PUBLIC HEALTH POLITICS IN NUNAVIK HEALTH CARE:

SHARED CONCEPTS, DIVERGENT MEANINGS

A Thesis submitted to the Faculty of Graduate Studies and Research

in partial fulfillment of the requirement of the Degree of

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FOREWORD & ACKNOWLEDGMENTS

This thesis is based on data collected during fieldwork in 1991. Nunavik has no doubt changed since. While the James Bay and North Québec Agreement was understood as a land claim agreement at the time of fieldwork, the Makivik Corporation, Nunavik local government, has recently made publicly known its desire to engage in negotiations towards a comprehensive land claim settlement. In matters of health care, Kuujjuaq was in turmoil in the spring of 1991, culminating with a change of executive and philosophy at the local hospital. The community held high hopes for change.

Unfortunately, developments since fieldwork will not be reported in this thesis. However, I believe that the larger issues of the relationship between culture, power and health, which in Nunavik is explored and negotiated through the discourse on community health, has importance beyond the context in which it is examined in this thesis.

I am indebted to professor Margaret Lock for her guidance and teaching during my graduate studies in Medical Anthropology. A special thank you to Professor Colin Scott for his insights, encouragement and unconditional support. Un merci tout particulier au professeur Carmen Lambert pour son apport, soutient et investissement personnel pendant la durée de mes études.

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ABSTRACT

In Nunavik, the question of self-determination in health care is becoming increasingly embedded in the community health discourse, which is used by both health planners and Inuit alike to negotiate diverging positions. While health planners envision northern health care as a subset of the Québec system, Inuit perceive it as a vehicle to ends that transcend conventional health issues. This thesis will provide an overview of the development of Nunavik health services since the James Bay agreement, focusing on how the use of the community health discourse serves to promote, but also shapes and limits regional and community self-determination.

RESUME

Au Nunavik, la question d'autodétermination des services de santé s'intègre au discours sur la santé communautaire. Les représentants de la santé et les Inuit utilisent ce discours, chacuns à leur manière, pour définir les besoins de la communauté et négocier des positions divergentes. D'un côté, les représentants de la santé perçoivent les services de santé nordiques comme une branche du système québecois. Les Inuit, quant à eux, utilisent ce système pour négocier des questions qui dépassent les limites conventionnelles de l'institution médicale. Ce mémoire démontre comment le discours sur la santé communautaire peut non seulement promouvoir, mais aussi définir et limiter une gérance communautaire et régionale Inuit des services de santé.

INTRODUCTION

The status of aboriginal populations in Canadian society has been described as that of an internal colony (Frideres, 1988a; Ponting, 1986), in which the power of the Canadian political system simultaneously incorporates and subordinates the "colonized". Paine (1977) uses the metaphor of the "Nursery Game" to frame White-Inuit relationships in northern communities. Brody (1975) suggests that Whites hold a romantic notion of the "real" Eskimo[1], against which the "Eskimos" they come in contact with are being evaluated, and judged. Never being able to meet the standard imposed, "Eskimos" remain excluded from the White domain. In recent years, self-determination for native people has become a major focus for natives, provincial and federal governments, as well as scholars. Often times, this avenue is presented as a matter of fact cure-all.

Likewise, self-determination in health care[2] has been presented as a solution, perhaps the only possible solution, for inequities and shortcomings claimed to exist in native health care services. The present system has been called "une vraie farce" (La Presse, 1986b: A8); accused of marginalizing Inuit (Julien, 1987); and has been qualified as "une structure centralisée et blanche" (Tremblay, N., 1991: 15). It is characterised as top heavy, misadapted to local needs, and impervious to local participation, its professionals living in a cultural ghetto (Kativik Regional Council of Health and Social Services, 1986; Simard, 1988; Weller & Pranga, 1987). Dufour (1989a) states that the model of health care delivery needs adaptation to the northern context, that in some cases it replaced or weakened local resources of self-help, and that it remains inaccessible culturally, since practitioners and clients do not share a common cognitive base. O'Neil argues that

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[1]Brody's term.

[2]Under the label of self-determination in health care, I wish to also include what in the French literature is called "l'autochtonization des services de la santé" as well as the Federal government's Health Program Transfer Policy. These avenues generally follow distinct models and may have very different implications in terms of their outcomes. However, they do share one very important quality: all treat health care services more or less as a black box, to be transferred from one authority to another. The transfer process does not necessarily aim at providing native people the ability to address the content of the box.

> Health services remain one of the most powerful symbols of the colonial relationship between northern peoples and the nation state, and the pervasiveness of this symbol in the intimacies of everyday life undermine further development in other institutional areas (1988: 47).

Labbé (1981b) claims that biomedicine, as implemented in the north, promotes Inuit dependence on the south.

