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Negotiating Health: the meanings and implications of
'building a Healthy Community' in Igloolik, Nunavut

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fulfilment of the requirements of the degree of Master of Arts.

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ABSTRACT

At the intersection of institutional, local and personal perspectives, this thesis explores what it means to build a Healthy Community in the Canadian Arctic hamlet of Igloolik, Nunavut. It observes that neither the dominant concepts of critical theory nor those of institutional health promotion can sufficiently account for the ways in which Healthy Community discourse and values are adopted and engaged locally.

Contextual semantic analysis is used to examine the health promotion values of 'community,' 'participation' and 'empowerment' in the narratives of Inuit interview participants. Along with historical and ethnographic data, these narratives suggest the ways in which health promotion and wellness values are variously adopted, redirected or infused with particular meaning in the context of both personal and political experience.

By destabilizing the consensus implied by institutional health promotion discourse and by recognizing the multiplicity of meanings and practices surrounding the Healthy Community, it can continue to inspire innovation in healthcare strategies.

RÉSUMÉ

À l'intersection des perspectives institutionnelles, locales et personnelles, cette discussion demande ce que signifie construire une 'communauté en santé' à Igloolik, Nunavut Canada. Ni les concepts qui dominent la théorie critique, ni ceux de la santé publique ne peuvent considérer les manières dont le discours de 'communauté en santé' est engagé au niveau local.

Une analyse des réseaux sémantiques en contexte socio-culturel, est employée pour examiner les principes de 'communauté,' 'participation' et 'l'appropriation de pouvoir' dans les discours des participants Inuits. Avec des données historiques et ethnographiques, ces discours suggèrent les manières dont les valeurs de la santé publique sont appropriées, adaptées ou infusées d'une signification particulière dans le contexte d'expériences personnelles et politiques.

C'est seulement, en déstabilisant le consensus suggéré dans les discours de la santé publique et en se rendant compte des significations multiples associées à la notion de 'communauté en santé,' que l'on pourra continuer à mettre en place des stratégies novatrices en santé publique.

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CHAPTER 1 - INTRODUCTION

1.1 Objective

What is a Healthy Community? How is it created and experienced? If the meanings of both 'health' and 'community' are historically and culturally constructed, what are the implications and assumptions of health promotion initiatives that seek to "build a Healthy Community"? In recent years, a reconceptualization of the notion of health has occurred through the practice of "new health promotion." Challenging strictly bio-medical and the individual-lifestyle versions of health, a new language, theory and expertise have emerged that broadens the definition of the determinants of health to include social, economic, environmental and political factors. This renewal in the field of health promotion has advocated the concept of the Healthy Community for its potential to mobilize local health strategies as well as to invigorate and redirect public policy according to the goals of health promotion.¹

This thesis deals with the discourse and technologies² of the Healthy Community and examines closely the implications of its central health promotion tenets: *empowerment through community participation*. It explores the intersection between institutional, local and personal perceptions of a Healthy Community. While the Healthy Community provides a conceptual question for analysis, it is the lived experience of Inuit

1

While the WHO supports certain 'official' Healthy Cities and Healthy Communities projects worldwide, the term has come to represent an unofficial social movement and motivational invocation for policy. The Healthy Community history and philosophy will be discussed in more detail in chapter 3.

2

From Michel Foucault, I am using 'discourse' as more than verbal and nonverbal communication. It includes the practices, conventions, mechanisms, techniques and procedures (also and especially by 'experts') that constitute the establishment of something as true (Prado 1995:123). I take 'technologies' to mean the "gamut of human effort to manipulate and control what is available to it in order to produce an effect or an end-product perceived to be beneficial in some way to individuals and also society" (Lock and Kaufert 1998:21).

in the Eastern Arctic hamlet of Igloolik, Nunavut (*Iglulingmiut*)³ which grounds it.

Igloolik is a significant setting for several reasons. Politically, with the creation of Nunavut in April 1999, this settlement of 1250 people is quickly becoming an administrative centre for social development programs which invoke a Healthy Community approach (see appendix A). At the community level, under the banners of “building a Healthy Community” and fostering “community wellness,” *Iglulingmiut* are mobilizing broad ranging social health⁴ initiatives which focus primarily on mental health promotion, healing from past abuses, early childhood development and family well-being, from the perspective of community development and cultural revitalization. At the level of family and individual however, little is known directly about how these health promotion values are experienced. Indeed, examining the personal meaning and lived experience of health promoting principles and strategies represents a general challenge to which researchers in the field have only begun to respond (Chandler and Lalonde 1998, Wilson 1996). A notable example of is this kind of work is Corin, Del Barrio and Guay (1996) on the meaning of empowerment in alternative models of mental health care in Quebec.

Despite a perceived need for such research however, much of the literature which critically examines the meaning of Healthy Community and health promotion principles does so by analyzing policy statements and the roles of health workers and promoters, while paying less attention to the point of view of community members. Jewkes and Murcott (1996, 1998) for instance, have explored the multiple meanings of ‘community,’

3

Iglulingmiut means “people of Igloolik.” In the Inuktitut language, the suffix *-miut* is added to a place name to denote the people whose place of origin it is.

4

Following the use of the term in the Royal Commission on Aboriginal People (1996), I understand “social health” to mean the perspective on health which situates it within the relations between individuals, families and communities – all considered a resource for health. The term broadens the concept of health beyond a strictly bio-medical understanding.

'community participation' and 'community representation' based on how these terms are operationalized from the perspective of the professionals who invoke them. Asking similar questions of community members however, will offer a fundamentally different perspective on the meanings which are espoused and employed, and on the relations of power that they imply.

Here, I address the multiple responses of Iglulingmiut to the values and premises implied by Healthy Community strategies. These strategies are designed to promote wellness by confronting the violence, substance abuse and suicide that are a painful legacy of past federal assimilationist policies. By examining the use of Healthy Community discourse and technologies in Igloolik, this study encourages a rethinking of critical models that have considered health promotion primarily as an avenue for the expansion of control by experts, administrators and bureaucrats in health. It draws on experiences of Iglulingmiut to explore instead how conventional concepts and values are variously appropriated, ignored or redirected and infused with symbolic meaning in both highly personal and public ways. In so doing, it broadens a current theoretical discussion in medical anthropology that is re-examining concepts of power in healthcare and challenging the assumption that people are passive recipients of medical knowledge and normative health and lifestyle advice and values (Lock and Kaufert 1998).

This assumption runs through much of the critical work that has examined the Healthy Community elsewhere. Indeed, its central precepts have been problematized in the theoretical literature mainly with respect to notions of both surveillance and power. For instance, some analysts view health promotion and the strategies of a Healthy Community as expanding the medical (and institutional) gaze into every corner of personal life including recreation and interpersonal relationships (Peterson 1996, Lupton 1997, Gastaldo 1997). Investigation has focused on the increased sites of control for an administrative bureaucracy that has come to envelop and shape daily life in the name of risk management (Peterson 1996:131, Castel 1991). This approach constitutes power as a

force that acts through the adoption of advice and routines, creating consensus and shaping moral, dutiful, active subjects of an idealized community, while obscuring uncertainties and competing interests.

Such accounts are problematic, however, insofar as they tend to see people as docile bodies, made the subjects of powerful expert knowledge. While this approach does draw attention to the invention of community consensus and to the danger in concealing local contradictions and struggles, it leaves unexamined the variety of opinions and actions with which health promoting strategies are met in practice. Ironically, these criticisms mute local voices just as much as does the discourse which they intend to unmask. Consequently, the possibility for a complex, mobilizing and productive side to putative power relations is effectively denied. Therefore, while I question the consensus implied by policy promoting a Healthy Community, it is from a perspective other than that which points strictly to the management of mute and docile bodies.

In the perspective adopted here, ambiguities emerge. On one hand, to leave unquestioned the promising claims of the Healthy Community is to ignore important local diversity and the often difficult life circumstances of many residents, and to assume that everyone has the will and the resources to participate in organized strategies for health and well-being. Overlooking these circumstances might also lead to a naive frustration when community participation is low and when incidents of 'unhealthy' behaviour persist. An imagined consensus distills a range of opinions and practices within the community. This ignores the tensions that can arise when historically constituted and personal values about health meet a legacy of bureaucratic and administrative structures, and when personal feelings of community are confronted with the reality of the state-established settlement.⁵

5

The inherent problem of southern style bureaucratic structures for Inuit governance has been articulated by Frank Tester. He indicates that while indigenous knowledge has been recognized and legitimized through land claims settlements, "the pressures of self-government and its financing have made it difficult for indigenous governments to develop using their own logic and wisdom (cited in Grenier 1998:6)."

On the other hand, this is not to say that the idea of a Healthy Community is not a productive and mobilizing force in Igloodik. Indeed, quite the opposite is true. Many Iglulingmiut point to Healthy Community and community wellness strategies as important practices that foster personal and cultural strength, awareness and resilience (regardless of whether or not they take part). This is echoed in the recent Royal Commission on Aboriginal People (RCAP) where it is suggested that "many of the problems now confronting Aboriginal communities can be addressed more effectively in a health promotion framework rather than from a curative approach" (O'Neil cited in Canada 1997:np). In the RCAP, 'illness' has been described as "loss, multiple losses, loss of ways of life, loss of language, loss of ceremonies and traditions. Loss of land base. Loss of meaningful control over day-to-day life" (Canada 1997:np). Given the diverse perspectives from which the notion of Healthy Community can be approached, there are ambiguities that neither the discourse of health promotion, nor the conventional tools used to criticize it, address adequately. Discussion of the effectiveness of Healthy Community strategies is therefore polarized in the literature.

This thesis is situated within the analytical space of these tensions. It observes the complexity of Iglulingmiut responses to and representations of Healthy Community discourse, which fit neither the assumptions of health and wellness promoters and policy makers, nor the criticisms of hegemony alarmists. It demonstrates that 'community' is neither a homogenous unit, nor an imaginary ideal; it is historically constructed and strategically invoked. Similarly, 'participation' is neither idealized nor dismissed locally; it is negotiable and sometimes negligible. Finally, the goal of 'empowerment' is neither a guarantee, nor the result of false consciousness or simple resistance;⁶ it is slippery and subjective. My analysis is intended to destabilize these common sense categories, but also to re-evaluate the 'hegemonic' discourse. This re-evaluation encourages a dialogue

6

The single quotation marks around these terms is intended to problematize the concepts. For the remainder of this document, the quotation marks are implied.

of transformative possibilities rather than the monologue of dominant concepts offered by either health promoters or their critics (Cruikshank 1997, 1998:63, Searles 1998:10).

To be sure, an examination of Healthy Community initiatives in the context of contemporary Inuit life and political realities poses inherent difficulties. The analysis could be misconstrued as critical appraisal of some of the ideals for which Inuit leaders have long lobbied. Indeed, the goals of health promotion in general are to some extent emblematic of the self-government and collective sense of empowerment that the creation of Nunavut fosters. My intention however, is not to comment on the achievements of Nunavut, which are considerable. Rather, I look at the discourse of the Healthy Community and community wellness as a body of knowledge, interpretations and practices that have been infused with particular meaning, and that have special implications in a Northern setting.

While I recognize that my research is filtered through southern, non-Inuit tools of analysis, I hope to convey, as accurately as possible, the complex and necessarily ambivalent engagement with institutionalized health promotion activity in Igloolik. The opinions and experiences that Iglulingmiut graciously shared with me encourage critical reflection on practical health promotion strategies, while also calling into question the conventional criticisms about its regulatory and disciplinary effects.

1.2 Context of Research

As a non-Aboriginal social scientist without clinical health care experience, I am highly conscious of my position as an outsider... (John O'Neil 1993)

As anthropology confronts its record of colonial complicity around the world, First Nations peoples rightly insist that their voices be heard in both anthropological and public discourses. Americanists work in collaboration with First Nations communities or they do not work at all. (Regna Darnell 1997:271)

The late 20th century crisis of representation in anthropology has had an immense impact on the discipline (Clifford and Marcus 1986). Most of us now admit our inherent situatedness in research and question the possibility of *truly* objective accounts. While we are rethinking our epistemological authority, we have also become acutely aware of the political implications of our work. In a post-modern and post-colonial world (which includes the internal colonies of the so-called “fourth world”), we are accountable to our ‘anthropological subjects’ for the work that we produce. This is especially true for those of us who work in societies other than our own.

Anthropologist Julie Cruikshank (1993) provides an insightful chronology of the way in which the practice of ethnography has evolved in Arctic and subarctic Canada. With the exception of Franz Boas’ Inuit ethnography in the late 19th century, and the work of Diamond Jenness in the early 20th century, there was little specifically ethnographic activity in the North until after the Second World War. Then, during the 1950s, Arctic and subarctic societies were considered something of a natural laboratory where anthropologists could test classical hypotheses and generate theory about social organization. Soon however, the ‘discovery’ of so much local variation among groups turned ethnographic efforts toward documenting variety rather than defining general principles. By the 1960s the Canadian government became the sponsor of much subsequent ethnographic exploration in the North. In these post-war years, the general interest was in acculturation models designed to measure (and perhaps mitigate) the impact of *inevitable* assimilation of Aboriginal societies into the mainstream society and economy. In the early 1970s Aboriginal northerners began to organize politically to express their own views on the future direction of their people. As land claims negotiations became a central concern, ethnographic work turned increasingly toward documenting traditional land use and cultural persistence. Cruikshank points to the tension that exists between models of stability and change in Northern societies. The acculturative models have been intensely criticized by Aboriginal northerners who now suggest that local people must have a primary role in defining research questions for anthropologists (1993:136).

For instance, where research questions are not directly generated by local residents, they must at least address local concerns. To this end, the Nunavut Research Institute issues mandatory research licenses for the territory. A major criterion for acceptance of a research proposal is its local significance (NRI 1997). The NRI acts as a liaison between researchers and community leaders to ensure that community concerns are addressed and appropriate changes to research design can be negotiated. The fact that this process of consultation is now legislated demonstrates the strong feelings of Aboriginal northerners about research of any kind. Increasingly, they are calling for participatory and collaborative projects (Cruikshank 1993, O'Neil *et al* 1993, Canada 1996).

During the winter and early spring of 1998, I had the opportunity to be part of just such a project. Our team of Inuit and non-Inuit researchers undertook a collaborative project to explore the meanings of distress, suicide and wellness in two Nunavut communities, one of which was Igloolik. The project, entitled *Unikkaartuit: the meanings of distress, suicide and wellness*,⁷ was initiated after the 1994 meeting of the Canadian Association for Suicide Prevention (CASP) held in Iqaluit, now the capital of Nunavut. At that time, a group of Inuit administrators and front line workers assembled to discuss the possibility of conducting local research on suicide, and formed a steering committee to oversee the project. In partnership with psychologist Dr Michael Kral and a multi-disciplinary research team, this steering committee's ideas began to take shape. The goal of the project was to collect and thematically analyze some of the deeply personal narratives behind Nunavut's suicide statistics.⁸ The *Unikkaartuit* project seemed to have

7

Unikkaartuit is an Inuktitut word that roughly translates as "people telling stories" or "the storytellers." The name was chosen by the steering committee to reflect and honour traditional ways to transmit knowledge through storytelling. At the time of writing, the *Unikkaartuit* project is in its third and final stage. The Steering Committee, the Baffin Regional Youth Committee and researchers are working together to develop appropriate suicide prevention strategies based on the project's findings.

8

The rate of suicide in Nunavut is 88 per 100 000, while the Canadian national rate is 13 per 100 000

(continued...)

great local resonance not only for its focus on suicide, but also because “talking” and “sharing stories” (in appropriate and confidential circumstances) are considered by many Inuit to be powerful tools in overcoming personal and family pain (Kirmayer 1997, 1996, Minor 1992, Drummond 1997).

Given my involvement in what came to be known locally as “the wellness project,” I was interested in the use of this expression and others like it: “community wellness,” “building a Healthy Community,” “community empowerment.” Our project appeared to fit seamlessly into this institutional and public discourse. Considering interview data which continued to reveal feelings of alienation and often suicidal ideation (especially among young people) however, it would be a disservice to Inuit collaborators and participants not to try to understand the consensus implied by this discourse, compared with the varied, complex, and sometimes deeply painful accounts among many Iglulingmiut themselves. It was important to balance these conceptual concerns with my practical responsibilities as a research associate. In delineating my analytical focus, I had to be mindful of ways in which this enquiry could inform the goals of the project.

