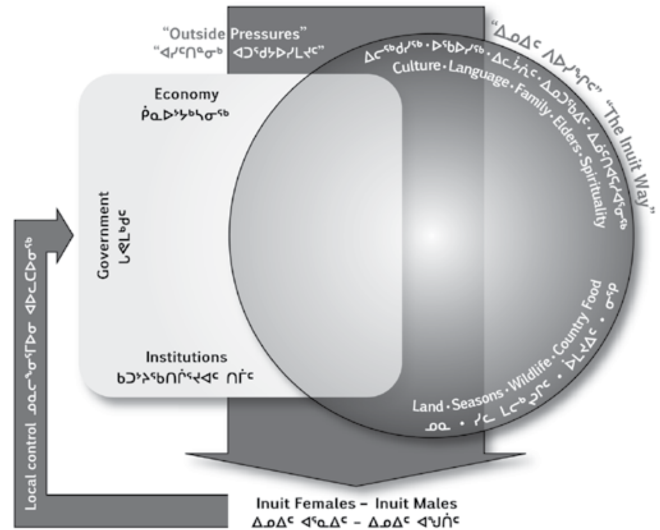

FIGURE 1

The challenge was to present these themes in a way that showed how Inuit life sometimes overlaps and incorporates the Euro-Canadian way of life, sometimes resists the Euro-Canadian way of life, and sometimes runs parallel to it, maintaining a distinct and separate Inuit Way (Pauktuutit Inuit Women of Canada, 2006). Thus, the diagram (Figure 1) shows the lives of Inuit men and women (the central arrow) flowing through an overlapping square (representing Euro-Canadian influences: economy, institutions, government) and circle (denoting "the Inuit Way": land, weather, animals, country food, Elders, culture, language, family, community, and spirituality). Sometimes these worlds overlap, sometimes they conflict, and sometimes they are distinct. While the roles and relationships of the categories affect one another, they are not static. When used in small group break-out sessions at the National Inuit GBA Health Indicators Conference, Inuit delegates found the diagram helpful in determining, discovering, and evaluating health indicators that were important to them. For example, during a workshop discussion of food and nutrition, delegates wrote out the issue ("food and nutrition") at the top of the central arrow, and then discussed it from the various points

of view in the diagram. This led to an unexpected result: participants insisted that government regulation was a key issue impacting Inuit well-being, nutrition, and health. The Inuit women delegates repeatedly linked government regulation of hunting to Inuit men's sense of self-worth. One participant said

> Government is imposing more and more laws upon the men, regulating hunting. The direct impact, the blunt hit, is more on the men, and then the ripple effect is on the women and the community. Government quotas on beluga, bear, and fish restrict the men. Then the women do less preparing of skins and sewing, and the children don't watch their fathers prepare food and don't learn how to cut up meat and don't watch their fathers give it to Elders so they don't learn that.

Another participant said that when "a lot of laws and money get in the way" preventing Inuit men from hunting, "then they don't feel good; they feel inadequate, their role in providing diet and nutrition has been taken away from them."[13] For Inuit, therefore, any study into country food as a determinant of health must also include survey questions on how severely and frequently government regulations interfere with hunting and harvesting.

Government regulatory intrusion was also raised during another break-out session using the diagram, when the topic switched to childbirth and midwifery. Delegates pointed out how the Euro-Canadian system interferes with the Inuit Way when it comes to the regulation of Inuit midwifery. Of particular concern was a new Midwifery Act passed by the Nunavut Territory that established new midwifery registration committees, practice auditors, boards of inquiry, hearing panels, and appeals processes, none of which were required to operate in Inuktitut or be competent in Inuit traditional midwifery. The new law also limited legal recognition of "Inuit traditional midwives" only to those who practiced traditional midwifery before 2008. Furthermore, the Nunavut Midwifery Act made no mention of a requirement for training to be delivered in Inuktitut or to include Inuit cultural values, and there was no requirement that Euro-Canadian or new southern-trained midwives wishing to work in Nunavut be evaluated by experienced Inuit practitioners. All this was in contrast to the provinces of Ontario and British Columbia, which did design laws that included the ongoing practice of Aboriginal midwifery. One Inuit Elder attending the GBA national conference said she felt that "The outside people like government people use scare tactics to make sure we don't practice traditional midwifery; they say that we must not have home delivery or the baby may die" (Buchan, personal communications, January 2008).

When the discussion moved to finding solutions, delegates repeatedly focused on reacquiring or reestablishing local control over the Euro-Canadian economic, governmental, or institutional agent that was disrupting the Inuit Way. The diagram included this emphasis on local control, using the narrow arrow on the bottom and left of the diagram as sort of a "feed-back loop," channelling the concerns of Inuit women and men toward gaining local control over Euro-Canadian systems. At the conclusion of the GBA conference, all the delegates were pleased with the Inuit GBA diagram, finding it to be useful in evaluating health indicators and measuring their relevance to Inuit (Pauktuutit Inuit Women of Canada, 2008).