Theorists, politicians, Inuit political authorities, community leaders, anthropologists as well as health practitioners all seem to have at heart the defense of Inuit securing greater involvement in their health care services. Termed self-determination, "l'autochtonization" or local control, it is assumed that this greater involvement would lead to the resolution of problems, conflicts and shortcomings of services delivered by the dominant society.

What self-determination, "l'autochtonization" or local control actually *mean*, however, remains obscure. The terms are rarely defined, either as ideological stances or in terms of the structural changes they imply. This "omission" leaves an aura of convergence of efforts, of consensus. In fact the terms are used loosely to signify an array of options, which vary considerably in scope and complexity. The discourse supporting self-determination[3] in health care invariably draws on concepts of community health in the construction of its arguments. These concepts are however used in a variety of ways, which often reflect political agendas.

This thesis will focus on the production and use of the public health discourse in relation to self-determination in Nunavik health care. Nunavik corresponds roughly to "Nouveau-Québec", which lies north of the 55th parallel. Nunavik is the toponym chosen by the Avataq Elders Committee in 1988, and means "*une très grande place où l'on vit*" (Anonymous, 1988). The region is inhabited by 6500 people, 91% of them Inuit, distributed over a territory which constitutes 36% of Québec's territory. The population is divided in 14 villages, along the coasts of the Hudson Bay, the Hudson Strait (3800) and the Ungava Bay (2700) (Dufour, 1989a).

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[3] I am here and will be using "self-determination in health care" as a generic expression.

Nunavik is a particularly useful case for the purposes of this study. The James Bay and Northern Québec Agreement was signed by Inuit[4] and Cree, with the Governments of Quebec and Canada in 1976. A comprehensive land claim settlement, the agreement was intended to put an end to federal and provincial jurisdictional debates, and allow for the development of coherent services in the north. Building on existing provincial structures, the agreement was expected to promote a regionalization of decision making in a number of areas, including health care. Given the political climate of the 1970s, with native associations increasingly making demands for greater control over their affairs and services, the agreement was touted as a political milestone by both the federal and Québec governments.

In areas of health care, as in others, the agreement was to be the starting point for yet more debate. This continuing debate hinges on how Inuit political leaders, and the Québec government, define "significant control" and "autonomy", concepts which are now inscribed in the current national debates over native political self-determination and self-determination in health care. Chapter one will provide a synopsis of these debates, through a review of the literature on political self-determination, self-determination in health care, and its linkages to the community health model. Current paradigms tend to rely on the community health model to formulate self-determination in health care. This is often justified on the ground that the community health model is "closer to the way natives think about health". There are obvious limitations to inscribing such a political process in a model which evolved from a western medical tradition. Such limitations will be reviewed and an alternative model will be offered, which proposes that self-determination in health care is not a "public health movement" (O'Neil, 1988: 48), but rather a political process which relies on this discourse to achieve its own ends. Theoretical and methodological approaches will be reviewed.

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[4]The word Inuit, a self-referent, is here used to signify the Inuit people of Nouveau-Québec, although the term itself is often used to refer to all Arctic populations in Greenland, Alaska and northern Canada. The indigenous word is the plural form of the singular word Inuk, and dual form Inuuk, and means "les êtres humains" (the human beings). In recent years, another self-referent, *inutuinnait* (real human beings) has appeared, apparently in recognition that Indians and *qallunaat* shared with Inuit their human quality! While Inuk/Inuuk/Inuit are never used in Inuktitut as adjectives, this form being non-existent (Dorais, 1984), it has become customary to use it as such in English and in French, a practice adopted in this text. The work Inuit is the plural possessive form.

The question of self-determination in health care in Northern Québec is of particular interest for a medical anthropological analysis, because both sides of the debate use a common vocabulary in the construction of their arguments: the language of public or community health[5]. On one side, native leaders use the language of public health to formulate what might otherwise appear as dissent from and rejection of medical services, or a simple quest for greater power. The reformulation of criticism in public health terms allows for increased credibility, giving statements a meaning divorced from political agendas, and imbuing them with an aura of rightfulness typical of prevention-oriented health care. On the other side, government representatives and practitioners use the public health discourse as a way to shift responsibility for health and to a certain extent, health care delivery, onto the shoulders of individuals and communities. Here, communities' criticisms of the services are coopted and reformulated in public health terms to give an impression of convergence of efforts, giving legitimacy to the planners[6]. This integration of a political discourse within the boundaries of the public health discourse also has the advantage of side stepping the larger question of the role of western health care as an instrument of a continued colonial endeavour.

Chapter 2 will provide a synopsis of biomedical paradigmatic changes which play into the production of the community health discourse in Nunavik. Since the sixties, the World Health Organization has been active in creating models of health care delivery, community participation and health status improvements imbedded in a rhetoric of humanitarianism and human rights. National and provincial models of health care delivery have been greatly inspired by WHO. Chapter 3 will focus on the historical development of health care services in Nunavik. In Québec, the 1970s' systematic secularization and rationalization of the health care system gave rise to the most comprehensive model in this country. Community participation was to be a component of

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[5]Public health and community health will be used interchangeably in the text. Although a definition of these terms should be provided for clarity, the use of these concepts in political medical debates is so lax, that any attempt at a definition would be misguided. A discussion of the uses of the terms in these debates is provided in Chapter 1.