In the chapter that follows, I present the theoretical influences that underpin my work, along with an explanation of research and analytical methodology. Chapter 3 begins with an introduction to the theory and practice of the Healthy Community and wellness movement followed by an historical sketch of Igloodik. This history highlights salient experiences of sedentarization and the advent of southern-directed medical services in the north. As a whole, this chapter historicizes the emergence of Healthy Community discourse in the context of Igloodik’s colonial history.

⁸(...continued)

(GNWT 1997:4). With a population of 24 730, an average of 23 people take their own lives every year in Nunavut. Cappon and O’Neil (1994) suggest that suicide is one of the biggest health issues that is faced in the North today. This fact is underlined in the Royal Commission on Aboriginal People (Canada 1996, 1997) and by many Iglulingmiut themselves.

In chapter 4, I explore the meanings and personal experience of three main principles in this discourse - community, participation and empowerment. The first part of the chapter examines how these are constituted through health promoting technologies, and juxtaposes these with some corresponding concepts in Iglulingmiut and Inuit tradition. In the latter part of the chapter, I reconstruct interview respondents' semantic networks surrounding each concept. Informed by the interview data and by elements of ethnography, careful consideration of the use of these concepts serves to destabilize them. This reveals some of the tensions and ambiguities surrounding Healthy Community values and reexamines the consensus that they imply. The advantage of the semantic mapping technique is that it also reveals the avenues of negotiation, translation and re-appropriation of health promotion norms and values in the context of local practices.

In light of interview data, chapter 5 reassesses the critical discussion on the Healthy Community and reframes its salient questions. By introducing local voices into the theoretical debates, this chapter demonstrates that remaining open to the possibility (and practical implications) of diverse interpretations of the values implied in the Healthy Community will ensure their continued analytical power for inspiring innovative approaches to health.

The concluding chapter is an epilogue that revisits the question of subjectivity and truth in the construction and maintenance of dominant discourses such as health promotion, the Healthy Community and community wellness. It takes this discussion beyond Igloodik to explore the power of Nunavut as a master narrative (Appadurai 1991) that inspires strength and consensus in a common goal, despite the ambiguities and multiple meanings of the values that this goal might imply.

CHAPTER 2 - THEORY AND METHODS

2.1 Theoretical Perspective

What difference does it make - for theory, for research, for policy and for societal ethics- to change the border between a social and a health problem? Now pulling the edge toward the social side, later on pushing it toward the medical margin ... The moral, the political and the medical are culturally interrelated, but how do we best interpret that relationship and its implications? (Arthur Kleinman 1995:16)

Medical anthropologist Arthur Kleinman has drawn attention to an important question in the discipline as he sees it. Where is the border between social and a health problem? Who has the power to draw one? I share with Kleinman a concern for the centrality of social issues as they have been framed in discourse on health. Indeed, in Igloolik, as in many Inuit and First Nations communities, social issues and health issues are considered one. By this I mean not simply that there are obvious social determinants to physical and mental health (economic, educational, living arrangements etc.). Rather, *social* issues are lived at the personal, family, community and political level as fundamentally *health* issues (Canada 1996, O'Neil and Kaufert 1998).

For most Inuit, to be healthy is to "have a good life" (*inusirqatiarniq*). The meaning of this descriptive term incorporates everything from spending time on the land and with family to enjoying good nutrition, housing and education. More recently perhaps, *inusirqatiarniq* also might encompass pride in Inuktitut language and traditional practices. Oral histories dating from the pre-Christian era in Igloolik indicate that good communal relations with extended family were considered the only guarantees of physical and mental health. Through the years, the emphasis on the links between health and social relations among Inuit has remained strong. (Shea 1988, Borré 1994).⁹

9

For similar discussion of an aboriginal conception of social health and its links to cultural identity, see Adelson's work in the Cree community of Whapmagoostui in Northern Quebec (1992, 1998). Adelson

(continued...)

The fact that this indigenous conception of health as a social resource and responsibility coincides well with the strategies of a Healthy Community and the tenets of health promotion is taken for granted by personnel whose models are built around it. Indeed, it seems natural that an administrative and bureaucratic infrastructure should have developed to counsel, treat, manage and mitigate the painful effects of colonization - domestic violence, alcohol abuse and depression.

Alan Peterson and Deborah Lupton (1996) attempt to unravel this kind of assumption about what seems natural in health promotion. Drawing attention to metaphors of the "New Public Health," they maintain that the appealing language of community participation and empowerment actually serves to mask coercive relations of power. These metaphors redefine citizenship according to morals, duty and responsibility. They romanticize a homogenous community, which marginalizes those who do not fit in or who are not visible to this health promotion gaze (Peterson 1997:204). Cautious of the Healthy Community, Peterson and Lupton suggest that health promotion is the product of Neo-Liberal rationality and argue that

...the new public health is, if nothing else, a set of discourses focusing on bodies, and on the regulation of the ways in which those bodies interact within particular arrangement of time and space. Perhaps less obviously, the discourses of the new public health also seek to transform the awareness of individuals in such a way that they become more self-regulating and productive both in serving their own interests and those of society at large. By providing norms by which individuals are monitored and classified, and against which individuals may be measured, the emphasis of the new public health is upon persuading people to conform voluntarily to the goals of the state and other agencies (Peterson and Lupton 1996:12).

Lupton (1997) has also raised concerns about the potential of health promotion strategies to actually "re-medicalize" in a broad sense where their goal has been "de-

⁹(...continued)

explores the Cree concept of "being alive well" to account for how social and political issues are framed in the discourse of health.

medicalization.” She contends that health promotion strategies move medical and health concerns “into every corner of life, including diet, physical exercise, sleep patterns and relationships with others,” through a growing “penetration of the clinical gaze into the everyday lives of citizens” (Lupton 1997:107). Thus the work of experts in social work, counseling, teaching, etc. is considered expansion of the clinical gaze and further medicalization (Gastaldo 1997, Peterson and Bunton 1997, Baum 1993).

While this line of argument critically confronts some of the assumptions taken for granted in the Healthy Community, it fails to recognize not only the role of individuals in perpetuating the dominant discourse, but also how people might use this discourse - strategically invoking it, as much as submitting to its constraints. Ironically, Lupton herself has called for a re-evaluation of the circulation of power in conventional medicalization studies, but has not applied this argument in the context of health promotion or to the implications of the Healthy Community. She suggests research that would re-align discussion about medicalization with local practices and situations, “devoting more attention to the ways in which the discourses of health are variously “recognized, ignored, contested, translated and transformed in the context of everyday experience” (Lupton 1997:108). If health promotion does echo medicalization through its expansion of the clinical gaze and its institutionalization and management of “healthy practices,” then could it not also be analyzed according to the line of enquiry that Lupton suggests?

Taking a cue from Foucault

The work of Michel Foucault deserves much of the credit for a post-structural shift in the analysis of power. No longer is power conceived as deceptive and oppressive strategies imposed from above. Instead, emphasis in post-structural analysis is on the circulation of localized “micro-powers.” With the influence of Foucault, power in the Healthy Community and in health promotion has been conceptualized as acting through education, persuasion, routinization, and incorporation of values (Peterson 1996, Castel 1991). It is thought to create self-regulating, self-monitoring, and morally conscious agents

of healthy living. However, while this framework may not be as deterministic as previous conceptions of power, it nevertheless leaves little agency or recourse to the individual actor beyond simply “resistance.” The Foucauldian treatment of power has privileged textual material and the workings of institutions, while paying almost no attention to what people were doing.

In his later work however, Foucault did begin to explore the actions and intentions of individuals. It is his discussion of the relationship of truth and subjectivity (Foucault 1991:2) that is useful here. No longer explicitly concerned with practices of discipline, surveillance and regulation, Foucault explored the relationship between subjectivity and truth in his analysis of how and why people come to embody and adopt certain dominant values (ibid. 2). He used the concept of entering into *truth games* to talk about how certain ways of being and acting are constructed and come to be naturalized. He understood “truth game” to mean:

an ensemble of rules for the production of truth ... an ensemble of procedures which lead to a certain result, which can be considered in function of its principles and rules of procedure, as valid or not, as winner or loser (Foucault 1991:16).

In this way, truth is not something universally acknowledged; it is negotiated and constructed. Through practices of the self, such as introspection, narration, or disclosure in a counseling group (Peterson 1997:195), people “enter a game” and take part in the production of truth and knowledge, shaping themselves as subjects of it. Eventually, “consensus...organizes itself, functions in a closed circuit, has its values, determines what is good/true and evil/false and so on” (1991:16). Understanding this process by which consensus (common sense) is created allows us to unpack the dominant concepts in the Healthy Community in a way that is attentive to the action and agenda of individuals.

At the same time, an enduring feature in the shifting theoretical ground of Foucauldian post-structuralism is the importance of historicizing concepts. Anthropologists who adhere to this post-structural tenet do so by first recognizing common sense as ideology. They can then challenge it by grounding it historically, culturally and locally. Thus, attending to the roles and actions of individuals, embedded as they are in a social and historical context, can help us to understand the construction of a discourse such as that of the Healthy Community.

In Igloolik for instance, overcoming the anger, depression, and emotional pain that continue to plague many Iglulingmiut is a deeply personal process that is characterized by ambiguity. Individuals stand at the axis of self, family, community and now Nunavut (Our Land), which imparts a new set of hopeful expectations - on young people especially. People must therefore negotiate decisions about how best to commit themselves to everyday healthy and healing strategies. By doing so, they overtly maintain a discourse of Healthy Community even though conflicting responsibilities often might require them to negotiate its meaning.

This negotiation is better understood when the turn towards the Healthy Community in Igloolik is considered in historical context. It is important to view the rhetoric of the Healthy Community against a history of medical and economic dependency that was created in the Arctic after the Second World War. A commitment to historical and cultural context, along with a concern for the practices of subjectivity, constitute a central theoretical paradigm in medical anthropology that provides a particularly useful way to look at Igloolik.

To consider the Healthy Community simply as an avenue for growing institutionalization and self-monitored social control is inappropriate. It does not account for the variety of local responses in which new health promotion principles are concurrently celebrated as empowering, challenged as marginalising and infused with

variable political, cultural and personal meaning (*cf* Lock and Kaufert 1998:18). Gaining a sense of empowerment and fostering an awareness of community through participatory methods can be seen not so much as imaginary ideals, but as games of truth by which consensus is *created* and differently perceived.

2.2 Methodological Considerations

Often confronted with human affliction, suffering, and distress, fieldwork in medical anthropology challenges the traditional dichotomies of theory and practice, thought and action, objectivity and subjectivity. The very nature of the subject matter forces the researcher to seek out a position of informed compromise from which it is possible to act. (Shirley Lindenbaum and Margaret Lock 1993:xi)

Method of data collection: listening to stories

While I am acutely aware of the methodological and epistemological concerns engendered by an applied research partnership, the experience has shown that critical reflection that remains mindful of the local research agenda is possible and indeed fruitful. For instance, it was against the background of *Unikkaartuit* that many Iglulingmiut engaged in reflective and critical discussion of the Healthy Community and community wellness issues. Their opinions and insights might not have surfaced had it not been for the freedom and opportunity that the project provided them. Anthropologist Gananath Obeyesekere (1990) has discussed the relationship between researcher and participant. He reminds us that respondents do not simply offer us “facts.” Rather, they are “involved with us in a crucial intersubjective relationship and are engaged in a continuing dialogue with us” (Obeyesekere 1990:226). I recognize that my analysis owes a great deal to this dialogue.

This thesis draws on selected interviews from within the body of data collected for *Unikkaartuit*. In that project, a total of 50 people took part in 30-40 minute semi-structured interviews which were designed in collaboration with respected community Elders. These discussions centred around descriptions of community life and social

activities, perceptions of suicide, abuse and violence, followed by strategies for help and healing. Participants also talked about their use and knowledge of local programs and public and private healing resources.

Sampling for *Unikkaartuit* was done according to snowball and quota methods to obtain an adequate range of responses. Given the sensitive nature of the enquiry, and respecting the fact that many people were simply “not ready to tell their story,” this method of sampling seemed more appropriate than would a random sampling frame. Of the interviews, 27 were conducted with women, while 23 were with men. Participants ranged in age from 18 to 94 years old. The majority of interviews (36%) were with young people under thirty. Elderly people over 65 years old comprised 18% of interview participants. People from 50 - 64 years old accounted for 14 % of participants, while those aged from 30 - 39 and from 40 - 49 each represented 16% of participants. There was generally an even split between male and female participants in each category, though women in their forties were over represented (75 % in that age range).¹⁰

To better reach young adults, the interviews were adapted as questionnaires and distributed in the high school. In addition to completing the questionnaires, students engaged in class discussions about suicide and violence, which they allowed researchers to attend. Following this, 5 teens accepted the invitation to continue the discussion in an interview setting. Those young people considered school non-attenders were accessed informally through friends. A similar method was used at the Igloodik’s Arctic College, where students are generally older (late twenties to forties). Additionally, key municipal personnel were contacted to add context to the narratives. While these discussions provided information on the structure of community wellness programs, they also offered insight into how the idea of the Healthy Community is constituted through administrative discourse.

¹⁰

Significantly, it is women of this age who seem to be the most visible and vocal on social health issues in Igloodik. Many Iglulingmiut speculate that the experience of residential schooling, endured by most people of this age group, has given rise to their critical political and social acumen today.

After a thematic overview of all *Unikkaartuit* interviews, I chose twelve to examine in greater detail. Anthropologist Wim Rasing has suggested that the diversity of opinions in Igloolik must be understood in the context of the vastly different life experiences of each generation, given the unprecedented changes created by sedentarization (1994:201). He describes three distinct perspectives: elders born and raised on the land; a transitional generation born on the land and raised partially on the land and in the settlement with a new formal education system; and contemporary youth whose main frame of reference is settlement life. Along with these distinctions, I also considered gender and social role, given that people's perceptions of the values and strategies of a Healthy Community are embedded in their own experiences and environment. Selected interviews with Iglulingmiut social policy-makers, wellness committee members, students, school non-attenders, hunters, homemakers and elders¹¹ were therefore chosen both for their range of representation and for their richness of detail.

While the selected narratives provide a great deal of semantic data, this method is inadequate in itself to encompass lived experience in Igloolik. Living with a family, whose network of relations and friends extended across the community, gave me the opportunity to spend time learning how Iglulingmiut themselves constitute healthy community - far away from desks of policy planners in community development, health care, or social services. These ethnographic elements are therefore used to supplement and illustrate salient points in the narrative analysis.

11

Discussions with elders were enriched by information drawn from the Igloolik *Inulaariit* Elders' Association Oral History database, which was used to orient and structure these conversations. Narrative excerpts drawn from this database are clearly indicated in the text. I thank Leah Otak and John McDonald of the Nunavut Research Institute in Igloolik for their help with my research in this database.

Implications of position

My position on the research team created both opportunities and constraints. Issues of community mental health and wellness are so important in Igloolik that most people with whom I spoke were extremely forthcoming. Many not only discussed personal stories, but also political expectations and social dynamics in order to contextualize suicide, wellness and the Healthy Community within the unprecedented political changes now occurring with the creation of Nunavut.

Despite this fortunate situation for learning, the possible effects of research circumstances cannot be ignored. For instance, associations made and conclusions drawn about the very nature of the research project may have affected the tone of conversations regarding the issues presented here. One common response was: “What is healthy? You mean *community* health or *wellness*...?” Was this link between “healthy” and “community” forged in reaction to the perceived goals of the *Unikkaartuit* project? Was it part of a current vernacular or the spontaneous expression of deeply held cultural associations? Was it a combination of these possibilities?

Another consideration is a suicide that had occurred in Igloolik just prior to the research period. Local counselors and care-givers acted quickly to heighten public awareness of the availability of both counseling and preventive help. The suicide cut across denominational lines as well as the tacit parameters that still exist among extended families traditionally associated with particular camp groupings. *Everyone* was aware and many were deeply affected by the suicide. As a result, there was a great deal of participatory momentum in the wake of yet another tragedy.

Late in 1998, I returned to Igloolik for a short visit to continue my conversation under somewhat less compelling circumstances.¹² Along with targeted discussions with policy planners, I was able to spend considerably more time among young people discussing their particular social and political perspective and their vision of a Healthy Community. Thus the data considered in this thesis are drawn from the selected interviews and personal discussions (where permission was granted for their use) which took place during a total of 7 weeks in Igloolik. This information is also given context for comparison by using government documents that attempt to define and operationalize the goals of community, methods of participation and empowerment.