A closer look at three culturally relevant Inuit health indicators

Inuit families and communities are very close-knit in comparison to southern communities (Duhaime et al., 2004, pp. 301, 303). Inuit families often have three generations living in close proximity (i.e., very near each other) and participating in family life, sharing food and work, and hunting together. This multigenerational proximity is a determinant of Inuit well-being not currently used in southern-style surveys. Decreases in multigenerational proximity might shed light on the extent of family isolation among Inuit and their increased dependency on services and institutions such as formal daycare. Surveys of multigenerational proximity and social togetherness might ask about the number of relatives living within a 5-mile radius, how often families get together to share food, or how often the family uses the land for harvesting or gatherings, such as spending time at the family camp.

A second potential Inuit-specific health indicator is the availability, acquisition, and consumption of "country food": whale, fish, caribou, seal, and berries. "Traditional food is of fundamental significance in the lives of Inuit individuals, households, and communities, holding nutritional, physical, cultural, spiritual and economic importance" (Chan et al., 2006). Country food plays a positive cultural and dietary role in Inuit life. A large portion of Inuit still hunt or do arts and craft activities (which depend on a ready supply of animal skins, antlers, and bones) in addition to working in the wage economy (Poppel, Kruse, Duhaime, & Abryutina, 2007).

As many Inuit assert, the production and exchange of country food (i.e. food hunted, fished, and harvested

> locally, including caribou, marine mammals, arctic char, and wild plants and berries) are vital cultural activities practiced by a wide range of Inuit of all ages and backgrounds, and many Inuit claim that these activities are necessary for the survival of Inuit tradition and for the well-being of Inuit communities. (Duhaime et al., 2004, p. 307)

Another culturally relevant measure of well-being for Inuit is access to and learning from Elders. In southern Canada, where ways and patterns of consulting Elders' wisdom are much less common, education is measured and valued mainly by degree status. Although academic education as a conventional health determinant is still important to Inuit, Inuit culture also emphasizes non-formal learning, particularly from Elders. This type of intergenerational transfer of knowledge is not evaluated by academic degrees; it is evaluated according to Inuit language ability, awareness of Inuit culture, and observance of behaviour over time. Researchers Oakes and Riewe (1997) further explain:

> Inuktitut does not refer to the language, it is a lifestyle. When the Elders ask for Inuktitut to be taught in the schools they are not asking for the language to be taught, but rather the Inuit life skills and philosophies to be taught. Inuit teachers in the school teach the language, not the Inuit lifeways or culture. (p. 110)

Culturally relevant determinants of well-being for Inuit should, therefore, not only address academic education of Inuit women and men but also include non-formal education, including the frequency and quality of interactions with Elders.

> In our Inuit heritage, learning and living were the same thing, and knowledge, judgment and skill could never be separated. In institutional life these things are frequently pulled apart and never reassembled. For example, schools spend much of their energy teaching and testing knowledge, yet knowledge by itself does not lead to wisdom, independence, or power…There are limits to how much can be achieved in a classroom. Wisdom can only be gained by engaging with life, by honouring one's heritage and by mastering the skills necessary for independence. (Nunavik Educational Task Force, 1992, pp. 115, 55)

While acknowledging conventional indicators, Inuit are interested in adding Inuit-specific indicators such as the three described above: multigenerational proximity, non-formal education and access to Elders, and acquisition and consumption of country food.[14] As researchers become familiar with Indigenous-specific health indicator frameworks, we can expect more "new" discoveries of "old truths," as they incorporate the insights of Inuit and other Indigenous cultures into their assessments of Indigenous health.

CONCLUSION

Some health researchers have described an indicator framework as a "lens." Pauktuutit has developed an Inuit-specific GBA lens that allows investigators to notice indicators of well-being that are difficult to see through non-Indigenous frameworks. Inuit often feel a disconnect between their communities' priorities and the priorities of outside researchers. Understanding and using an Inuit-specific indicator framework can help researchers ensure that they are studying issues that Inuit want to know about. This emphasis on respecting Aboriginal priorities in research guidelines is an important part of the growing agreement around ethical guidelines for research in Aboriginal communities.[15] Using an Inuit-specific indicator framework can help researchers build equal relationships with Inuit so that both parties can benefit.

What a society chooses as worthy and not worthy to be measured can shed light on the attitudes, values, and "blind spots" of that society. Researchers who do not try to include Indigenous indicators of health and well-being may be accused of only evaluating Indigenous well-being in terms of the successfulness of adopting another culture; using only Euro-Canadian indicators of economic and social well-being might only tell us to what extent Indigenous peoples are becoming Euro-Canadian.