[6]And incidentally, leaving the dispensary and the hospital to carry the burden of all criticisms.

this model, mainly in the formation of boards of administration. The James Bay and Northern Québec Agreement, was to entrench this model in the north. These processes are crucial to an understanding of the agendas at play in the production of the community health discourse in the north, as well as the play of agendas in the manipulation of this discourse.

Chapter 4 will provide an overview of the manner in which the community health discourse is produced and utilized to satisfy divergent interests in Nunavik. The community health model offers avenues on which Inuit capitalise in their pursuit of greater control over health care. The focus of para-professionalism has allowed the entry of Inuit into a structure which was mostly impervious to Inuit involvement. De-professionalization has led a greater number of Inuit to access higher levels of decision-making. While some claim that the content of the structure is now slowly being "decolonized", the community health model has also favoured the recolonization of Inuit knowledge. The production and use of the community health discourse in Nunavik has given rise to two processes. On the one hand, Inuit can now access greater administrative control over health care. On the other hand, the alleged Inuit ownership over health care provides a mechanism through which certain aspects of Inuit know-how, such as midwifery, can be reconstructed through the biomedical model. Rather than being contradictory, these dual processes can be understood as complementary.

CHAPTER 1: CONTEXTUALIZING NUNAVIK HEALTH CARE

1.1 Self-determination, autonomy, "autochtonization", local control and "prise en charge": theoretical approaches in the politics of northern health care

Regardless of the actual terminology utilized, Inuit self-determination in health care seems to refer to at least three (not mutually exclusive) threads of thinking[7], located at different levels: the first utilises individual Inuit interactions with the health structure to sustain arguments *against* a transfer of control; the second focuses on difficulties in Inuit-practitioners' communications to justify the promotion of Inuit employment in health care; and the third looks at the interaction between Inuit society and the nation-state, qualified as colonial in nature, to justify its endorsement of a political transfer of health services to Inuit.

1.1.1 Paradigm 1: Inuit must learn to take care of themselves before they can be trusted with their health care services.

This first paradigm revolves around the concept of dependency:

> La dépendance est devenue l'une des caractéristiques du Nouveau-Québec actuel et le secteur de la santé n'y fait pas exception... La responsabilité de la santé n'appartient *plus* aux individus mais aux «spécialistes de la santé» que l'on viendra consulter au moindre bobo. Les méthodes traditionnelles pour faire face aux problèmes de santé ont été mises au rancart, ainsi que les initiatives personnelles....
>
> En raison du système de «colonialisme d'assistance» auquel ils ont été habitués, *les Inuit ne perçoivent pas la responsibilité qu'ils ont quant à leur santé et les améliorations qu'ils pourraient y apporter individuellement en modifiant leurs habitudes de vie et collectivement en améliorant leur environnement* (Labbé[8], 1981a: 73, my italics).

Thus it appears that dependency, an artifact of the colonial encounter of which bio-technical medicine was an integral part, is now responsible for (some of) the health problems encountered in the north. To palliate this dependency, health advocates, taking inspiration from community

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[7]Typifying complex arguments into analytical categories invariably involves oversimplifying. The exercise is nevertheless helpful in identifying underlying assumptions.

[8]Labbé has been linked to Nunavik health care since 1975, first as a paediatrician and since 1981, has served as an advisor to the Département de Santé Communautaire du Centre Hospitalier de l'Université Laval, responsible for "Projet Nord", which until recently coordinated community health programmes for Nunavik.

development, believe in fostering community participation. Communities are now expected to be able to define their own concept of health, as well as prioritize their needs and take their health care into their own hands. Gradually, control will be transferred as people learn to take responsibility for their own health. While rhetorically attractive, the means of action, and concepts of what constitute appropriate interventions have remained mostly in the hands of professionals. This is illustrated by the following paragraphs, taken from the Government of Québec's handbook for professionals interested in working in Nunavik:

> Dans son travail auprès de ces petites populations, le professionnel s'occupe autant de l'aspect préventif que curatif. Il favorise *la prise en charge* par les Inuit de leurs problèmes de santé en les aidant à les identifier et à y trouver des solutions...
>
> Il doit également toujours avoir à l'esprit la nécessité d'assurer une *relève locale*. Il profitera de ses contacts quotidiens avec eux pour leur donner de la formation. Il jouera ainsi pleinement le rôle *d'animateur, de formateur et de conseiller* inhérent à sa tâche (Québec, 1987: 18; my italics).