Method of analysis: words, actions, meaning

A central premise of this thesis is that contemporary critical models that draw attention to the regulatory and normative nature of health promotion are as inadequate as conventional health promotion theory to account for people's varied engagement with the implied premises of the Healthy Community. Any examination of the apparent consensus or assumptions surrounding these premises in Igloolik *must* come from within Iglulingmiut social dynamic. Therefore, it would be inappropriate to claim that, by their very nature, Healthy Community principles constrain and create subjects through forced consensus and obligatory participation. Such criticism imposes its own moral authority and assumptions; it remains distant from local sites of health practices. A subtler, more flexible method of analysis is required to attend to the personal words and practices that are rooted in cultural particularities and influenced by political and economic realities. It must account for people's own perceptions and role in the shaping of Healthy Community discourse - and the shaping of themselves through the discourse. To achieve this goal, I model my analysis on a method developed by Corin and associates.

¹²

This opportunity was free of the factors which seemed to have the most influence during the previous visit: a completed suicide, and our explicit mandate to discuss suicide.

Ellen Corin (1990) has proposed a “contextual semantic analysis” which adapts the “semantic network analysis” developed by B. and M. Good (1977, 1982), and the “explanatory models” perspective of Kleinman (1988). This method builds from the discourse, narratives, and interpretations that people themselves assign to (mental) health issues and strategies enacted locally (Corin *et al.* 1990, Bibeau and Corin 1995). The analysis begins from the premise that people’s ways of thinking and acting are embedded in the social order in which they have been historically constituted and they cannot be understood independently of this context (Corin *et al.* 1990:21). It contextualizes narrative and locates the *signs, meaning, and actions* of people within their sociocultural origins. The dominant themes identified in the narratives are “expressed in the form of a semantic net which interweaves various threads around a few central knots and which contribute to form distinctive patterns” (Bibeau and Corin 1995:42).

In Igloodik for instance, these associative semantic chains typically link land activities, family, trust, and the ability to express emotional distress in the semantic net of mental and social health. Depending on context and speaker, the associations can be self-consciously expressed, but they might also be manifested more tacitly in practice. Therefore, in addition to individual narrative, complementary ethnographic elements are used to locate the organizing “focal points” around which social and cultural life revolves.

While anchored within Iglulingmiut culture and tradition, these focal points are in turn subject to the constraints of external forces - the historical, political, and economic realities that Corin has labeled “structuring conditions” (Corin *et al.* 1990). Semantic networks are therefore viewed in the context of these conditions. The construction and adoption of dominant concepts and practices thus occurs in the interplay between these conditions and locally rooted interpretations. Bibeau (1997) expresses it in the following way.

The key ethnographic unit of investigations should be neither individual acts or events, nor the dominant cultural meanings, but rather the actual *networks* through which actors enact and transform unique values and meanings into practices (Bibeau 1997:248, emphasis added).

A similar method of contextualized semantic mapping is used in this thesis to gain an understanding of the personal experience of community, participation and empowerment. These concepts are examined according to the associations of meaning and practices through which they are articulated in respondents' discourse. These sets of meaning demonstrate the ways in which different categories of people interpret the concepts and use them to assess and mobilize personal and collective practices of health. The similarities and differences in people's engagement with health promotion and wellness discourse are thus revealed and show how the values might be ignored, appropriated, or reconfigured and assigned specific meaning at the level of both sentiment and action.

To trace the semantic networks, the three concepts are sometimes tracked as responses to purposive questions. More often, they are encountered diffused throughout the interviews, which are considered holistically as narratives about health and the experience of community. Analysis is guided by the way in which the concepts are constructed, defined and operationalized in the government documents which introduce them as the values and premises of a Healthy Community. It then decentralizes these political elaborations by comparing how respondents themselves discuss, define and develop the concepts through their own discourse and practices. The notions of community and participation are familiar enough that their deployment and associations can be tracked and compared both across the narratives and against the central institutional definitions. However, interpreting a sense of empowerment is less obvious because, as a health promotion term, it is not shared in local vernacular. Comparison must therefore begin from the *premises implied* by its institutional definition, to examine

whether or not these correspond to familiar elements within Iglulingmiut society. As much as possible, these networks and associations will be presented in the words of Iglulingmiut themselves.

The fact that I am imposing organizing categories conceived in the bureaucratic offices of a southern / non-Inuit / federal institution (the health promotion branch of Health Canada), cannot be ignored. From an anthropological perspective, simply transposing the terms risks committing a category fallacy by prescribing an order which may not have any emic resonance. However, it is precisely because the three concepts have gained considerable currency in northern health policy discourse that they are the focus of this analysis. The apparent consensus surrounding these terms can obscure the fact that they involve certain basic premises about the notions of personhood, responsibility, authority, rights, social relations and the delineation of public and private spheres that are introduced through new health promotion discourse. To what extent do these external notions fit with local ideas? Are they transformed or reoriented at the level of popular discourse? What are the practical implications of learning how the values of health promotion are engaged locally?

The following chapter introduces the rationale of the Healthy Community and situates the town of Igloolik. These topics are then combined in an historical examination of the construction and adoption of Healthy Community and wellness discourse in Nunavut and in Igloolik. The chapter demonstrates that this shift must be understood in terms of the structural realities of both colonial history and politics to help account for the ways and contexts in which the principles of the Healthy Community are invoked and experienced today.

CHAPTER 3 - THE HEALTHY COMMUNITY AND IGLOOLIK:

Constructing a discourse

3.1 The Healthy Community and Health Promotion

The discourse and technologies of the Healthy Communities movement constitute a significant branch of the “new health promotion” that has been gaining momentum since the early 1980s. The roots of this movement can be found in a 1974 working paper entitled *A New Perspective on the Health of Canadians* (Lalonde 1974), which was released by the Canadian Department of Health and Welfare. Indeed, the early years of health promotion are often associated with Canada. For instance, Toronto became the first city internationally to adopt a “Healthy City” policy and Ottawa hosted the 1986 World Health Organization conference (which culminated in the WHO’s Ottawa Charter for Health Promotion).

It was also in Ottawa that Health and Welfare Canada refined its vision of health promotion in *Achieving Health For All: A Framework for Health Promotion* (Epp 1986). This key document emphasizes the cost effectiveness of reducing social inequalities, increasing prevention, and encouraging local empowerment in issues related to health. It contends that fostering an atmosphere in which individuals and communities can enhance skills, take responsibility and make decisions about their own health priorities will improve public health. Thus by 1986, ‘empowerment’ became enshrined as a central concept in the discourse of new health promotion.

Prior to the adoption of the empowerment framework, the practice of promoting health had generally targeted problems such as stress, tobacco, alcoholism or child abuse. Solutions involved encouraging better individual care and promoting healthy ‘lifestyles’ (Flynn 1996:300, Raeburn 1998). By individualizing public health issues however, the efforts of health promotion resulted in blaming sufferers for their health problems - an

unpopular tactic. The move away from this 'victim blaming' approach gave rise to multi-leveled strategies which broadened the determinants of health to include economic, social, environmental and political factors. This has considerably expanded the mandate of health promoters.

One important strategy of this new mandate is the so-called *healthy public policy*, the aim of which is to "build health priorities into the decision-making processes of local governments, community organizations and business ... and to change the community culture by incorporating health" (Hancock 1993:8, Robertson and Minkler 1996:296, Peterson 1997, Mechanic 1999). Healthy public policy maintains a concern for health and equity in all areas of policy, not simply those traditionally associated with health services: education, housing, job training, recreation facilities, the regulation of urban space and work environments (Peterson 1997:190). A second strategy is *intersectoral collaboration*, which is characteristic of the Healthy Community philosophy in particular.

This strategy is intended to forge alliances between local government, private bodies, non-government organizations and community groups, privileging these over national health campaigns. It also means combining the agenda of government departments (at least in principle) to bring health policy into line with social issues.

Conceptually, the Healthy Community philosophy places great emphasis on process. In fact, a Healthy Community may not necessarily be one that enjoys a high health status, but one that puts 'health' on the agenda of as many public decision makers and members of the public as possible (Hancock 1993:7). Central tenets hold that community members should help to determine health priorities and necessary measures to meet them. In this way, the Healthy Community is considered a vehicle for everything from public participation, community development, and personal skills development - all of which constitute apparent forms of empowerment.

Because the mandate of new health promotion and the Healthy Community is so broad in scope, it now extends into areas that have traditionally been the domain of mental health. Concepts like empowerment, coping skills and well-being are assumed to have positive repercussions on physical health, but they have long been tools in the community mental health arena. This overlap is confirmed in a recent document on mental health promotion by the Canadian Mental Health Association.

If health promotion is being interpreted in terms of the broader, more socially critical, and empowering ideals of the Ottawa Charter, then it might not be necessary to distinguish between mental health promotion and generic health promotion (Willinsky and Pape 1998:9).

This broad interpretation of health promotion is particularly powerful when applied to a northern settlement. For instance in Igloolik, the history of colonial management of healthcare, housing, education and economic policy is a legacy that Iglulingmiut are eager to replace. The challenges left in its wake are now addressed through an integrated approach to health that eliminates the imposed boundary between physical health, mental and spiritual well-being, and community and social development. Strategies of the Healthy Community and Community Wellness are intended to encourage people to discuss their own priorities for health and ideally to incorporate these into the local political agenda. The following two sections address how the hamlet of Igloolik emerged as the Healthy Community of Igloolik by recasting health as 'social health,' by realigning it with social development, and by revaluing local knowledge in health and care-giving.

3.2 - The Community of Igloolik

My wife needed medical attention, so I did not mind moving here. I wanted her to live longer so I did not mind making this place my home. We were treated very well and were provided with a dwelling. This happened when this place was just being settled in. I did not mind being among people for the sake of my wife, I wanted her to be in a place where she could get medical attention. I have been treated well throughout my life. (Igloolik Oral History participant 1994)

Because I grew up in a camp that was isolated from the rest of the people, I did not know of any action that might have caused the disruption of good relationships. When we started to live in a more populated place, then I saw instances where relatives, among themselves, were filled with animosity. (Igloodik Oral History participant 1994)

The ethnohistory of Eastern Arctic Inuit, and especially of Iglulingmiut, is well documented (Perry 1823, Rasmussen 1927, Damas 1963, 1975, Mary-Roussiliere 1984, Creary 1993, Rasing 1994, Stevenson 1998). Like other Inuit groups of the Eastern Arctic, Iglulingmiut traditionally lived in camps of extended family members, and migrated seasonally to hunt land and sea wildlife. Today, most families still supplement their diet with fresh country food and spend several weeks each year on the land, but all have undergone a rapid transition into life in a government settlement. The social impact of this transition, both for the generation who experienced it directly and for those affected intergenerationally, cannot be underestimated.

For the purpose of this study, I limit historical discussion to the creation of the settlement of Igloodik. This section presents a general overview of the events surrounding the move into a permanent settlement, and briefly addresses its impact on social health issues. The second section then explores these themes more deeply with a discussion of the role of health and social services in the North. Thus the remainder of this chapter provides the historical background of structuring conditions against which to consider current Iglulingmiut networks of meaning and practices regarding the Healthy Community.

The hamlet of Igloodik is located on Igloodik Island in the Eastern Canadian Arctic. It lies at the mouth of the Fury and Hecla strait in Northern Foxe Basin. To the southwest is Melville Peninsula and to the northeast is Baffin Island. Anthropologists have used the term *Iglulik* to characterize the Northern Foxe Basin region where "Iglulik Inuit" have traditionally camped and hunted. With a population of 1250 people and an expected influx of 200 more for "Nunavut jobs," contemporary Igloodik is the 3rd largest

settlement in the new territory. Situated approximately 350 km north of the Arctic Circle, it is almost 900 km north of the Iqaluit, and 2500 km north of Montreal (see appendix B).

Unlike some Arctic towns that were created by forcing the relocation of Inuit to regions completely new to them (Tester and Kulchyski 1994, Marcus 1995), contemporary Igloolik is composed of families from at least nine well established camps in the surrounding area. Indeed the traditional Inuktitut name *Iglulik* means “place of houses (*iglu*).” Whereas most other modern settlements have Inuktitut names that reflect the natural attributes of the land, Igloolik has long been known as a site of human endeavour with an archeological record that extends over 4000 years (GNWT 1994:7).

British Naval Officers Parry and Lyon were the first known Europeans to visit the area. Wintering in Iglulik in 1823, Parry observed that this island was the most important meeting place for hunting and trade (Stevenson 1997:267, Rasing 1994:9). Through the neighbouring Aivilingmiut, Iglulingmiut traded indirectly with European and American whalers, since commercial whaling was never prominent in the area. Consequently, Iglulingmiut remained relatively isolated for much of the century following Parry’s stay. During the Fifth Thule Expedition in the 1920s, explorers Mathiassen and Rasmussen found small-scale camp societies much like those that had been described by Parry and Lyon (Rasing 62, Stevenson 269).

Christianity was introduced in the early 1920s by Umik, an Inuk from Pond Inlet to the north. In 1931, a Roman Catholic mission was established at Avvajaaq, one of the main camps near the island. This was soon followed by the arrival of the Hudson’s Bay Company (HBC) which encouraged the Iglulingmiut to trap fox and also introduced the Peterhead whaling boat (GNWT 1994:8 and Stevenson 270).¹³ The HBC soon built a

¹³

Stevenson (1998) discusses the impact of the Peterhead on family structure. Briefly, he suggests that the few available boats initially served to maintain the co-operative structure of the extended family and the
(continued...)

trading post on the shores of Turton Bay (site of present hamlet), making it easier to trade in fox furs by eliminating the need for long trips to the post at Repulse Bay.

With the mission dispensing rudimentary medical care, and the HBC issuing relief when fur prices plummeted in 1948, people from around the Iglulik region migrated steadily toward the growing settlement. Additionally, nearby Hall Point became the site of a military Distant Early Warning (DEW) station in 1956. This military presence drew Iglulingmiut deeper into the mainstream economy, offering a few opportunities for wage labour.

It was also the military that had first drawn outside attention to the living conditions of Inuit families in Iglulik camps. Harrowing stories of infectious disease and starvation filtered southward and prompted the federal government to develop its northern assimilation policies in response to the critical media coverage (Rasing 152). As part of the government's intensified social welfare and education campaign, Igloolik acquired a permanent nursing station and a Federal Day School in 1960. Throughout the 1950s, education of Inuit children had been left in the hands of the Roman Catholic Church. The children of Roman Catholic families were flown to a residential school in Chesterfield Inlet until a day school was constructed in the settlement.

In 1961, the RCMP census of the Foxe Basin area recorded 20 families (about 100 Inuit) living in the settlement of Igloolik, while another 106 families (about 490 Inuit) remained at their camps (Rasing 156). By 1965, the settlement population had more than doubled as Igloolik grew to 49 families (229 people). To attract more Inuit to the settlement, the federal government instituted an affordable housing rental program in the

¹³(...continued)

authority of its leader in hunting activities. Stevenson and Damas (1963) each suggest that later acquisition of more boats encouraged the trend toward the "socioeconomic independence of the extended family" by the 1950s. (Stevenson 271, Damas 1963:27, see also Rasing 68.

early 1960s. Rasing argues that the goal of this new policy was the complete assimilation of Inuit, allowing the government to take a more direct control over the delivery of social services previously left to HBC traders and the clergy.

In 1963, anthropologist David Damas suggested that this combination of federal relief, seasonal wage labour opportunities, and social resources such as the school, HBC, Catholic mission and new Anglican church, contributed to the establishment of Igloolik as a major village in the region by the mid 1960s. Hindsight can now also suggest the consequences. Iglulingmiut who recall the period, talk about the rapid changes that they were experiencing in a very short span of time. Sedentarization and increasing economic dependency would permanently alter social relations. For instance, many people discuss the detrimental impact of this dependency and how it led to the abuse of alcohol once contact with outsiders (specifically military personnel and traders) and other Inuit became more frequent (NSDC 1998:2, Rasing 157).