A better approach is to design frameworks that meet the test of the old economist's maxim: if you want something to count, then you have to count it.[16] If researchers want to show that Indigenous ways of life are important, then they should measure the life factors that Indigenous peoples consider meaningful.

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ᖃᐃᖏᑦᓯ! ᐃᖅᑲᓇᐃᔾᖃᖅᑐᓂ ᐃᓅᓕᓴᐃᔨᐅᓂᕐᒥᒃ ᐱᐅᕝᒪᕆᒃ! ᑖᓐᓇ ᖃᓄᑕᐅᔭᒃᑯᑦ ᑐᑭᓯᒋᐊᕐᕕᐅᑉ ᐱᑐᖅᕕᖓ ᐊᒻᒪ ᑕᕝᕙᓂ ᕿᓂᕈᓐᓇᖅᐳᑎᑦ ᐃᓅᓕᓴᐃᔨᐅᓂᕐᒧᑦ ᐃᓕᓐᓂᐊᕈᑎᒃᓴᓂᒃ ᐊᒻᒪ ᐱᓕᕆᐊᕆᔭᐅᕙᓂᒃ ᓯᓚᑦᑐᓴᕐᕕᖕᓂ ᑕᐃᔭᐅᓯᒪᕙᓂ ᐊᒻᒪ ᓯᓚᑦᑐᓴᕐᕕᒡᕙᐊᖏᓐᓂ ᑲᓇᑕᐅᑉ. ᖃᐅᔨᒋᐊᕈᓐᓇᖅᐸᑎᑦ ᐅᕙᓂ ᖃᓄᑕᐅᔭᒃᑯᑦ:

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ᐃᓱᒪᕕᑦ ᖁᕝᕙᓯᓐᓂᖅᓴᒥᒃ ᐃᓕᓴᕈᒪᓂᕐᒦᒃ?

ᐃᓱᒪᒋᓚᐅᖅᓯᒪᕕᐅᒃ ᓂᕈᐊᕐᓂᕐᒥᒃ ᐃᓅᓕᓴᐃᔨᐅᓂᕐᒧᑦ ᐃᖅᑲᓇᐃᔾᒃᓴᒥᒃ?

ᐃᑲᔪᖅᑕᐅᕐᑯᓪᓗᑎᑦ ᐱᒋᐊᓕᖅᑎᓪᓗᑎᑦ ᑕᒪᑐᒧᖓ, ᑕᑯᓇᒎᓐᓇᖅᐸᑎᑦ ᐃᓅᓕᓴᐃᔨᐅᓂᕐᒧᑦ ᐃᖅᑲᓇᐃᔾᖃᕐᓂᕐᒧᑦ ᑐᓴᒐᒃᓴᑦ ᖁᓛᓂ ᑎᑎᕋᖅᓯᒪᕙ ᖃᓄᑕᐅᔭᒃᑯᑦ ᑐᑭᓯᒋᐊᕐᕕᐅᑉ ᐱᑐᖅᕕᐊᓄᐊᕐᓗᑎᑦ!

ᐊᐱᖅᑯᑎᒃᓴᖃᕈᕕᑦ, ᑐᓴᖅᑎᓪᓗᒋᑦ ᐃᓄᐃᑦ ᑐᑦᑕᕐᕕᖓᑦ – NAHO ᐅᕙᓂ 1-877-602-4445 ᐅᕝᕙᓘᓐᓃᑦ ᖃᓄᑕᐅᔭᒃᑯᑦ ᑎᑎᕐᓗᑎᑦ ᐅᕗᖓ: inuit@naho.ca

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ENDNOTES

[1] In their Report of the Inter-Agency Support Group on Indigenous Issues, the UN Permanent Forum on Indigenous Issues (2005) notes that "Indigenous and tribal women commonly face additional gender-based disadvantages and discrimination. (…) Disaggregation of data is needed in order to extend the analysis beyond simple national averages that can be misleading, signal false progress or mask disparities related to ethnicity. (…) The development of relevant indicators and the collection of disaggregated data must be undertaken with the full participation of the Indigenous peoples concerned."

[2] Delegates to the national Inuit GBA Health Indicators Conference, January 28, 2008 were Martha Akoluk – Umingmaktuuq; Barbara Beveridge – Baker Lake; Goota Demarais – Edmonton; Nellie Elanik – Inuvik; Minnie Etidlui – Kangirsujuaq; Annie Ikkidluak – Kimmirut; Alicee Joamie – Iqaluit; Faith Kakuktinniq – Rankin Inlet; Annie Kumarluk – Ivujivik; Jeannie Manning – Yellowknife; Valerie Taqtu – Arctic Bay; Jennifer Williams – St.John's; Martha Greig – Kujuuaq; Mary Matoo – Coral Harbour; Annie Buchan – Taloyoak; Annie Lidd; Rhoda Innuksuk – Ottawa; Kitty Pearson – Kuujjuaq; Leesee Qaqasiq – Kimmirut; Leena Metuq – Inukjuaq; Becky Kudloo – Baker Lake; Anita Pokiak – Tuktoyaktuk; Ann Curley; Jeannie Evalik – Cambridge Bay.