The use of "prise en charge", which conveys the imagery of control and autonomy, in conjunction with the promotion of the professional role as educators, are inherently contradictory, unless the aim is for Inuit to be able to identify their problems essentially in biomedical terms and to act on them accordingly: the new "approche communautaire" has not resolved the dilemma of populations defining (even partially) their health in non-biomedical terms. This approach leads people to be treated as if they were "empty vessels", the relevance of their beliefs, needs and expectations being excluded from the educational encounter.

It is not so much the paradigm itself which is of interest here, as the way it is used. Although this paradigm does not appear often in written works (Julien, 1987 being a rare example[9]), it remains part of the "popular medical discourse", brought forth by some practitioners and bureaucrats encountered in the field[10] as an objection against Inuit being given greater control over their health care: if individuals cannot take care of their own selves (by adopting healthy life-

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9 "Récemment, une volonté s'est exprimée pour reprendre contrôle de la santé à travers divers éléments significatifs: les femmes Inuit de la Baie d'Hudson ont manifesté leur désir de reprendre en main la périnatalité... De nombreuses personnes inuit [*sic*] ont participé à l'élaboration et à la mise en place du programme de contrôle de l'otite et de l'audition (Julien, 1987: 19).
Julien goes on to associate "la santé communautaire" with autonomy

10 O'Neil (1988: 80) makes a similar claim

styles), how could they manage their health care services? Alternatively, if Inuit have not yet internalized the basic precepts of "good health" as defined by biomedicine[11], how can they operate the services which hinge on these precepts?

1.1.2 Paradigm 2: Inuit do not understand the biomedical message offered by northern health services because it is culturally coded: by promoting the entry of Inuit into the health care structure, these messages can be decoded and recoded in culturally relevant terms, thus promoting autonomy and community "prise en charge".

A second and more prevalent paradigm in the literature opts for defending the need for Inuit to secure greater involvement in the delivery of health care, drawing either on the difficulties of effective cross-cultural communication, or more simply on the undefined rationale of protecting the northerners' "culture". Hence a number of authors stress the need for the structure to employ Inuit, this in the hope that the presence of indigenous staff will resolve problems of communication, professional obtuseness to local community dynamics and the popular medical system, and improve the cultural appropriateness of programmes (Crago, Hurteau & Ayukawa, 1990), as well as address problems of high staff turnover (Labbé, 1987a; Simard, 1988; Weller, 1981; Weller & Pranga, 1987). Expressed more succinctly:

> Training is the means to autonomy (Kativik Regional Council of Health and Social Services, 1990: 2).

Thus, the "gap" between two cultures, between their ability to communicate, is to blame for the lack of success and popularity of the health services. This gap curtails "l'accessibilité culturelle" (Dufour, 1990a). The concept of cultural accessibility entails an Inuitization not only in term of staffing, but also in terms of medical ideology and practice: an attempt at closing the gap

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[11] The choice of an appropriate terminology to depict "western" health care is problematic in this case. Biomedicine as a term recalls the technologically-oriented curative form of medicine so highly criticized by National and Provincial Ministries of Health, perhaps for economic reasons, and obscures the social surveillance mechanisms now inscribed in the Health Units (DSC and CLSC in Quebec). However, depictions of "northern western health care depending on the south" are even more problematic. For the purpose of this thesis, biomedicine and biomedical health care will be utilized as a comprehensive term in substitution for "western" health care.

existing between health care and the Inuit culture. Working on identifying the Inuit and biomedical construction of otitis media[12], Dufour argues that biomedical closure[13] to the Inuit popular medical system, its ignorance (rejection) of its relevance, actually contributes to the production and reproduction of otitis media (1989b; 1990b). To solve the problem of cultural accessibility, she proposes

> [de] cesser de travailler sur une population pour travailler avec elle, à lui reconnaître la compétence et la capacité de se prendre en charge par l'intégration du système médical populaire au système médical professionnel (1990a: 13).

In other words, the health services offered must be integrated into the fabric of the community and attuned to Inuit culture. Dufour does not operationalize her stance in terms of health care reform, beyond supporting the employment of Inuit within the (northern) structure (1989a; 1990a)[14]. However, it often appears as if the services are first to be elaborated, and then adapted through the inclusion of Inuit, thus the relevance of this questioning with regard to cultural accessibility. Accordingly, it is at the level of services that attention must be paid to "culture", not at the level of ideological and structural health care conceptions.

This argument tends to underplay the extent to which services are embedded in a coherent, albeit heterogeneous, whole in which the Inuit medical system has little or no place. This includes a structure which:

1. produces health services: the medical, nursing and health administration schools;
2. maintains health services: the hierarchical political structure of health care, starting from the Québec Ministry of Health and Canadian National Health and Welfare, but also including the professional corporations which define educational and professional standards; and

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[12]While generally a benign problem, otitis media is in the north a major health issue: its incidence among native nations is 15 times that of Caucasians. Inuit seem prone to developing chronic otitis media, leading to the loss of the tympan and/or hearing disability.