There was no violence at the time I was a child. I only started experiencing or hearing about violence when people started drinking alcohol. It was from the traders - the people that had friends from the South - I think they just shared it. But I don't think anyone drank at the camps. (former residential school student, late forties)¹⁴

Children of the 1950s and '60s now express the sense of confusion that characterized this time for many them. Some describe the anxiety they felt when boarding the plane to Chesterfield Inlet or when a parent or sibling went missing after the tuberculosis screening ship had visited Turton bay.¹⁵ Most still speak of adjustment to life in a populated settlement with its associated adaptation to the impositions of school, police, social workers, and to each other.

¹⁴

For the purposes of maintaining confidentiality, names and exact ages are withheld from narrative excerpts. The description included is a self-identification.

¹⁵

Grygier (1994) examines in detail federal health and welfare activities during the TB epidemic. She pays specific attention to the socially disorienting effects of evacuating patients to southern institutions with seemingly little regard for the impact on families during the outbreak.

I was noticing that there was more drinking, and we started to hear bad things happening. But traditionally, it wasn't good to talk about other people when they were not there. It was something that my grandfather didn't allow to happen in our family. Instead of correcting the problem, people just gossiped about it, and that creates a disliking for some. So that was one of the signs that we started to all fall apart (ibid).

Less than forty years after the establishment of Igloolik, it is this fading of ancestral values and skills that most older and middle aged Iglulingmiut now associate with settlement life. The traditional responsibilities of hunting, sewing, maintaining equipment and teaching children have been eroded by the boredom, chronic unemployment and the resulting powerlessness in the federally administered settlement. However, Iglulingmiut who lived in camps do not overly romanticize the past. Indeed, compared to the security and 'relief' available in the settlement, camps were plagued with hardships. Thus, to many sick and elderly, as well as families whose children were obliged to attend school in Igloolik, the move into the settlement seemed logical.

Anticipating the difficulties of settlement life for Inuit, the federal government set out to mitigate the impact by providing the resources generally associated with maintenance of well-being. Social workers, police officers, nurses, visiting doctors, teachers and administrators from the South were all considered necessary support for the transition. The next section addresses the unintended consequences of one of the most powerful and symbolic components of this northern administration - its health and social service sector.¹⁶ In the last decade, it has been the reshaping of discourse in this sector that has produced the strongest voice of the Healthy Community.

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According to Rasing (1994) this sector was also the most comprehensive and expensive of the campaigns launched by the federal government in connection with its post-war concern for Inuit.

3.3 The Healthy Community of Igloodik

The first part of this book is about how to be healthy and happy. When we have good food, warm clothes, good kind friends and no sickness we are happy ... The second part contains advice about how to be prosperous, how the King is helping Eskimo children, how to make your rifles and boats last a long time, how to save the food animals from becoming scarce...

The traders are working with the Police to help you and your families, and the King has instructed them to issue goods only when it is necessary. He does not wish you to become lazy and expect to receive goods any time. You are to continue to work hard at hunting and trapping, teaching your children to be good hunters and workers. (The Book of Wisdom for Eskimo, Department of Mines and Resources Canada 1947)

In Igloodik, just as throughout the Arctic, the history of the emerging notion of a Healthy Community is really the history of the slow and continued erosion of colonialism, tutelage and overt southern control in healthcare and social services (Dyck 1997). Consequently, the concept of empowerment through participation in health planning, promotion, and decision making has a particularly strong ideological and political resonance for Inuit. Frank Tester has written extensively about welfare in the Eastern Arctic, while anthropologist John O'Neil has examined the "colonial health care system." Together, their work provides a background for the changes in approach that began to take place as Inuit became politically vocal about health and social services.

Tester (1994) demonstrates that, whatever their benevolent ideals, the main agenda of the first northern social workers had been to ease the integration and assimilation of Inuit into the Canadian mainstream society and economy after the Second World War. Until then, little had changed in the federal policy of non-interference in the North. However Tester outlines a variety of factors which already combined to create a situation of dependency for Inuit. Among the most influential was the way in which the Hudson Bay Company (HBC) administered the little "relief" that was made available. With little regard for traditional leadership, methods of resource redistribution, or family

and camp structures, the HBC inadvertently created a substantial underclass by distributing relief according to its own criteria of need (Tester 1993:114).

By 1948, epidemic tuberculosis, the failing fox fur economy and the public recognition of the 'plight' of the Inuit, led to an intensification of these relief efforts across the Arctic. The federal northern administration then decided that the relocation of families into southern style 'neighbourhoods' would alleviate the rising cost of relief (Tester 1993:119). The HBC had moved a few families in the 1930s to exploit the potential of hunting Arctic fox, but the hardships of the 1950s marked the beginning of large scale relocation. The federal government recruited trained social workers to help "integrate" and establish Inuit in the settlements. With many Inuit returning from long-term tuberculosis treatment in the South, the rehabilitation centres built in Rankin Inlet and Frobisher Bay (now Iqaluit) served multiple purposes. They were sites of recuperation, but also of integration and training for settlement life (Tester 1994:169).

While Iglulingmiut were not explicitly forced into the settlement, federal agents with assimilationist policies now actively tried to integrate them into the Canadian mainstream. Medical attention, economic development initiatives and compulsory education were all available in the settlement, and became the tools of assimilation. The practice of assimilation and integration, which was carried out through the work of Eurocanadian administrators, teachers, nurses and social workers, was consistent with the benevolent and humanitarian world view of the post-war government. Benevolence however, obscured unexamined assumptions about how the Inuit should live, treat their families, earn a living, and maintain their health (NSDC 1998:2).

Working under these assumptions, northern social workers exerted control which profoundly redefined the structure of social organization, living arrangements, family dynamics, and personal relationships among Inuit generally. Indeed, Tester argues that the historical expert control of development, relief, and the regulation of everything from

alcohol consumption to education and adoption practices, “set in motion other historical events, which have in themselves generated significant social problems and social needs” (Tester 1994:119).

Sedentarization and assimilation posed unprecedented social challenges for Iglulingmiut who had been tightly integrated into discrete extended family camps under the leadership of a senior hunter (*issumataq*). Southern practices of justice, medicine and especially education imposed severe constraints on the way of life that Iglulingmiut had always known. Children who were sent to school were denied the opportunity to learn by observing the duties of their older relatives; a new system of municipal leadership came to supersede heads of families; and until recently, the town had been literally bisected between Anglican and Roman Catholic families. In Igloolik, as in other Arctic settlements, the resulting anomie, social and cultural dislocation, and chronic unemployment are considered major contributing factors in alcoholism, sexual and child abuse and suicide that many Inuit are battling today (Tester 1994, Kirmayer 1996, 1998, Grygier 1994, Tester and Kulchyski 1995, NSDC 1998:2).

Ironical though it may seem, the very efforts to ensure well-being through healthcare, shelter, education and ‘relief’ are those that engendered this cultural dislocation and thus a sense of anomie. It is here that John O’Neil has analyzed “colonial” medical care for its role in perpetuating social problems by not recognizing the holistic links between social and individual care. More than a decade ago, O’Neil argued that health care represents one of the most ideologically charged symbols of colonialism in the North. He suggested that self-determination in health care was the main solution to the insidiously iatrogenic effects of colonial medicine on Inuit (O’Neil 1988, 1986, 1985). He suggested that solutions must broaden the determinants of health to consider the pressures of contemporary socioeconomic factors on Inuit families. For instance, “from the Inuit perspective, both traditional and modern subsistence strategies must be maintained within an extended family structure,” where older men rely on younger

members to contribute capital for the equipment required to sustain hunting practices. If the system falters, the whole extended family suffers (O'Neil 1989:292). Thus, O'Neil asserted that true self-determination in healthcare would allow for a broader focus that links health to social and economic concerns.

Although transfer of health services had been underway in the NWT since the early 1980s,¹⁷ O'Neil wondered whether this was leading to *real* self-determination in healthcare. He contended that because northern health ideology maintained a strong distinction between health and local development concerns, the "real sources of cultural discontinuity" that lead to social and thus health problems, were being overlooked. Even Inuit leaders and land claims negotiators at the time "saw little relevance in their work to improvements in health. It was considered the responsibility of health care professionals who remain outside the developmental forum because of their symbolic power and formally bounded ideology" (O'Neil 1989:293). O'Neil suggested that this point of view was perpetuated by the southern institutional grip on the health care system which effectively colonized local consciousness and expectations about approaches to treatment (O'Neil 1989).

With a decade of political transitions since O'Neil's first analysis, this picture has evolved. According to Warry (1998:130), the federal government finally began to address the issue of Aboriginal mental and social health in 1991. Its *Agenda for first Nations and Inuit Mental Health* set the groundwork for community-based treatment and early intervention programs. The issues were revisited with the Royal Commission on

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Transfer to the GNWT of the hospital in Iqaluit (then Frobisher Bay) was undertaken in 1982. This was soon followed by the transfer of all nursing stations in the Baffin region. Regional health boards were created to administer these facilities, taking control by 1988. In 1994, GNWT Department of Social Services was amalgamated with the department of Health at the territorial level, followed by amalgamation in the regions in April of 1997. With the creation of Nunavut in April 1999, some municipalities are now negotiating for full responsibility as the final stage of devolution of services. In Igloolik, social services were fully transferred to the hamlet in 1996. Transfer of the nursing centre is now under discussion but appears unlikely in the near future.

Aboriginal People (Canada 1993, 1997) which has further oriented policy for 'health' in the North. Through RCAP's open fora with Aboriginal people, 'health' has been redefined in public discourse to encompass "social and emotional health," "community health" and "environmental health" (Canada 1993). In his report to the Commission, O'Neil argued that non-Aboriginal medical personnel, administrators and researchers must now recognize the unique approach to health concerns that is common to Inuit and First Nations communities.

Not only do they integrate standard medical interests with broader social, emotional and spiritual concerns, but there is also an expanded interest in 'health' as opposed to the 'sickness profiles' common to mainstream epidemiology. *Issues such as family violence, addictions, and mental and spiritual health are fundamental rather than secondary concerns* (O'Neil cited in Canada 1997:np, emphasis added).

At the territorial level, this official public discourse had already begun to shift with the establishment of the Special Committee on Health and Social Services in 1992. The high degree of interdepartmental collaboration on this committee is evidence that the government at the time was at least demonstrating an integrated approach to defining and treating health problems as social problems.¹⁸ In their final report in 1993, the Special Committee made recommendations on more efficient use of programs and expertise which included the establishment of locally responsive mechanisms for implementing health promotion strategies in early childhood development and community-based treatment, as well as providing support for front-line workers.

In 1995, regional "Community Wellness Coordinators" were hired to address some of these concerns under the direction of existing Regional Inuit Associations (significantly not under Regional Health and Social Services Boards). These new regional offices have since become the "funding distribution centres and political fora,

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The project was a collaboration between the GNWT departments of Education Culture and Employment, Health and Social Services, Justice, Municipal and Community Affairs, and the Housing Corporation.

responsible for helping *communities themselves* to access newly available resources and to establish local programs and initiatives according to their own priorities” (Baffin Regional Wellness Coordinator, personal communication). The programs and projects to which they directed federal funds have to be community-generated initiatives that meet the federal guidelines for their respective source of funding.¹⁹

In Igloolik, the Hamlet Council’s concern over social health priorities prompted it to assume control of social services in the community. This sector was fully transferred from the Baffin Regional Health and Social Services Board in 1996. To implement the territorially sponsored “Community Empowerment Initiative,” municipal councillors assembled a Social Affairs Committee whose task, during and after transfer, is to “keep the community informed and ask for comments and criticisms” (Igloolik 1996:24). In turn, providing advice to the Social Affairs Committee is the Igloolik Elders Society (*Inullariit*), the existing Interagency Committee and finally, “the community at large” (Igloolik 1996:16).

One of the first tasks of the Social Affairs Committee was to develop a list of community priorities which includes healing victims of sexual abuse, suicide prevention, addressing domestic violence and substance abuse, enhancing youth education (both traditional and conventional) and recreation, and dealing with unemployment and the communication gap between the generations. Under the auspices of this committee, the Hamlet has created a position for its own “community wellness coordinator” to access community development funds, establish programs and plan events that address these issues locally. A major support to this position has been the help of “regional specialists” who are available to assist in program planning or to conduct short training

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Major federal funding initiatives which promote mental health and early intervention through community development include Healthy Children and Brighter Futures (with special First Nations, Metis and Inuit components), Building Healthy Communities and Aboriginal Head Start (developed specifically for Aboriginal communities), and the Community Action Fund.

workshops for local staff and volunteers in addressing alcohol and drug abuse, sexual abuse, violence and suicide prevention. However, in a job without precedent and with little preparatory training, the local wellness coordinator still relies on the strength of individual groups to play a main role in actualizing their own project ideas.

Following the agenda of contemporary (mental) health promotion, the projects that have been initiated in Igloolik deliberately blur the boundaries between (mental) health, social issues and community development. A significant example is an early childhood and family support center which opened in 1997. Building on an existing Health Canada initiative, staff at the centre deliver programs in Inuktitut to preschool children and their parents or care-givers. In addition, the centre holds teen classes in association with the high school, and prenatal classes for new parents. These programs emphasize the development of life and coping skills, personal esteem, health promotion and nutrition (especially prenatal). Along with these objectives, staff members consider their own training to be an important goal of the program. This is consistent with the philosophy of new health promotion which suggests that skills development, through training and participation, is personally empowering.

Along with other ongoing community programs offered through municipal social services (anger management, healing groups, addictions counseling, etc.), there are also short-term projects which have been initiated by local groups and funded through the offices of Community Wellness. These have included land and heritage programs that link young people with elders to learn traditional sewing and hunting skills, and a current Youth Committee project to script and film a movie on suicide and its prevention.

What all of these initiatives and others like them have in common is their marginality to issues typically associated with health. Instead they emphasize training and skills building, entrepreneurship, artistic expression, cultural and linguistic renewal,

and fostering youth-elder relations. Initiatives in Igloolik thus explicitly invoke the language and practices of the Healthy Community. They not only promote the conventional determinants of health, but add to them an awareness of language, culture, and the preparation of young people for valuable roles in Nunavut.

This sketch of the emergence of Healthy Community and wellness discourse in Nunavut and in Igloolik has demonstrated that while it has given rise to new forms of expertise, these do not simply involve increased opportunities for social control by outside health professionals. Rather, given the history of health and social services in the North, discourse and technologies of the Healthy Community represent unprecedented local power for Inuit in an arena which has been dominated by Southern and *Qadlunaat* (White) ideologies of health. However, the nature of distribution and participation in this new empowerment - and what it means to Iglulingmiut - remains unclear. Therefore, analysis now turns to the practices and meanings assigned to the principles of community, participation and empowerment. It is intended to unpack these concepts and re-examine the consensus that they imply.

CHAPTER 4 - FINDINGS: Rethinking Consensus in the Healthy Community

4.1 Introduction

L'homme est toujours situé dans un environnement de signes qui renvoient inmanquablement à autres choses qu'eux mêmes, et dont la signification est généralement polyvalente (Corin et al. 1990:116)

As this excerpt implies, understanding the processes by which people assign significance to words and actions must begin with the premise that any given sign can have multiple and shifting meanings. These meanings are organized along associative chains which are mobilized according to a person's position within society. Thus, although history has shown that the ideological principles of the Healthy Community are particularly suited to the North, consensus about how these principles are enacted is less obvious. Indeed, the ideals of community, empowerment and participation, can represent entirely different perceptions and practices depending on how they are invoked, by whom, and under what circumstances.

4.2 Community, participation and empowerment as cultural constructions

The domain of institutional health promotion and that of Iglulingmiut tradition constitute two distinct perspectives from which to define social health. Together they contribute to an understanding of the differences and similarities between the theoretical goals and the actual lived experience of the Healthy Community which is revealed in the narratives. This section examines the values implied in each domain.

The context of health promotion

In a healthy community, the community takes care of its own problems in ways that support wellness. The community controls or, at the very least, is actively involved in, programs and services that serve community residents. When the community is not involved in the delivery of social programs, it cannot take on the responsibility for solving its problems (GNWT 1995:31).

The health promotion materials currently used in Igloolik provide a good starting point for recognizing the way in which territorial and federal government institutions define and operationalize Healthy Community principles. According to Jewkes and Murcott, the “mission statements, handbooks, even job descriptions” are technologies through which institutions define their perspective on health and community development. Here I examine three types of document that have been widely circulated among wellness coordinators and program planners in Nunavut. These materials ascribe official meaning to the notions of community, participation and empowerment, for both personal and socio-political contexts by establishing a conceptual link between the two. They highlight the dominant premises with which to compare both traditional perceptions of health and community, and contemporary local engagement in the strategies associated with new health promotion and Healthy Community principles.