[3] Inuit could also be said to live in six distinct areas if Nunavut is further divided into the Kitikmeot, Kivalliq, and Qikiqtani regions.

[4] The Inuit versus non-Inuit income difference is $13,090 versus $50,128 according to Statistics Canada 2001 figures cited in Nunavut Tunngavik Inc.'s Inuusiqattiarniq: Annual report on the state of Inuit culture and society 2003/04 and 2004/05, p. 14. The 2-year average turnover rate of southern workers is cited in Nunavut Tunngavik Inc.'s (2003) PricewaterhouseCoopers: The cost of not successfully implementing Article 23.

[5] A 2004 report (Elliott & Macaulay), Public health surveillance in the Inuit of Canada's four northern Inuit regions: Currently available data and recommendations for enhanced surveillance notes that low diabetes numbers may also be in part due to lack of monitoring: "A 2002 study in Repulse Bay, Nunavut reported a diabetes prevalence of 5% among adults over 18 years of age, diagnosed by blood sampling. Seventy percent of cases had not been previously diagnosed." The authors go on to comment that "The history of development of high diabetes rates in other aboriginal populations worldwide, in combination with the prevalence of diabetes risk factors, does raise concerns about the potential for similar increases in Inuit diabetes rates. However, the still relatively low prevalence of diabetes, when compared to other aboriginal groups, presents an opportunity for prevention of an epidemic among Canadian Inuit."

[6] From Inuit healing in contemporary Inuit society by Pauktuutit Inuit Women of Canada, 2004, retrieved March 21, 2007 from http://www.pauktuutit.ca/pdf/publications/abuse/. It is worth noting that even the word "healer" is problematic for some Inuit Elders: "In Inuktitut a literal translation of the English word 'healer' means, 'someone who fixes or repairs someone' and this goes against the Inuit cultural belief that healing comes from within the person needing to be healed."

[7] From Gender-based analysis: Building blocks for success by the Standing Committee on Status of Women, April 2005.

[8] From "Canadian Arctic Indigenous Peoples, traditional food systems, and POPs" by H. Kuhnlein, L. Chan, G. Egeland, and O. Receveur, 2003, in D. Downie, & T. Fenge (Eds.), Northern Lights Against POPs: Combatting Toxic Threats in the Arctic, p. 27, Montreal (QC): McGill-Queen's University Press.

[9] From Survey of living conditions in the Arctic (SLiCA): Results by B. Poppel, J. Kruse, G. Duhaime, and L. Abryutina, 2007, Anchorage: Institute of Social and Economic Research, University of Alaska Anchorage. Retrieved November 12, 2010 from www.arcticlivingconditions.org.

[10] Here is one example, according to an Ottawa report (2003) by Inuit Tapiriit Kanatami, "Inuit Kanatami: Inuit of Canada": "Many families leave the permanent communities during the spring and summer to set up their camps. This is an important part of traditional culture, far from modern distractions, the young are immersed in their culture and language for long periods of time. They learn harvesting and land survival skills used by Inuit for thousands of years."

National Aboriginal Health Organization (NAHO)
Organisation nationale de la santé autochtone (ONSA)

[11] From Development of a First Nations health reporting framework by the Assembly of First Nations, March 2005.

[12] The role that a framework can play in bringing forth certain issues and hiding others is noted by Kaliss and Fridere: "I agree with Fridere's statement, in his 1983 book, Native People in Canada: Contemporary conflicts [page 294], that 'The nature of the analytical framework through which Native-White relations are viewed largely determines what solutions can be put forward'" (Kaliss, 1997).

[13] Both quotes are from the authors' notes from the national Inuit GBA Health Indicators Conference, January 28, 2008.

[14] Culturally relevant indicators such as multigenerational proximity or intergenerational knowledge transfer do not need to be considered unique to Inuit; if incorporated into general Canadian indicator frameworks, these indicators might also shed light on the self-perceived well-being of non-Aboriginal populations.

[15] Illustrated by Chapter 6 of the Tri-council policy statement on research involving humans by the Canadian Institutes of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada; and Tri-council policy statement: Ethical conduct for research involving humans, 1998 (with 2000, 2002, and 2005 amendments).

[16] This phrase is generally credited to John Kenneth Galbraith.

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