[13]i.e. the professionals' perception of their monopoly over what information is relevant or not, the spacial organization of the clinics, and so on, which contribute to the reproduction of hierarchic relations where communication is thwarted.

[14]Her model is illustrated as two interlocked circles: the first representing the southern practitioners, the second the Inuit population. In the interface of these circles are the Inuit health care givers (as trained by southerners), mediating between the two systems. This paradigm has the disadvantage of leaving Inuit health care workers in the role of a dual culture broker, while conceptualising both circles as isolated, indeed impermeable to exchange, but through these brokers (Dufour, 1989a).

3. reproduce health services: the health care workers, from the Minister to the lay person.

It is doubtful that the inclusion of Inuit within the structure, either as "para-medicals", nurses, doctors or even as Minister of Health, would lead to a significant sharing between the biomedical system as implemented in the north and the popular Inuit medical system. It appears overly optimistic to expect Inuit operating within the biomedical system, and having been socialized by this system, to be able to balance and articulate two distinct medical ideologies, often hinging on contradictory precepts, and deliver coherent services which will nonetheless retain medical and cultural relevance for both parties. A second assumption is that the biomedical culture merely "packages" underlying universal truths. These truths, it is further assumed, can be stripped of their biomedical cultural packaging and repackaged with Inuit culture. This paradigm neglects that biomedical concepts are first and foremost cultural constructions (Hahn & Gaines, 1985; Lock & Gordon, 1988). Another assumption, which is even more problematic, is the belief that socially significant roles can be created by foreign institutions in isolation from community processes.

1.1.3 Paradigm 3: Northern health care services are a subset of the colonial system, which is why they fail in their endeavour. Effective health care will happen only when these services become decolonized, i.e. community oriented.

A third paradigm situates northern health services as an extension of the colonial system. For example, O'Neil (1986a) talks about northern health care reflecting an internal colonial political economy, where the structural development of health services is an outgrowth of the dominant society, and remains outside the realm of community control, isolated from issues of community development.

> Self-determination in Native health care is *a public health movement* of historic proportions and the effective delivery of the full range of preventive, curative and educational health services in the North will not progress until the transfer is complete (O'Neil, 1988: 48, emphasis added).

The message is clear: the problems identified with northern health services will not be resolved until health care is politically decolonized. Interestingly, decolonization is defined as a public health movement.

Broader in scope and compelling, this paradigm falls short of ideal by its lack of specificity. While its ideological message is clear, its pragmatic application is problematic Indeed, how much control is control? Given the actual political health care structure, how much change must it undergo in order for Inuit to be able to negotiate and/or create locally meaningful health care services[15]? The political economy thesis[16] tends to downplay local events and subordinate them to macro-processes. Local dynamics are glossed over in favour of national trends. The approach tends to collapse levels of analysis which would be better left distinct. In fact, the discourse of public health and arguments revolving around dependency are generated at three levels of analysis, and by different actors, to signify different processes These levels are:

1. the international and national levels which focus on mega trends in medical ideology, the relationship between Inuit society and the Canadian and Québec societies;

2. the provincial-regional level which includes local politics and institutional debates generated in the communities; and

3. the community level which affects families and individuals.

Each level offers a multiplicity of perspectives, which shape, albeit with different weight, the discourse of public health and arguments revolving around this discourse. Whereas the first level has been successfully analyzed through a political economy of health thesis (O'Neil, 1986a), this thesis misinforms other levels of analysis: the political economy of health thesis neglects "the periphery" it aims to explain. At the meso- and micro-social levels, current paradigms in biomedical wisdom play an important role, and an unexpected one: here the discourse is shared,

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[15]O'Neil (1990) offers a case study of the impact of devolution on health services in the Baffin Region, in which he reviews at length the structural changes that followed the transfer of health services from the federal to the territorial government. He concludes that this transfer had limited success in the pursuit of better community representation in health care issue, taking again the yardstick of community health as the basis of his assessment

[16]Morgan defines the political economy of health thesis as a "macroanalytic, critical and historical perspective for analysing disease distribution and health services under a variety of economic systems, with particular emphasis on the effects of a stratified social, political, and economic relations within the world economic system" (1987: 132).

both sides using public health to formulate arguments, to seek political and pragmatic support, and to compete for continuity on the one hand, and autonomy on the other.

The analysis presented above raises a number of questions. First, is the community health paradigm really conducive to true autonomy, or rather is it a new maneuver to capitalise on the popular discourse of resistance by reintegrating it into a larger and institutionalized medical discourse? Second, what is the place of culture in northern health services? Must it provide a politico-culturally adapted structure which would then shape health care delivery? Must it be a component of health care delivery, a merging of two (or more) explanatory models? Or is the role of culture dynamic and in flux, depending on the political context, and a cultural group's relationship with the dominant society? Third, what is control and what is the relationship between control, healing and health? And fourth, what is the role of northern health services? Must it be defined strictly in terms of efficacy in improving Inuit health status, or can it be redefined as serving other purposes which would include meanings beyond a biomedical concept of health?