Included in these materials are: a territorial government position paper which provides the initial framework of understanding; a series of advice manuals produced by Health Canada to help with the implementation of community development and wellness initiatives; and a current tool for the evaluation of such programs. These types of document are intended to enable community members to establish programs (in healing, education and prevention for instance) and actualize their project ideas (workshops, special events, trips etc).

To begin, the territorial government’s seminal report entitled *Working Together for Community Wellness* (GNWT 1995) sketches an initial framework for collaboration between “Social Envelop Departments,” levels of government and community organizations. It established the territorial government’s new agenda for health in northern communities. Here, a Healthy Community is one that promotes: “a strong sense of community which values belonging, shared responsibility and trust; a sense of family life; an emphasis on personal dignity and self-esteem; a state of holistic well-being; a strong sense of culture and tradition; zero tolerance on violence; and integrated services

that involve community members and care-givers working together to achieve these goals” (GNWT 1995:9).

This early statement on community wellness and new health promotion highlights four proposed “areas of change” that are now the sites of some of the most intensive government sponsored social development efforts. The first area is “prevention, healing and treatment” in which the government links policy and people by suggesting that “if healthy communities are our common goal, healing is how we get there. Healing starts with the individuals: to heal a community, it is necessary to heal oneself first” (GNWT 1995:11). The second proposed area of change is “education and training” which encourages local people to acquire the skills necessary to deliver services themselves. Local and culturally relevant training programs for paramedical, caregiver, and community development services are emphasized. A third change is interagency collaboration which would integrate community resources for a holistic approach to treatment and efficient delivery of programs. The final recommendation encourages community empowerment, ideally as a mechanism for municipal councils to assume increasing jurisdiction over services provided by the territorial government. At another level, community empowerment can also mean accessing community development funds for various wellness projects.

A new series of instructional manuals produced by Health Canada echoes this empowerment goal. Described as a “self-help tool for Aboriginal communities,” it promotes a community development approach to operationalize empowerment through community-based planning and development of wellness projects. It emphasises the recruitment and nurturing of volunteers as an avenue through which citizens can contribute to their own well-being and that of the community by fostering “a spirit of community and feeling part of a group who care about each other” (Canada 1998).

Finally, through its tools of evaluation, Health Canada reiterates its perspective on empowerment and recognizes particular methods for achieving it. For instance, the assessment questionnaire used for Igloodik's initiative in early childhood development implies ideal forms participation intended to foster a sense of community. Local program staff are asked to rate the frequency with which they feel that their "initiative engages in activities that develop a sense of community through family interaction and cooperation among parents" (Health Canada 1999:17). The survey then asks staff to rate the frequency of public participation for each in a hierarchy of types. At the top of the list are the more formalized types of participation: "participation in curriculum development," then "management and decision-making," through to "participation in special program events" and finally, "informal communications, advice seeking and exchanging ideas" (ibid:20).

Developed specifically for use in Inuit and First nations communities, these documents highlight the interaction between personal and political empowerment. They support healing, and emphasize involvement in education, training and skill-building strategies as the link between personal and political empowerment. When people feel strong and are better educated, it is suggested that they are better able to participate in decision-making bodies and governing structures. Along with these avenues to empowerment, these documents also underline the development of a conscious 'sense of community' as a constitutive and evaluative criterion for programs and strategies linked to health.

Given that these documents outline the premises on which public support for community-based programs rests, they involve certain assumptions. For instance, a shared holistic vision of community and shared interpretations of empowerment (along with participatory ways to achieve it) must be constructed to ensure adequate delivery, evaluation and justification of local initiatives. In reality however, the transition from theoretical and political ideal to practical action involves ambiguity and negotiation.

Policy that is intended to enhance mutual aid, collective responsibility and participation may echo important traditional values, but it also collapses the frontier between public and private space. For many people, this requires new methods of interaction and interpersonal relations. The following section expands on this ambiguity using relevant elements of classical Iglulingmiut ethnography.

The context of Iglulingmiut tradition

I always hear about changing the values of policies and procedures of social workers to suit the values of the people in Igloolik, but it is sometimes not clear how to apply our own values because they come from a family context and not a whole community context (male college student, early thirties).

Although much has changed since Damas conducted fieldwork in 1963, what he then called the “principles of Iglulingmiut social organization” still provide an ethnographic grounding from which to understand reactions to institutionalized social health promoting strategies. This is not to say that these “principles” are prescriptive rules of predictable behaviour. Rather, they are some of the enduring values that, according to many Iglulingmiut, can still influence it. For instance older people often invoke traditional values directly, while many young people - especially young women - demonstrate how the power of traditional expectations can be both a nurturing and a constraining force in their lives.

Drawing on Damas’ work, Rasing (1994) has suggested that traditional Iglulingmiut social relations are characterized by an interplay between the cultural values of interdependence and respect for personal autonomy, which is set within a hierarchically structured extended family context (*ilagiit*). Thus, expectations about how one should act toward relatives and non-relatives often mediate interpersonal encounters (Damas 1975, Rasing 1994, Searles 1998:91). Damas learned of two main social mechanisms through which these interpersonal relations are expressed and negotiated. The concepts of *naalaktuq* and *ungajuq* influence action with respect to rights and obligations.

The meaning of *naalaktuq* has been described as both 'dominance-subordination' (Damas 1963, 1975) and as 'obedience-respect' (Wenzel 1995). Searles suggests that the etymology of the word best expresses how it is practiced: the root *naala-* means "to listen to him/her," while the verb ending *-tuq* gives the word a subject "he/she listens" (1998:95). *Nalaaqtuq* directives structure interpersonal relations according to age, generation, gender, and kindred affiliation. They help people to establish relative authority (and thus an appropriate course of action) for any given social encounter (Damas 1975:24, Stevenson 1998:273). *Ungajuq* is described as a feeling of closeness, and emotional support between siblings, cousins and across generations. The combined influence of these two concepts consolidates the extended family by describing an ideal support network and determining, for instance, how resources should be distributed or how decisions should be made.

As traditional values, behaviour associated with *nalaaqtuq* and *ungajuq* help to maintain an individual's sense of place and belonging within the extended family (*ilagiitiarniq*). At the same time, other types of association reach beyond kinship to maintain cohesion and strengthen interdependence between neighbouring extended families as well. Although Rasing notes that much of the traditional interdependence within and among families has been undermined by sedentarization and welfare colonialism (1994:263), many practices have been translated into contemporary settlement life and remain strong. For instance, consistent patterns of kin-based summer camping, the adoption of children, and the practices of sharing a name (having a namesake - *saunik* or *atiq*) and sharing food resources (*ningituq* or *ningirsiniq*), continue to form important links that reinforce solidarity among families and extend alliances to build community.

Sharing food not only reinforces alliances, but it also enacts the strong sense of personal responsibility for the well-being of others (Elders' Oral History participant,

1995). Wenzel (1995), Collings (1998), Stairs (1992) and Borré (1994) discuss the dynamics of food distribution in other Inuit communities as a “responsible social action” (Borré 1994:10). Borré notes that the harvesting, processing and distribution of fresh meat (particularly seal) serves the nutritional, ritual, and psycho-social needs of a community, and restores a sense of well-being to those who partake (Borré 1994:11).

4.3 Community, participation and empowerment as lived experience

While these ethnographic accounts reflect some of the central values of Healthy Community at a conceptual level, the personal networks of meaning and practice assigned to these values suggest a more nuanced engagement. Individual experience of Healthy Community principles is shaped by complex and interacting factors such as: the public discourse of the community wellness movement; cultural associations about health and family responsibility; political/economic constraints and opportunities; the personally and socially dislocating effects of tragedy; and an individual’s own life history, and social position. Previous sections have laid the historical, political and ethnographic groundwork for understanding these factors. Now a turn toward personal semantic networks can demonstrate how they interact to shape the multiple meanings of community, participation and empowerment in the context of everyday life.

Constructing Community

On arrival in Igloolik, I met with the respected Elders who serve as traditional counselors at the municipal social services office. We worked together to develop the interview questions for *Unikkaartuit*. Associating suicide with a the loss of a sense of belonging and a feeling of alienation, researchers were interested in the practical aspects of social integration in Igloolik. To render operational this notion, we first considered the existence of several clubs in Igloolik including bible studies, a sewing group, the youth committee, the Elders’ Association, and sports teams. Then, the suggestion was made to “ask people whether they take part in any regular activities with others.” One of the traditional counselors grimaced very slightly at this and responded: “We Inuit like to visit a lot, talk a lot and eat together. If the research only counts involvement in organized community activities, then you won’t find *ilagiitiarniq*.” *Ilagitiarniq*, he explained slowly and precisely, is literally “like being family (*ilagiit*).” (personal field notes 1998)

This account implies some of the complexity in identifying the meaning of community for the purposes of health promotion. Yet the holistic goal of fostering community solidarity as a protective factor is so commonly invoked to orient discussion on health policy that a shared and static sense of its meaning is implied. In reality, there are distinct and individual connotations surrounding the meaning of community in Igloolik, which are expressed at both the level of sentiment and action.

A general consciousness of community and a link between community solidarity and social health were diffused throughout most of the collected narratives. However, several prominent themes emerged as signposts for recognizing the ways in which community is experienced by respondents. Many invoked memories of a past community as well as the encompassing events and activities that can bring community sharply into focus today. Embedded within these broad themes was a more detailed subtext about the changing nature of family, the distance between elders and young people, and the mix of uncertainty and hope about the impact of Nunavut on family and community life. While these were common themes, people drew on personal frames of reference to find meaning and make associations about community. Indeed, there can be as many ways to construct the community as there are voices within it.

Older people for instance described a sense of true community that is embedded in time. It is a remembered community - much smaller and more intimate than today's growing settlement. It is rooted in a time when social integration was necessary to the very survival of family camp members.

In earlier times, when the people noticed an individual not living to the standards, they would get that individual and make him/her the centre of reform. So the people would live in harmony. In that time they were not equipped with what is now available to our generation. Instead, they would harvest animals together as partners, also the women would share the making of clothing with family members. That way it helped amalgamate family members. (Igloolik Oral History 1995).

Framed within this historical context, community was associated mainly with kin-based relationships, since for the older people, the extended family camp once defined the community. Accordingly, many older and more traditional people perceived community mainly in terms of family, where the directives associated with *nalaaqtuq* and *ungajuq* can still be invoked.

When a family member does not hesitate to ask for something they need, I thoroughly enjoy that and appreciate it. But when a family member hesitates to ask for something from me, but that person goes outside the family circle to get what she needs, then despite the fact that I am the oldest in the family including the extended family members, I will look at myself as someone who is not leading my own peers the way I am supposed to (Igloodik Oral History participant 1994).

This excerpt illustrates the importance of interdependence within a family which is a traditional value still taught by elders. Here, community is synonymous with family such that strategies extending beyond kinship affect the family dynamic and would require new ways of interacting. While this tacit acknowledgment of kin-based integration is common among elders, it is also expressed as a structuring influence in the lives of many others.

When a hunter returns from a successful trip for instance, he is likely to offer his catch to the eldest member of his extended family for redistribution. Often, the hunter or the elder will make a public announcement over the local radio, inviting anyone to share the fresh meat. But while the invitation is open, those who attend are usually the hunter's extended family members and people who bear the names of family members (*atiq*). Rarely is this type of meal attended by non-kin or people with no association to the host family. Whereas a "community feast" is generally sponsored by a club, church, or other organization and is a contemporary total-community special event, the more common communal meal described here is an occasion that implies a highly specified 'community' of kin.

Within the collected narratives, the children of elders echoed this association of family and kin as the nexus of community. However, many of them also added a significant nuance. These respondents constitute a transitional generation who experienced rapid social change under federal colonialism. Given the uncertainty of their early years, some speculated on the creation of “the community” as the origin of social dislocation rather than integration.

There are too many people who came from different camps, before moving here. Because we're from different places, there's too many things happening to the younger people, even the older people. There were people living at outpost camps before the government told them to move here. That was maybe thirty years ago that they started to get together here and since that time, this place has been growing every year, more people are coming here to stay and more babies are being born. Young kids, couples get together and separate again. This type of thing is happening so much in town now it would seem (grandmother and college student, late forties).

It is perhaps not surprising then that both men and women respondents of this generation spoke of community not simply in terms of family, but in terms of *changes* within the family structure and practices. Their recollections revealed how the experience of family itself is shaped and constrained by multiple and complex demands.

The community's changing a lot. Nowadays we don't visit our relatives, our older uncles and older aunties anymore. Maybe it's due to the fact that there's so many people here now. But, the times have changed a lot and the young people are now in a place where they don't really know the old traditional ways but they know the new way more. And they have changed a lot because there's TV, there's radio, everything that we didn't have in the past. When I was younger and there were less people, we were able to share more. We could help each other more, and respect our elders more. But nowadays, even for myself, I'm very changed because I don't go visiting around much anymore or see some relatives. It's because, it seems to me, I have more things to do at home and then I have this job which I have to go every day. I'm not the same person I used to be. I have more responsibilities. And sometimes these responsibilities get a bit too much, so my priorities have changed a lot (grandmother and educator, late forties).

Everything is changing fast. You know, when I was young we were a family, we were a good family and we were living in one house. We helped each other with the money and the meat (part-time hunter, late forties).

Just as the notion of community cannot be universally glossed, nor can the experience (and thus definition) of family. In these excerpts, both the extended family and the more immediate family are unique elements which contribute to a sense of togetherness and social integration. Each implies a particular structure of authority and inter-personal responsibility in which individuals are embedded. Other respondents reflected this sentiment while also underscoring both the contemporary constraints of the wage economy and the traditional practices by which community - as family - was constructed.

Aunts and uncles and cousins all used to go into one building, not only on Sundays but all through the week to have some cariboo meat or just gather around in one house. It's changing now because of mainly financial reasons. Money, always money. I think money is the reason why families are more distant. We can't really afford to feed all our uncles and all our aunts and cousins in one house so we're sort of separated now. My family doesn't gather that much anymore, but other families I have seen are still very close (mother and college student, early forties)

These comments are from Iglulingmiut whose references are grounded in long-held practices of interdependence, despite the changes that they have endured and accommodated. While they emphasized visiting, providing food and ensuring the well-being of relatives as expressions of community solidarity, this transitional generation also produced some of the most informed and skillful Inuit leaders and policy-makers whose perspectives were somewhat different. With a professional eye on demographics, they framed community in terms of economic and social development issues with the primary concern of finding employment for young people now coming of age. For them, social integration was intimately linked to creating meaningful employment which serves as a socially protective factor. Yet, as Warry (1998) and Frideres (1991) have noted, a true division between personal (family) and public (political) responsibility is a false dichotomy and very western (southern) assumption in the North. Within their experience, elected officials and policy-makers must integrate the demands of these multiple communities.

The children of this transitional generation are the first group to be born and raised in the settlement. Their experience of community differs from that of their forebears in part because of the unprecedented leisure time that has been at their disposal. Condon (1992) argues that the concept of teenager was new to Inuit in the 1960s and '70s. With the responsibility for welfare in the control of the state, markers of life-cycle change have shifted accordingly, and young people no longer assume a defined set of responsibilities as they come of age. For many respondents of this generation, the experience of community was grounded in the changing definitions of self which are shaped by changing responsibilities within the family. Many respondents in this cohort conspicuously moved the ideological borders of their real, lived community to include both extended family and social relationships that reach beyond it.

If the elders ask me to go to their house, if they want me to be with them, even for that short time, they're accepting me. When they call me to see if I have enough country food, or if I've eaten lately, they're accepting me. Also, with younger people, at the dances and at volleyball. Even much younger people see me as one of them, that's a good feeling. (mother and municipal employee, mid thirties)

When we came back here to live, we just had to get used to seeing so many people. We never used to go out, but when we came back here, we had so many places to go and so many people to visit and that was the best part. And with all the activities around, we had a lot to do. We visited our relatives and friends and go to church (educator and mother, late thirties)

Despite reaching beyond family for meaning in community, respondents of this generation generally invoked the family as the potential solution to address current social health problems. A sense of belonging and integration was expressed as a family matter which must be guided by elders.

I think it all really comes down to the family and what's going on with the family and the family situation. Whether its family strengths or bad things...abuse or neglect or just giving kids everything they want (mother, early thirties).