1.1.4 The Roots of Dependency

The concept of dependency, which informs arguments in favour of or against self-determination in health care, is deeply rooted in a particular view of the history of northern health care development. Summarized, this view postulates that Inuit contact with western culture disrupted Inuit society. This claim is sometimes contextualized with mentions of the Depression, the two World Wars and the devastating measles, smallpox and tuberculosis epidemics of the 1940s and 1950s. The depressed Canadian economy, and the disintegration of the northern fur market led to hunger[17]. A posited genetic vulnerability to infectious diseases, compounded by hunger, is believed to have further challenged Inuit society, disabling or killing entire families. Theorists further postulate that this disruption left Inuit society vulnerable to be infiltrated by foreign institutions such as biomedicine, fostering an ever-increasing dependency on the south.

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[17]By the turn of the century, Inuit already relied a great deal on such goods as guns and bullets for hunting. This reliance on goods purchased at Hudson's Bay Company outlets requires a reliable income, which until the Great Depression was sustained by the fur trade

An assumption is that southern institutions *replaced* Inuit knowledge: the development of northern health care apparently led to or followed a devolution of medico-religious Inuit practices. As concepts, notions of "disruption" and "dependency" can inform, but also misinform analyses, and as such, deserve close attention.

Scholars and medical practitioners, at least in their writings, have tended to trivialise Inuit medical culture. "Traditional" medicine, according to a number of authors, is something of the past[18] (Bérubé *et al*, 1971; Dufour, M.-J., 1983; Labbé, 1981a; Sampath, 1988, Tremblay, F., 1979). Whenever provided, rationales for Inuit medicine's disappearance are constructed around the power of biomedicine in dealing with the great epidemics in the 1940s and 1950s, the transformation of Inuit society, and the confrontation with Christianity and scientific medicine (Labbé, 1981a). Sampath (1988) suggests that it is the nature of Inuit medicine, the power of the shaman hinging on fear, which pushed Inuit towards western institutions such as Christianity and medicine, leading to a separation of medical and religious beliefs. The underlying assumption is that Inuit medicine was a weak (primitive) and/or non-desirable form of knowledge in the face of biomedicine:

> Avant le début de ce siècle, *les Inuit ne devaient compter que sur leur propre ethnomédecine* pour leurs soins de santé. Toutefois, ils *bénéficiaient à l'occasion des connaissances en premiers soins* des étrangers de passage sur leur territoire: missionnaires, policiers, commerçants ou marins (Labbé, 1981b: 61-2).

The tone is clear: the unfortunate Inuit only had themselves to rely upon, until the arrival of outsiders with First Aid kits.

More often however, authors stage a textual disappearance for Inuit medicine: it serves as a chronological introduction to the development of (federal, western, biomedical) health services in the north, never to be mentioned again (as in Dufour, M.-J. 1983; Labbé, 1981a & b, 1987a; and many others). This cultural lip-service is perhaps most revealing of the perceived lack of importance given to Inuit medicine, illustrating that: first, authors writing on northern health issues remain largely ignorant of how popular medical knowledge is deeply rooted in culture. This

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[18]Significant departures from this pattern are Blake (1978: concerned with northern Labrador), Dufour (R., 1989b: concerned specifically with Nouveau-Québec Inuit), O'Neil (1988: Keewatin district of the NWT) and Wenzel (1981: Canadian Inuit in general), who consider the Inuit society medically pluralistic

ignorance contributes to the maintenance of this dichotomy; and/or second, this oversight serves rhetorically to enhance discussions of dependence which are perpetuated, and may indeed be used to validate the continuation of "parentalistic"[19] attitudes (see Labbé, 1981a, cited above).

Whenever discussed, authors focus on what *remains* of Inuit medicine, which is usually assumed to be little: shamanism's disappearance is quickly and regretfully pointed out. As biomedicine moved in, Inuit medical beliefs are assumed to have phased out. The assumption of a substitution is a product of the western premium placed on empirical medicine, rather than a socio-meta-physical concept[20]. Health is something to be documented and measured, protected through bodily and social discipline. Health is presumed challenged by individual and social behaviours, but not through meta-physical occurrences like spirits. The possibility of a co-existence of biomedical and Inuit medical concepts is rarely mentioned. Theorists also tend to construct Inuit medicine as static: any change means fading. The virtual silence regarding the process by which this substitution would have occurred, an "omission" which conveys the impression that Inuit were just "waiting for civilized medicine to come to them", is also revealing. A sensitive historical review of Inuit medicine, focusing on ***what was and how it became what it is***, remains to be done[21]. Further, no society is uniform in its conceptualizations of health and illness: such concepts are dynamic and redefined with time, according to events and the availability of new information, and so on (Lock & Gordon, 1988). In Inuit society, conceptualization of health and illness are likely to vary generationally, based on personal experiences of epidemics, of contact with southern health care as tuberculosis patients, or as para-medical practitioners, etc.

Rather than the biomedical system being a straightforward successor to traditional medicine, I believe that, from a consumer's perspective, both approaches are viable, intertwined and in constant flux. Indeed Dufour (R., 1987) proposes that Inuit society superimposes at least

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[19]"Parentalistic" is a term I substitute for the term "paternalistic", which in my view is outdated. Gender roles have changed: "paternalistic" no longer conveys the image sought, but rather perpetuates a particular view of family dynamics which no longer holds

[20]The focus is on the techniques of healing and the prevalence of specialists, rather than on a belief system.

[21]Blake (1978) and Vanast (1991b, 1992a & b) are showing leadership in that direction.

two cognitive models. Others propose a parallelism (Wenzel, 1981). Yet the problem is more complex, since it entails a dynamic exchange between (initially) two or more[22] cognitive systems.

1.1.5 Reflections and Orientations

In summary, a great deal of attention has been placed on questioning the relevance and legitimacy of health care services in the north. These reflections, however, appear to draw on the current reorientation of biomedical health concepts and health care approaches, rather than on an Inuit questioning of the dominant health care ideology and structure: the uncritical use of public health concepts in discussions of Inuit self-determination is problematic. More attention has been paid to the exploitative aspect of biomedical health care than to the way in which biomedical precepts may have become integrated into the popular Inuit medical system. Likewise, the way in which health services might play alternative roles in the communities has received no attention.

A second problem revolves around the question of dependency, which frames Inuit as empty vessels, as acted upon rather than actors. Little attention has been paid to the popular Inuit medical culture, beyond perhaps a note in passing regarding the death of shamanism. Yet, it is known that Inuit society is medically pluralistic, medical systems being conceived as superimposed (Dufour, R., 1989b), parallel (Wenzel, 1981) or syncretic (O'Neil, 1988). Pluralism in the north is, however, rarely explored.

What remains to be clarified is the way in which public health concepts have become imbedded in the discourse on self-determination in health care in the north. It is highly significant that Inuit political leaders encountered in the field are also making use of the public health discourse to convey their messages. Is this an example of acculturation, or an example of effective marketing?

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[22]It is rarely acknowledged that western medical practitioners bring north their own popular medical beliefs, intertwined with their medical science. Since this group is essentially culturally heterogenous (French, Filipino, English, Inuit, East African and Indian practitioners were encountered in the field), there are grounds to believe that a number of cognitive models are at play in the north.

1.2 Theoretical Framework

It is a postulate of this thesis that the association between the public health discourse and Inuit self-determination in health care has followed two trends. First, the biomedical institution has been eager to interpret native political movements in terms that are apparently meaningful to its own continuation, and in doing so coopts what could be taken for dissent in the face of a foreign institution, and shapes it in medically relevant terms such as community responsibility, community health and community driven health program. A second trend is the Inuit leaders' use of the public health discourse to voice dissent in terms that are significant to the governmental and biomedical institutions, that are marketable, that can be funded and that will produce at least in part the effect sought: the securing of greater control and autonomy.

In his *"Two Lectures"* (1976), Foucault suggests that beginning in the nineteen-sixties, "totalitarian theories" become increasingly challenged through the "insurrection of subjugated knowledge". By "subjugated knowledge", he means,

> 1. the blocs of historical knowledge which were present but disguised within the body of functionalist and systematising theory and which criticism... has been able to reveal (1976: 81-82); and
>
> 2. a whole set of knowledges that have been disqualified as inadequate to their task or insufficiently elaborated: naive knowledges, located low down on the hierarchy, beneath the required level of cognition or scientificity... A differential knowledge incapable of unanimity and which owes its force only to the harshness with which it is opposed by everything surrounding it (1976: 82).

This subjugated knowledge acts essentially as a local form of criticism, "an autonomous, non-centralised kind of theoretical production... whose validity is not dependent on the approval of the established régimes of thought" (1976: 81). This resurgence of popular knowledge, however, opens the possibility of a re-codification or re-colonialization of this knowledge. Conversely, Comaroff & Comaroff (1989) understand southern Tswana's experience with colonialism as "the colonization of their consciousness and their consciousness of colonization", the former leading to the incorporation of western concepts within the Tswana life-world, the latter giving rise to conflicts and movements of resistance (1989: 268).