It really lies with...it's gotta come from the older people in their fifties. Things need to change with them because it's difficult to understand the Inuit culture sometimes (father and municipal employee, mid thirties).

Respondents of the second and third generation to be born and raised in the settlement (now teens and young adults) shared a sense of community built upon the memories of their parents and grandparents. From stories and accounts, these young people described an ideal image of community that informs and structures their values, if not always their lived experience.

I think the community's changing. Families are splitting up. I heard that they used to be a lot closer to each other when I was younger but now I see a lot of them separate. Too many relationships are going on with young people...A guy's got a girlfriend and he hardly talks to his family anymore... I think it's going to change even more. (male, not currently in school, late teens)

Old people talk about the past saying that people used to visit around a lot to other houses and just go in there and make themselves at home, nowadays I see they're even sort of afraid to go. I just go to my friends' houses - a few friends. But in the old days, they used to just go into any house and sit down and talk with them (male highschool student, late teens).

For teens in particular, community as a source of support was often associated most closely with social networks of friends. This was especially true for those young people who, for a variety of reasons, have grown up across several settlements and within the homes of far-away relatives or care-givers.

For wellness, hang out, definitely hang out with friends who agree with you and accept you for who you are. But stay away from drugs and alcohol (female high school student, late teens)

I socialize with a lot of young people at volleyball and at school. The only time I really spend time with older people is when we play cards. I'd like to go hunting more, but I have school 5 days a week so there's only Saturday to hunt if I can find someone who will take me. I'm not so familiar with a lot of Igloodik people. (male high school student, late teens)

The discussions of community among different categories of people indicated they experience a sense of community that is neither static nor predetermined. Rather it is the product of both cultural values, personal history and contemporary social and

economic influences. These can often combine to make family the true locus of community, but as we have seen, the constitution of family is itself subject to personal interpretation.

While these examples have suggested the variety of ways in which community is interpreted and experienced, two special circumstances depicted a particular experience of community that transected the collected narratives regardless of life experience, family or religious affiliations. The first case is a sense of community solidarity that is felt within the context of tragedy, while the second case emphasizes the power of the anticipated changes in Nunavut to heighten awareness of community. In both cases, the notion of community was appropriated to express the feelings and experiences common to many Iglulingmiut, and to mobilize efforts surrounding these feelings.

In the first instance, an awareness of community developed within the shared pain surrounding the devastating effects of suicide. Perhaps ironically, many people suggested they have the most palpable sense of community solidarity in the face of such a tragedy. This is expressed as a shared sense of urgency and immediacy about a common plight and a common problem that is attacking the underlying fabric of community life. In the narratives considered here, this sentiment was referred to mainly by women - both young adults and those of the transitional generation. But while they are the ones to articulate the sentiment, they seem to speak for many.

You'll be able to reach a lot of people because it [suicide] affects a lot of people here in the community, and knowing that there are people that are trying to help with this - and I'm sure, I'm pretty sure that they will - it will help them lots.... so that this person won't feel that he or she is the only one feeling this way or the only one to have been physically or mentally abused. It's a lot of people sharing (grandmother and educator, mid forties)

Not only does tragedy bring the experience of community sharply into focus because it affects so many, but the process of healing also provides a unifying focal point.

The importance of disclosure and the realization that “I’m not the only one” is an expression of communal solidarity that appears thematic in the narratives of a range of women especially.

When there’s problems in the community, that’s when you realize that people care. There are a lot of people out there who can be an example of me. They could be almost the same as I am because we have similar things going on, similar problems, and we two could help each other maybe in some way. Healing is a very big thing. It’s tough work, it’s not just about talking about your problems, you’re there for others too (high school student, late teens).

I’m glad that people are trying to help. Not just to prevent suicide but also helping those whose son, daughter or relative committed suicide to cope with this and that way they’ll be able to give a better hand to others if any of their relatives commit suicide. Healing is being not afraid to talk about something and also not afraid to hear something from other people (high school student, early twenties).

The discussions of the communal sentiment surrounding the healing movement did not simply repeat the institutional rhetoric of wellness. Rather, they tended to fluctuate between apprehension and hope, and between the levels of self, family, friends and community. Healing was recognized as a solitary activity which is embedded within a matrix of support from and responsibility toward family. Therefore, at the level of sentiment, there was a strong sense that everyone must take part and “put an effort into it” for self and for others. At a practical level however, young people especially were cautious of optimistic assumptions that paint community in broad and monochrome strokes.

There’s probably nothing anybody can do, I don’t know, just the whole community working together can make a difference. Like if everybody put an effort into it. I guess suicide can’t really be stopped if someone wants to do it. But people can sort of stop it if they help others believe and have faith in themselves (female high school student, early twenties).

It’s a small town. Everybody knows everybody and sometimes they get so against each other. How can the community help? I don’t know, maybe *family* meetings? (women’s activist, early twenties - emphasis mine)

A second circumstance that cut across many individual particularities to construct and reinforce a sense of community, was the creation of Nunavut and its implications for Igloolik. Igloolik is in a special situation as it is the (decentralized) headquarters for the

new Department of Culture Language Elders and Youth (along side the existing Nunavut Social Development Council). While not stated explicitly in their documentation, local leaders in this department suggested that this combination of sectors is instrumental in fostering Healthy Communities. However, despite this logical mandate, they were also aware of the potential impact of the resulting population increase on the community of Igloolik.

With an expected influx of at least 50 new families as Igloolik's "Nunavut-jobs" become available, concern about rapid growth brought implicit feelings of community to the forefront. The practical implications of Nunavut were discussed in greatest detail by students who emphasized the physical and emotional impact of the changes.

If there aren't enough Inuit educated to have government jobs, there'll be a lot of people coming in from the South or maybe even people who will come and have a different knowledge than we do. They might try to change some stuff around here. Sometimes it feels like the community's going to be invaded or something (female high school student, late teens).

I heard that a lot of new people are going to come up here and look for jobs and we're going to have to make new friends with these people. And people from Igloolik are going to have to move out to look for jobs too. Lots of people coming in and moving out. So we're going to have less family to talk to I think. I might even have to leave for the career I want to achieve (male high school student, early twenties).

There was both excitement and apprehension at the prospect of newcomers with new ways and new knowledge. This revealed a sense of community that transcended families, churches and classrooms. Nunavut is an impetus for recognizing the ideological boundaries of community.

Indeed, both of these cases are a reminder of how the ideological borders of the settlement expand or contract according to the experience of the speaker. Situating the ideological locus of community, people's semantic pathways circumscribe its boundaries. These boundaries can change according to occasion, position and sentiment. For those

who take pleasure and solace in time spent on the land for instance, the ideological frontier of community, might move more profoundly into the open landscape of the sea ice and tundra itself. For others, the frontier might shrink to describe only the family as community, or - as with many young people - it might be a network of friends. In the case of suicide, the meaning of community is more encompassing because "everyone is affected by it" and because the healing goal of talking openly fosters a sense of community solidarity. The creation of Nunavut is also a special circumstance with the power to make obvious and elastic the ideological borders of Igloodik. Concern about "invaders from the South" shrinks its borders, while the increasing mobility of Iglulingmiut and other Inuit enlarges these frontiers as communities merge.

With respect to the sorts of actions that best reflect these interpretations of community, responses moved beyond this level of sentiment to describe a level of practice and lived events. This section has touched upon some of the salient actions through which Iglulingmiut recognized and expressed the meanings of community. In the next section I further explore the implications of these actions by juxtaposing and comparing them with the methods of participation that are privileged in Healthy Community discourse.

Prescribing Participation

On a return visit to Igloodik, I met with the staff of an early childhood program as they were completing a self-evaluation questionnaire for their funders at Health Canada. By page 20 of the extensive survey, the staff had concerns about a section asking them to assess involvement in their program. Health Canada needed to know how frequently parents participated in program planning, management and decision making, and whether it is difficult to get them involved (see p.38 and 43, this document). This sparked an animated discussion among staff members: "What do they mean by involvement? How about the fact that a lot of parents like bringing their kids here now, and more parents are talking with each other?" What the staff seemed to be wondering was whether this type of involvement was also significant. (personal field notes 1998)

The issue of community participation is perhaps the most important challenge for those involved in promoting strategies for wellness and a Healthy Community. Community involvement has been called the cornerstone of a Healthy Community, because it is intended to operationalize strategies for personal and collective empowerment (Labonte 1990). However, as this account illustrates, simply trying to delineating methods of empowering participation enters some very ambiguous terrain - not least because empowerment itself is differentially perceived as we shall see.

The way in which participation was constructed in the discourses of community members took many paths. Some of these were high profile social development planning, volunteering and committee work. However, most followed implicit interpersonal channels and everyday ways of "being there for someone," similar to those along which meanings of community were constructed. Underlying all of these strategies are the values of mutual aid, interpersonal communication and trust, which respondents recognized as grounded in their own cultural heritage rather than forced upon them as some moral imperative of new health promotion (Petersen and Lupton 1996). These ways of participating were identified in the interviews as the *actions* that respondents suggested are important for healing and for creating a Healthy Community.

In the context of social health issues, everyone interviewed expressed a profound desire to "do something," to "help out" and to "help make the whole community better." However, for many people, the question of how best to do this was a difficult one. There was a manifest detachment from both organized helping resources and from the structures of power and decision-making which oversee such initiatives. This distance was a common theme across the range of people interviewed.

Everybody's pretty caring and they're trying to find ways to stop the hardships. Now they're trying to stop it because they're talking about it and that's the first step in stopping anything. But I'm not really affected by it because I don't involve myself even if I want to be helpful, I don't get involved like that. There's something happening though. It's just out there (mother, late thirties).

A lot of kids are really into drugs or gambling and they don't get involved with any resources and they won't volunteer. But they could do a lot. They can open a friendship centre, or sponsor the dance. They should just start doing instead of just sitting around and thinking (former high school student and women's activist, early twenties).

I see my sister always trying to help so many people and I just can't do that. I think I'm part of the problem. I don't contribute to the community. But right now I'm just doing my own thing and starting to feel good about myself again. It takes awhile (recent college graduate, male mid thirties).

Reasons for this distance are varied and complex. People tended to emphasize those reasons closest to their own experience, but they all suggested issues that are fundamental across a range of people. Iglulingmiut social policy planners for instance, speculated that while the sense of interpersonal responsibility is inherent and strong, the impetus for community action was suppressed by a taught dependency on the colonial state and government over-service. They pointed to the need to first understand the impact of history in order to be critical of personal practices and to become more actively engaged at whatever level - from healing to management and decision-making.

Parents always had a role in bringing up their children, rearing them, counseling them and lecturing them about what life is. Well now that's wiped out almost completely so we depend on outside help and healers because parents no longer see themselves as playing those roles. When you depend too much on healers and outside help, the only people that attend genuinely want help, but there are also others that are really sick in their mind that are not even going to go to any circles or resources. They withdraw themselves from the community. The sense of usefulness is gone - the sense of dignity and self-reliance. You know, it's too bad, and it's the result of government over-services (Iglulingmiut social policy analyst, late forties).

I mean the people who work in the helping field - we need more of those people to be critical about the problems that we are facing so that they can be dealt with or opened up and recognized. Nobody's being critical to the point where things get rolling. Maybe they're saying it, but I haven't heard anything and I haven't heard anybody talking about these problems. People are not seeing this because nobody is saying it. Prevention is about recognizing the source of the problem. And nobody's talking about it. People need to be more aware. Us as parents, we say it's not my fault, but things that happen with your kids, they go back to you. Then you know that it is your problem. We need to look into that (Iglulingmiut social policy analyst, mid forties)

Women respondents were equally reflective about the barriers to institution-driven forms of community action. Some of these barriers included responsibilities within the home and lack of time. Another barrier commonly mentioned was sparse resources that leave the care of children on the shoulders of most women and limit their access to other activities.

There are so many choices. You can go to complete a course if you wanted to. But I have so many friends who have to stay at home because of babysitting problems or rent going up. You know, these little things that are blocking their way, but there are so many choices out there. And tradition can block the way too - expectations to be a wife and mother (mother and college student, mid thirties).

For their part, many adolescents who took part in interviews emphasized the innovative potential of youth to initiate projects and mobilize collective support. Across the interviews, teens were motivated to action, but were also insightful about the realities impeding them. These included issues of trust, self-esteem and the need for mentorship.

People my age are doing a lot of dope and gambling with friends so the culture is going down by teens doing other things. I want to help, but I don't know what's stopping me. I would do what elders tell me to do, but right now they seem to be saying nothing about us doing drugs and all that. They don't understand (male high school student, late teens).

I tried to start something with a friend and it was doing well but I don't know what happened. It was a group of people, young people. They went to the group and they talked about their problems. People who feel uncomfortable went with someone they could trust to talk to. That was going well but it was before Christmas and after the break, we didn't do it. I want to try it again. Some of them liked it, but the younger ones, they want to keep things more to themselves (male high school student, late teens).

People could take more healing programs together. They want everybody to go but it doesn't work out that way. You can go and just sit there and listen to others without talking and you start thinking about your own problems. You have to heal for yourself first before you do it for others (female high school student, late teens).

A theme within the narratives of these young people was an obvious thirst for reconnection with adults and elders as mentors. However, the fact that both teen and elder might feel awkward about initiating communication makes it difficult for either to

address this need. Indeed, many identified a gap that separates youth from elders since the imperatives of their lives take them in increasingly different directions. Closing this gap has already been recognized by the Igloodik Social Affairs Committee as a social health priority.

Adults sometimes say that we don't listen, but we *do* listen, we *are* listening. They sometimes say "you're not good at anything, you can't do anything so they [teens] can't see what is in them. If everybody believes in themselves that's a healthy community (former high school student, female, late teens).

They usually say that if you want to be well, talk it out. Talk to somebody about it. But I really don't have people to talk to, thinking that they're just going to talk behind my back. Maybe I could go to them myself, to the youth committee or to the elders. They say there's lots of helpers around here to solve these problems but I'm not so familiar with the people around Igloodik. Well if elders want to help, let them say it. Some people are picky and they just want to talk to their relatives instead (male high school student, early twenties).

These excerpts suggest the need for a more sensitive understanding of apparent adolescent disinterest. For instance, one young person suggested developing projects with elders, but chose not to personally initiate the contact. Instead, this person preferred that researchers present the idea because "you're the ones doing the study." On the surface, by privileging the position of an outsider, this youth might appear complacent about becoming involved in community affairs. However, this action might also reflect more fundamental social processes, including the fact that *nalaaqtuq* directives of respect, obedience and humility might supercede a narrow definition of community action.

Whether the issues were related to trust, lack of time, other responsibilities, or even to discouragement from relatives about disclosure or political action, respondents speculated about a range of subtle barriers to apparent community participation. Consequently, the ideal candidates for community and social development work are those "strong enough" to do it. To be strong enough often means to be able to maintain the

necessary level of professionalism required in a southern institutional setting, while remaining anchored within community and family affairs. For many in the helping field, being the strong one also means that personal and emotional resources are incredibly overburdened and there is a constant threat of burn-out.

The one thing that makes me unhappy is being disappointed in myself for not being strong enough to help help help all the time. Especially when it's your own family! So I think there should be people with drive and who are well-liked and just more energetic to try and get things done when nobody hears the first time, even if they were interested, but if you don't repeat it, I don't think they'll hear you. So we need people with drive to keep things happening and eventually people will start noticing - ok, that's really good, let's keep doing that - it can be just one person but that person needs a lot of drive and strength. Especially with a community this size, you need a lot of voice to eventually get heard (mother, mid thirties).

Given the apparent discrepancy between an obviously profound sense of mutual responsibility and the practice of involving oneself in institutionalized strategies of community action, it is important to understand the way in which involvement is already perceived as everyday acts within people's lives and experiences. Embedded as it is in daily experience, this type of participation may not be as explicit as health promoters would expect, but front-line workers know that attendance at a prenatal class, speaking for the first time in a group, or bringing children to the preschool and having coffee with other parents, are real and significant ways of becoming involved in community affairs. But perhaps even more significantly, the care taken to listen to a troubled friend or family member, to advise someone, or to share resources and food are considered fundamental avenues of community participation.

For instance, it has already been suggested that the commensal meal and the sharing of food are social institutions that reinforce solidarity. For middle-aged people, the knowledge that this practice is happening less often, led them to emphasize its participatory value. Women in particular suggested the importance of roles played by

various family members within the commensal meal. "Participation" is therefore attending, eating and listening to and telling stories that are all part of the event.

I think going to [an elder's] place to eat is one of the nicest things. I love their stories and they always have something to talk about and I just listen. (mother, mid early thirties).

Men of the same age considered sharing food to be important because the provision of fresh meat had been taught as a primary responsibility toward others. In fact, most suggested that the practice of hunting together and furnishing food is the means by which they can best contribute to community solidarity. Unfortunately, this method was also recognized as one that now requires a great deal of time and financial resources which are not easily (or regularly) available for some.

When I was young we helped each other with the money and the meat. Today it's a lot different. Probably from the bills that they have to pay. And me, I'm not giving any money to my relatives because I got to support myself. It's very hard to help other relatives. Still I help them with the meat. I still share the meat (part-time hunter, early forties).

Children of this generation, though removed from the imperatives and immediacy of survival themselves, still understood the importance of offering meat - for both giver and receiver.

My dad went through a lot of hard times, but he helped me to survive, you know. Like sending a part of caribou to my house when I'm just sitting home alone. He would just come in and bring the meat. I think as life started to get better for him, he would come in and bring some meat to my house or call us everyday to see how we are doing and how the kids are doing (Homemaker, late thirties).

Alongside material expressions of mutual support were the interpersonal channels of help and advice that constitute community involvement. Women especially emphasized these methods of involvement. This is not surprising considering women's traditional roles as care-givers responsible for family health. For instance, some middle-

aged women who had learned their skills by observing and listening to mothers and elders, tended to be active at the quiet margins of need. These respondents implied how they balance the non-interference borne of respect, with their primary role as care-givers. Others were more vocal at the forefront of political and social change within the community. With new social health problems to confront, people are developing new ways of interacting and redefining the limits of mutual aid. Establishing support that does not undermine the autonomy of others, was a recognized challenge.

I don't go out very often, only when I get a call from outside. People who need help sometimes call me. I'm not a very good counselor but some people ask me to help them when they get too down. And quite a few people ask me to make parkas for them. So weekends, I always make something mostly for people who have asked (grandmother and college student, mid forties).

You have to show your feelings, tell what your feelings are by talking. And if you're able to help people, other people, you go and help no matter where you are. That's a healthy thing to do is to help other people. In order to be healthy, you have to show other people that you want them to be healthy. You have to be understanding, listening and talking about things. Those three are the most important, and you just go visit and be yourself (grandmother and educator, mid forties)

Younger women echoed these sentiments and also expressed them within the context of daily practices. Like their mothers and older relatives, many of these women are deeply immersed in what the health and social work establishment labels the 'informal sector' of helping and healing resources. As one Iglulingmiut front line worker pointed out however, insofar as this sector is 'informal' it is only because it operates independently of institutional resources. Otherwise, it can be considered a structured process of advice seeking and giving, which involves only very specific people within an individual's network of relations and friends. Within families for instance, couples might consult the *Issumataq* (Respected Elder of the kin group) or other higher ranking and more experienced family members. Valorized (but not immutable), these advisory roles are a reminder of the abiding importance of *ilagiit* in defining and structuring methods of participation.

When my oldest sister asked me about her marriage, that was so unexpected because she was really confused and she asked *me* about it. And that lifted my spirits up really high, being the youngest daughter, the girl, the youngest. I didn't expect anybody would ever ask me about anything (mother, late twenties).

Although family networks figured significantly for many women, some also indicated that it can be difficult to find an impartial and trusted confidant among close relatives. This is especially true in situations where domestic violence traps a woman within a web of relationships that appear only adversarial. A woman can find herself in a difficult position where the interests of individual physical and emotional safety are in direct conflict with the strong directives of family and often her own desire to "keep it together" and to "work things out." This can mean having nowhere to turn for support. However, because remaining silent itself is recognized as emotionally dangerous, some women suggested that talking to a trusted friend within one's own social network is an appropriate and healthy course of action. Consequently, so too was listening and supporting a friend. Investment in trusting networks was highly valued, especially among those women whose family situations might rob them of the emotional resources to direct their strengths toward institutionally recognized methods of participation.

A friend of mine was talking about suicide lately so I just go there and grab a cup and pour myself a cup of tea and just sit beside her. I hope that's good enough. I know that she calls me when she doesn't know what she is thinking and I think that's what everybody needs (mother, early thirties).

The preceding examples have described not only some of the perceived barriers to narrowly defined forms of community participation, but also the ways in which everyday and implicit actions are themselves seen as contributions that help to actualize the local vision of a Healthy Community. This is not to say that organized and collective social action is foreign to Igloolik. As Wilkinson (1986) cited in Frideres (1994:2) notes, the nature of community participation changes over time. Communities act politically and socially, but only under special circumstances - suicide clusters, trauma, or other issues

that cut across and mobilize the whole community. More frequently, the perception of involvement is shaped according to everyday strategies of health and helping.

At an institutional level, the government's First Nations and Inuit wellness agenda recognizes that these ways of participating fall along a continuum from personal healing, to training and education, through to enhanced individual capacity for meaningful engagement in collective community development and political issues. The agenda also recognizes that the nature of the empowerment process is such that enhanced self-esteem is both prerequisite and result of healing, education and participation in socio-political initiatives for a Healthy Community (GNWT 1995, Labonte 1990, Robertson and Minkler 1996).

To be sure, this agenda represents a welcome shift in health care thinking that now supports strategies to enhance self-esteem and community development. Yet despite acknowledging the importance of family and social integration (both of which remain undefined and uncontextualized in any documentation), the overall vision of state-sponsored strategies privileges both self-actualization and collective empowerment. This makes a conceptual leap between individual and society, as though people were unattached to intermediate structures such as families or social networks which can have an enormous influence on personal development depending on where one is situated within these networks (McLean 1997). Within the institutional discourse, social and family networks remain unexamined and incidental to the social development process, rather than becoming its focal point. This risks misunderstanding or by-passing the interpersonal relations that people themselves emphasized as important modalities of involvement in the wellness and Healthy Community movement. It also might overlook the power of these networks to structure - for better or for worse - the personal choices about how to become involved.²⁰

20

Gwen Reimer (1996) has examined the ambivalent position of Inuit women. She highlights the "inherent
(continued...)

Given that the institutional discourse of the Healthy Community links a particular vision of participation with empowerment (for both individuals and communities), and considering the actual diversity of ways in which participation is mobilized, how is empowerment recognized, felt and lived in Igloolik? The following section addresses this question.

Negotiating Empowerment

An organizing principle in discussions of Inuit health policy has become the connection between empowerment and an increased health status. As a multidimensional concept, empowerment can function within territorial or community politics where it is embodied in restructured policies and greater municipal control of services. These testify to increased local jurisdiction and decision-making power. Within personal experience, empowerment can also be seen as the creation of an atmosphere in which people are better able to fulfill what they themselves find personally meaningful. Indications of empowerment were identified in the narratives by first determining which accounts most closely matched the principles and values implied in wellness and new health promotion literature. These were then examined through respondents' semantic associations.

Conventional thinking on empowerment would assume such instances to be embedded within a spectrum of participatory activities through which individuals or groups appropriate the power to determine and act on their own goals. In reviewing all of the narratives however, it became apparent that the accounts most resembling the conventional elaborations of empowerment were not about the self-oriented appropriation

²⁰(...continued)

tension in many women's dual obligation to support both the family unit and each other as individuals" (Reimer 1996:88). This tension is compounded when the family situation is abusive.

of power or control. Instead, they described finding a confident place from which it is possible to take action. In short, both individual and collective empowerment was closely aligned with the notion of *trust* across a range of narratives and in a variety of circumstances.

As a compelling theme in the interviews, trust is mentioned but not adequately addressed in either health promotion or community development literature, which takes it for granted that empowerment is the obvious result of participation. However, as respondents emphasized, the ability to trust is both a prerequisite and a goal of the entire participation/empowerment process. In this section, I consider local reactions to conventional discourse on both collective and individual empowerment with the goal of opening discussion on the meanings and importance of trust.

To begin, Iglulingmiut policy makers and civil servants recognize that some of the mainstays of conventional empowerment discourse in healthcare have acquired new meaning in the North. For instance, whereas inter-sectoral collaboration is elsewhere considered key to balanced community control of decision-making, in northern communities it is important to take into account exactly who is represented within this collaborative structure, and how this continues to affect the balance of power.

We have interagency committees, which are basically imported experts, teachers, police, you know. If they're concerned about the Inuit, then the Inuit should have a role in the interagency committees and so forth. The Inuit themselves should be the ones who are raising all the concerns. We've gone through a stage where everything was done for the Inuit, and Inuit were expected to live with it when in fact it was not the creation of Inuit that they had to live with, so the animosity toward the system is quite high (Iglulingmiut policy analyst, late forties).

This "system" is the gamut of administrative and social services that were imposed and maintained by white colonizers. As the balance of power slowly shifts under the Nunavut administration, there is an expressed need to rebuild (or build) trust in

a system which has, since its inception, privileged the assumptions and agenda of a southern bureaucracy. Among those who discussed political issues, the goal of establishing trust in an empowered Nunavut government was a common theme. This was especially true for middle-aged respondents who have witnessed (or taken part in) the creation of Nunavut from its beginnings as a land claim negotiation.

I know a guy who's in politics. We grew up together and I know he's been trying to help other people for the future. But sometimes he doesn't ask what he should do. He's been doing politics for a long time and he doesn't ask other people. Sometimes he just thinks he's right and he can do it himself. Politicians are smart people, but they can fool you. I don't trust politicians (part time hunter, early forties).

I think Nunavut is going to be a point of pride for Inuit but some of them might be kind of scared. Are we ready? But I put trust in the people who handle these things. The government has been doing it for years, and I know that Inuit are very caring people and it's their way to care for each other and help out. I think the new government is going to be understanding to people and try to be helpful. I just hope not too generous so we don't run out of money!...But I know that the Inuit leaders are looking out for us even though we might not like it sometimes (a wife and mother, mid forties).

In these examples, the perceived effects of political empowerment were described in terms of negotiating trust in others. This perspective considerably broadens the meaning of empowerment and makes it a relational activity rather than a unidirectional appropriation or transfer of control.

Similarly, in instances where more direct participation or community action is generally linked to empowerment, the concept was also addressed in terms of negotiating trust-building relations. One young community organizer implied that activism can be a question of establishing trust in both the municipal administration and among other participants. Here, trust is a valuable resource, since "fixing things" can depend on how people get along with one another.

Most of the agencies are relying on the Hamlet funds. We don't want the money from either agencies or companies. Right now we need second hand clothes or whatever people are not using. Even if we do rely on the Hamlet, they're going to take over and take control for sure. And tell us what to do and what not to do, you know? Maybe they'll even want to charge admission (laugh). They can't always fix things. We can. It always depends on people. *It depends on people, how they feel about themselves and each other* (activist, early twenties - on establishing a women's collective, emphasis added).

At a personal level, empowerment has become synonymous with the benefits of self-help. That is, the concept implies a sense of self-esteem and control over personal life. However, the need to establish trust is perhaps more important here than at any other level within empowerment discourse. Through their narratives, men (especially young men) were particularly vocal about this issue. They suggested that involvement in the self-help strategies, which are intended to foster personal empowerment, will not occur if potential participants cannot first establish the trust necessary to share their feelings.

A lot of us aren't so familiar with those people [in the helping field] so we don't really know what to say to them and whether they can take this pressure and stuff like that and will they be really quiet about it (male not currently in school, late teens)

Lots of people want to help and a lot of people know that there's help out there. I guess they're just afraid to let people know what problems they have in their life (male high school student, mid twenties).

Talking in a big group, its very bad, I'd rather talk to one person that I trust and know that he or she won't tell it out (male, early forties).

Given this expressed need to foster and maintain a level of trust, the benefits of devolved social services are immediately apparent in Igloolik. By hiring local traditional (elder) counselors and training local workers, some respondents felt that social services are now helping to emphasize personal empowerment rather than reinforcing the disempowering effects on families with which it has long been associated. A newly trained social worker described the change with respect to negotiating trust and empowering young people especially.

I think there's already a difference with me doing this job. Like with kids at the highschool they say that they can really talk to me and they open up more because they trust me (social services worker, mid twenties).

These examples from the collected narratives suggest that the tools for the notoriously ill-defined concept of empowerment (individual and collective) are found in its relationality and the negotiation of trust, rather than in its imperative to public action. 'Trust' itself can mean faith in the action of leadership, or a level of interpersonal comfort that makes participation possible. Regardless of the level at which it operates however, the variety of associations surrounding conventional descriptions of empowerment generally depicted the creation of an environment of confidence, rather than any overt appropriation of power for oneself or one's group. This perspective has the potential to inform the development and delivery of services and programs designed to foster empowerment within a new health promotion framework.

This examination of the values implied by institutional Healthy Community discourse has suggested both points of divergence and of convergence with Iglulingmiut values and practices, which themselves vary according to personal circumstances. Analysis has unpacked the apparent consensus surrounding the concepts of community, participation and empowerment. It has suggested some of the ways in which these values are appropriated, reconfigured or assigned new meaning according to personal experience, structuring conditions and local values. Therefore, the discourse of the Healthy Community and wellness movement is a 'truth' that is sometimes contested but always negotiated. The final two chapters conclude the discussion by suggesting both the practical and theoretical implications of this understanding.

CHAPTER 5 - DISCUSSION and CONCLUSIONS: From monologue to dialogue - reframing theoretical questions to inform practical goals

The problem is that many hamlet dwellers do not consider their community to be home and understandably so... The communities seem like artificial constructs, as if Inuit were being made to play Qallunaaq. They know that their true home stretches across a quarter of the Canadian Arctic itself... Consequently, no one actually feels ownership over a hamlet. They have never planned it, never fought for it, and most certainly did not build it. ...a settlement of people only becomes a true community when sufficient numbers of people come to call it home and are willing to work for it. The common people must care.... Every citizen of Nunavut must ask himself if his hamlet is truly his home. If only a few people can claim so, they are a community" (Qitsualik 1998:31).

It is significant that this excerpt is at once an historical justification while at the same time a provocation and call to community action. It demonstrates that the ambiguity surrounding the values associated with social health promotion and community development in northern settlements must be understood in the context of colonial history. Community health or wellness is not an exclusive ideal with one universal method for its maintenance. Rather, as this quote by an Inuk columnist clearly argues, it is the product of both culture and history. While the author implies some of the inherent problems in trying to effect policies that work *for*, *from*, and *with* the community, she holds strongly to the ideological importance of "true community" and to the hope that people are "willing to work for it." Like many of the Iglulingmiut who took part in this study, she shares the ideology of the Healthy Community but adds nuance to its values with an explanation of "Inuit ways" and a cautious reminder about the impact of colonialism.

This thesis began by introducing a related point of tension. Beginning from the type of ambiguity described here by Qitsualik, I noted that neither the dominant concepts of critical theory, nor those of health promotion and wellness, could sufficiently account for the ways in which Healthy Community principles are met in practice. Critical theory applied to the new health promotion tends to essentialize the expanding power of health

and wellness professionals and to invoke the hegemony of discipline and regulation. At the same time however, this critical voice does raise important concerns about the tendency of new health promotion principles to homogenize the community and overly idealize the participation and (thus) empowerment of citizens. Moving beyond the dominant concepts of either perspective, historical and narrative data demonstrate that a more informed approach is in a dialogue between the two.

Indeed, while the discourse and technologies of the Healthy Community movement have become the conscious tools in a new language of wellness, power and renewed cultural awareness for those who invoke them, the values that they imply are neither identically nor universally espoused. People choose pragmatically what is meaningful and possible for them in their journey to *inusirqatiarniq* (being healthy) and in establishing productive roles for themselves within family and a changing community (*ilagitiraniq*).

Reframing conventional criticism in this context recognizes these diverse interpretations of the values of a Healthy Community and can help to harness their analytical power to promote effective ways to achieve it. This perspective recognizes that, when reinforced by formal bureaucratic structures which set parameters for participation, apparent consensus might alienate the very people whom the Healthy Community discourse is intended to reach: those who feel marginalized from the existing structures of power or social supports. This fact can easily be overlooked when participation is associated with goals such as empowerment and democracy. Indeed, an assumed consensus (based on a dominant institutional perspective) about how these values are experienced in practice robs them of their ability to inspire innovation in health strategies.

As Warry (1998) has noted for First Nations communities in southern Canada, there is a subtle difference between creating a supportive atmosphere for promoting wellness and a Healthy Community and promoting approaches that 'institutionalize'

community healing resources and capacity (and in so doing, continue the colonization of community life). Many respondents indicated that informal and unthreatening situations are the most conducive to building community cooperation for talking, healing, planning programs and making decisions. The holistic goals of the Healthy Community and wellness movement would therefore be enhanced by recognizing the inherent diversity in interpretations and experiences of community and health, and by encouraging flexibility in the bureaucratic structures that supply resources and training.

This perspective has implications that can inform wellness and Healthy Community strategies. While recommendations must come from within community-based initiatives themselves, the themes that have emerged from the collected narratives suggest at least three possible areas for consideration. First, the complex dynamics of social and family *networks* should be considered for their valuable potential in both prevention and intervention strategies. Additionally, the constraints of external evaluative criteria for wellness programs need to be addressed. Finally, a deeper understanding of the circumstances and experiences of young people is necessary. This perspective must respect young people's sense of initiative and responsibility, while remaining sensitive to the issues that presently inhibit their involvement.

Health promoters already recognize that it is inappropriate to narrowly address social health issues such as domestic violence, substance abuse or suicide, from the perspective of the individuals involved. Socializing rather than medicalizing problems makes them a community responsibility. To be sure, programs that focus on community integration or the renewal of cultural skills play an important role in long term prevention. However, the broad scope of these initiatives means that they cannot target specific issues. To address this tension, one suggestion is to focus on the true source of both conflict and harmony: the interpersonal, social, and family networks that are the cradle of community.

Such a focus would require a deeper understanding of the complex levels within these networks, especially the structures of authority within families. One's position within any social network in Igloolik is necessarily relational. Among kin, it is embedded amid a hierarchy of roles that influence interpersonal interactions and give elders a special authority and responsibility for the well-being of families. At the same time, impinging structural constraints deeply affect this traditional role.

The way I see it, now people are more informed but they know less how to deal with . problems or stuff like that in the community. This is due to the fact that elders' voices are diminishing (grandmother and educator, late forties).

Dr. Laurence Kirmayer has addressed similar issues in Inuit communities in Nunavik (Northern Quebec). He suggests that family and social network interventions, which fit squarely within the life-world of (for instance) troubled youth, would be more effective than an individualized treatment focus (Kirmayer et al. 1998:205). Kirmayer points to community-organized heritage camps as one such intervention that reintegrates young people with each other, with elders, and with the practices of their culture (1998:206).

Building on these suggestions and on the experiences recounted in the narratives, a further step might combine both prevention and intervention strategies within the real, lived space of social and family networks. Such a model is already being tried in the Igloolik Early Intervention Project. This innovative resource combines the openness and freedom of a drop-in play centre with more tightly focused programs that cater to the various requirements of children, youth, and family support. The combined strategy can expand or narrow its scope according to the needs and wishes of individual families. This approach emphasizes flexibility over institutional processes and definitions. It places family at the very centre of community integration, thus addressing both intervention and prevention perspectives with appropriate adaptability.

The delivery of such an initiative reveals a second area for consideration - the constraints of externally imposed criteria and methods of program evaluations. Supported by transferred funds that are targeted to community wellness, staff must remain vigilant about meeting the criteria privileged by state programs. However, the important flexibility that Igloodik staff have built into their program to suit client families can make it difficult to meet the rigid criteria of funding agencies. This difficulty arises despite the fact that these criteria are clearly based on broad health promotion principles. Consequently, front line staff in Igloodik are developing a model of local participatory evaluation using the tools of internal assessment and action research. They recognize the eminent need to redefine evaluative tools and criteria and to realign these with a new culturally-anchored perspective.

Finally, a third emergent theme focuses attention on the difficult position of Iglulingmiut young people, specifically those in their late teens and early twenties who are not presently in a training or educational program (school non-attenders). While many of these young people appear to their older onlookers to be complacent, disinterested and "spoiled," narrative data and personal discussions often indicated quite the opposite. The problem, as some described it, is to find their voice amid imposing bureaucratic ("big politics") structures and the counsel of concerned elders within the family and community hierarchy. For others, possible child-care responsibilities or the escapism of gambling and dope smoking (generally among young men, but for some girls too) compounds impediments to action.

Despite these common barriers, several young people indicated that they had started groups, talking circles, clubs and committees on their own initiative. However, efforts were often thwarted by poor attendance, holiday disruptions and transience between communities. Within the Nunavut administrative strata, there is a place for youth on local and regional youth committees. But just as with any 'representative' body, these committees may not be able to address all of the concerns of young people

and may end up electing to centralize their efforts on a few special events and projects. By contrast, among many of the young respondents from Igloolik, there was a sincere interest in sustained and youth-driven initiatives. These young people are looking to their families and elders for the support and confidence to carry out such initiatives. Investment in long term initiatives that regularly bring young people into meaningful contact with elders could enhance these efforts.

In Igloolik, like in all communities, there are important ideological divisions on issues and practices that are close to people's hearts - ways to heal, ways to contribute to society, and ways to become empowered, for instance. In the range of ideas about the values of community, participation and empowerment that emerged in the narratives there is fuel for dialogue and innovation. The diversity of skills and differences in opinion, both within the community and between community and institutional bureaucracy, can be a source of "creative tension" that leads to change (Warry 240). With close attention to diversity, constraints and apparent challenges, Healthy Community values can be translated into strategies that are truly responsive to the variety of local needs. Greater and more open dialogue, along with continued critical reflection will only complement a move toward increased solidarity and community integration (Frideres 1994:291, Laroque 1997).

CHAPTER 6 - EPILOGUE: The personal and the political in the Healthy Community - thoughts on Nunavut.

6.1 The power of Nunavut to consolidate a discourse

In chapter two I suggested that Michel Foucault's notion of a "truth game" is a useful way to understand how people adopt and actively make themselves part of a discourse such as that of the Healthy Community or the wellness movement. This perspective understands that truth and consensus are constructed and negotiated, rather than the product of pre-existing standards or ideals. It acknowledges that people are themselves pragmatically engaged in creating what is considered valid and true in a public discourse.

By analyzing the variety of ways in which people react to the values implied by Healthy Community discourse, this study has first drawn attention to the underlying negotiations and complexities in what seems to be common sense and timeless truth. It could then suggest some of the practical implications of this more subtle understanding. For instance, locally responsive strategies for social health should consciously build on - rather than potentially stifle - existing community strengths, supports and innovations. But while analysis has focused on multiple meanings and contested or negotiated values, it does not deny the transcending importance of community solidarity and a collective sense of responsibility and power that Iglulingmiut and their neighbours in other Nunavut communities are working hard to renew.

In closing, I consider this goal in the context of Igloolik's current historical moment, the recent creation of Nunavut. Corin (1990) has suggested that elements in a discourse - including those that produce knowledge and apparent consensus - are only understood within the larger framework of a culture and the historical/political events in which they are embedded. Chapter 3 presented the antecedents that established a

consciousness about the Healthy Community in Igloolik, but it did not yet consider the impact of Nunavut. Thus, given its new and complex implications for personal and community life discussed in chapter 4, what is the power and potential impact of Nunavut (or self-government)²¹ to fuel this discourse and to consolidate the way in which principles of the new health promotion are perceived and enacted by individuals?

Anthropologist Veena Das has proposed the idea that certain “critical events” within a society’s historical trajectory can incite new meanings and modes of thought and action that come to be naturalized. She argues that social analysis cannot ignore the events that shape values. With respect to the independence of India, she describes a “critical event” as one that

... institutes a new modality of historical action which was not inscribed in the inventory of that situation....After the events, new modes of action came into being which redefined traditional categories such as codes of purity and honour, the meaning of martyrdom and the construction of a heroic life. Equally, new forms were acquired by a variety of political actors, such as caste groups, religious communities women’s groups and the nation as a whole (Das 1995:6).

These events have implications for institutions, family, community, bureaucracy, courts of law, the medical establishment and the state. As such an event, the birth of Nunavut contributes to a new mode of communication and new ‘rules’ for the production of knowledge surrounding health. Indeed, this political restructuring has the potential to broadly affect health discourse in at least three perceptible ways. It will promote a level of community control that has been denied during decades of colonial administration. It will enhance economic and employment opportunities for Inuit. Finally, it can safeguard a discursive space where the locus of health and illness is shifted from within the bodies of individuals to become the preserve of the social whole, which is unique to each community.

²¹ It should be noted that Nunavut’s is actually a public government. However, with a population of over 80% Inuit, the result is a *de facto* self-government, the blueprint for which includes unprecedented decentralisation of departments and community control of human services.

Specifically, the creation of Nunavut currently puts *Inuit* leaders in charge of making decisions about the future of the people they represent. While the interviews suggest a perceived distance from leadership in practice, the decentralized structure of the new government has the potential to at least increase access to these decision makers and to render more 'user-friendly' the government mechanisms for local input. Amid the ambivalence of both hope and apprehension found in the interviews, the overall message is that the Nunavut government - with its Inuit majority and its location closer to home - already seems to be more familiar to people.

To be sure, some Igloodingmiut remain cautious about government, but they are also convinced about the promising potential for Nunavut. This is particularly evident among Arctic College students who are training for "Nunavut jobs." Unlike their southern counterparts who might expect to be employed within a giant anonymous bureaucracy, students at Igloodik Arctic College know that their responsibility and potential is multiplied by virtue of the smaller pool of eligible applicants. Everyone who is successfully trained will be employed - doubtless, some in very high profile positions. This fact forces students to seriously consider a new set of responsibilities and new modes of interaction. Anticipated government jobs could mean relocation of community members, transfer of newcomers to Igloodik, and the continued rigours of negotiating between Inuit and bureaucratic cultures.

The multiple imperatives of Nunavut require young people to assertively confront whatever personal impediments might keep them from fulfilling the expectations of their potential new roles. Fortunately, the promise of focused goals for the future, meaningful employment and a sustained way to support extended family make this process easier. In this way, Nunavut serves as a testing ground that maintains the discourse of the Healthy Community by putting into practice some of its most explicit goals.

Finally, as a post-colonial enterprise, the Nunavut government can now more openly recognize the barriers to community action that are, at least in part, the unintended consequences of historical colonial processes. Indeed the culture of communities has been shaped by a foreign state in a very tangible way. However, as the overt colonial structures recede, so too does the *Qadlunaat* (White) tendency to view communities within the gaze of disease profiles: sick and disorganized (O'Neil 1988). This discourse of need is being replaced by a strengths perspective which draws inspiration from new health promotion to encourage, among other things, accountability in leadership and the preparation of municipal councils to take control of devolved services.

Nunavut leaders and the territorial media are actively helping to cultivate this discursive space within the public imagination. A "master narrative" (Appadurai 1991) within the story of Nunavut has become that of wellness, resilience and reclamation that is grounded in understanding the impact of colonialism and rediscovering Inuit traditional strengths. Even the Premier-elect Paul Okalik has often publicly discussed his emergence from a difficult and abusive past. Striving for transparency, openness and accountability in leadership and casting the young Okalik as an apt role-model, government and media promote and maintain a discourse of wellness and Healthy Community sensibilities.

Yet insofar as people in Igloolik share in this master narrative, the semantic networks reconstructed around the principles of the Healthy Community demonstrate that their meanings are not entrenched and dominant truths. Rather, they are shifting and negotiated according to personal experience and lived reality. People involve themselves through the practices that they determine are possible and culturally as well as interpersonally important - adopting, appropriating or redirecting values accordingly. This process helps to create a new consensus about what counts as 'community,' 'participation,' and 'empowerment' in the project of fostering social health in Igloolik.

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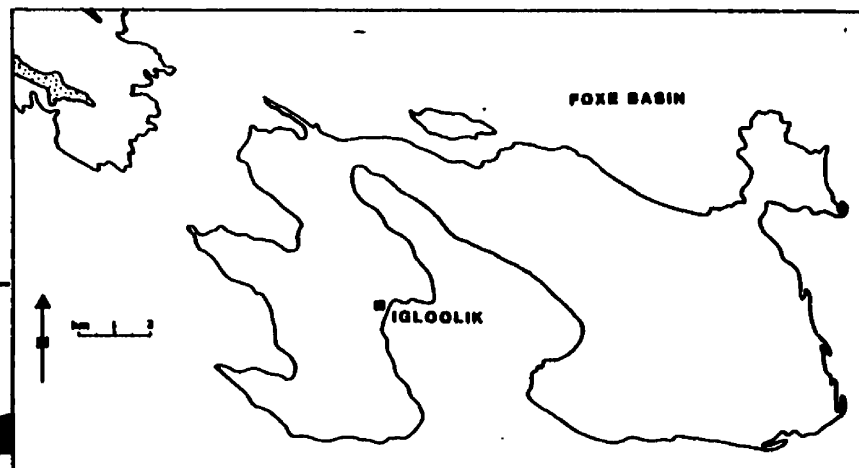
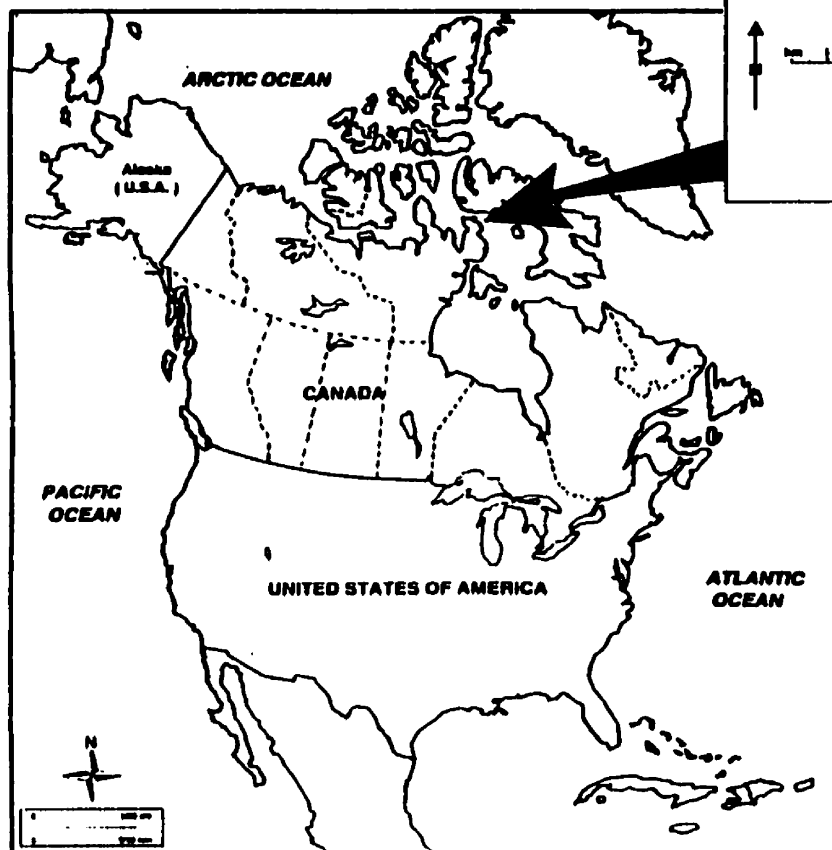
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The Structure of Nunavut

On 1 April 1999, the political map of Canada was officially redrawn. The division of the Northwest Territories to create Nunavut is the culmination of a long struggle on the part of Inuit leaders since the 1970s. The new territory covers 1.994 million square kilometers of land. From the northern Manitoba border, it follows the tree line to the northwest and encompasses most of the Arctic archipelago to Baffin Island in the east. The territory also includes the islands of James Bay and Hudson Bay. Nunavut will be home to 28 towns and villages with a total population of 27 719 residents, 85% of whom are Inuit.

The defining feature of Nunavut's new system of government is decentralization into administrative hubs. In practice, this means that various government departments are spread among several hamlets. Igloolik was already the home of the Nunavut Social Development Council (NSDC) the mandate of which is to oversee the development of culturally appropriate social programmes for the territory. With the new government, Igloolik is now also the headquarters of the territorial department of Culture Language Youth and Elders as well. As an integral part of the government's "social envelope," this department will be informed by NSDC recommendations.



Igloolik, Nunavut Canada

The Hamlet of Igloolik is located on Igloolik Island, off the coast of Melville Peninsula. The island lies to the southwest of Baffin Island in Canada's newest territory, Nunavut.