From this perspective, the political mobilisation inherent in the negotiation process leading to the signature of the James Bay and Northern Québec Agreement, and the developments which followed it, provided Inuit with a stepping stone from which to start reclaiming northern biomedical institutions. This can perhaps be best represented as the beginning of the decolonization of the Inuit self[23]. Indeed this political mobilisation gave rise to the formalization and reintegration of local knowledge, some of which, in effect, is being recolonized by the medical and perhaps other institutions[24]. But it also provided the opportunity for one dissident community (not a signatory of the JBNQA) to reclaim a western institution, the hospital, in the pursuit of its own political aspirations. In this context then, the decolonization of the Inuit self, is the process by which Inuit start representing north-based western and/or westernized institutions (i.e. the hospital and the commercialization of subsistence activities) as an extension of Inuit society, imbedded in and central to a contemporary northern community dynamics.

Thus, it is postulated that the development of Nunavik northern health care services since the JBNQA gave rise to two processes:

- The decolonization of the Inuit self, whereby the elaboration of certain structures and programmes following the signature of the JBNQA provides Inuit with mechanisms by which they feel they can recover elements of their culture, taken away because of colonialism.
- The recolonization of local knowledge, whereby perceived traditional forms of knowledge and practices are integrated into and redefined by the health care structure.

The two processes are not contradictory, but complementary. It appears that, given the current political climate, and the relationship between the Government of Québec and its northern medical institutions, the decolonization of medical knowledge must be prefaced by a decolonization of the institution, in terms of human resources: Inuit employment in the Nunavik health care structure

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[23]The use of the "Inuit self" as a concept is problematic, and leads to speculations as to whether there is a true Inuit self or whether the Inuit self is solely the product of the socio-cultural environment. This kind of philosophical gymnastic lies beyond the scope of this thesis. For the purpose of this thesis, however, *the decolonization of the Inuit self* will be defined as the process by which an Inuk becomes consciously aware of colonialism and its influence of Inuit culture, and where action is taken to either benefit from or curtail colonial influence

[24]The creation of the Hunters Support Program, through which hunters can now be remunerated for the harvesting of country meat, can perhaps also be framed as an example of the dual processes of decolonization of the self and the recolonization of knowledge

has yet to allow for a reconceptualization of that structure, and of the forms of knowledge on which it hinges. The decolonization of knowledge then must be preceded by a recolonization of the knowledge in question, to satisfy current provincial employment requirements[25].

The above framework allows an examination of the relationship between "tradition", "culture" and the community/public health discourse. The community/public health discourse is the mechanism by which Inuit attempt to decolonize medical structures, and the mechanism by which practitioners realize a recolonization of Inuit knowledge[26]. Again, both processes are symbiotic, depending on one another for their own legitimacy.

This approach is set in a larger framework which situates northern health services in their national/international context. The invasion of the northern frontier by the Hudson's Bay Company, missionaries and the RCMP marked the beginning of Inuit subjugation to the southern gaze[27]. This, however, was to be of limited significance until after the Second World War, which saw a new federal interest in the protection of its northward frontier, as well as the proliferation of social safety nets across the country translating into an interest for the well-being of the northern populations. Epidemics raging in the north provided an incentive for extending northward the medical services being developed in the south. The sixties' secularization of health care in Québec provided the state with a privileged rationale and mechanism for its nationalistic northern expansion, through a process similar to that described by Armstrong for Great Britain (1983).

For Québec, the vehicle for secularizing health care was the creation of a "comprehensive" multi-level health care system, with each level focusing on a compartmentalized aspect of the

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[25] I am here paraphrasing an Inuit informant; this perspective will be developed in more details in Chapter 4.

[26] A number of informants in the field mentioned that certain recent developments in Nunavik health care appear to them as attempts to give back the "culture" driven underground by the colonial process. This line of thinking however, was often followed by discussions of the many hoops Inuit now have to jump through in order to have access to these opportunities. The Povungnituk maternity and the para-medical roles, both mentioned in such conversations, will be discussed in details in Chapters 3 and 4.

[27] The concept of the gaze is borrowed from Foucault (1979) and Armstrong (1983), and will be expanded upon in Chapter 2. The Panopticon, and its gaze, represents "a creative arrangement of power which fabricated an individual body - that very body which was to be the point on which repression could be exercised and not which ideologies could be inscribed, but, nonetheless, a body which had no exercise prior to its crystallisation in the space created by the monitoring gaze" (Armstrong, 1983: 5). In the context of this thesis, the Panopticon refers to the colonial power and its institutions, and the gaze to the mechanisms by which Inuit were made visible to this colonial power.

human experience. Each level was linked for information sharing. Thus the hospital no longer dealt with bodies divorced from their social context. Rather, practitioners could access information from the health unit, the Centre Local des Services Communautaires (CLSC), who observed human beings in their social context, reached out for "at-risk" pockets of population, screened for ailments and referred clients to the hospital. The information now accessible was integrated into a network of information designed to further medical understanding of ill health, to be utilized in health care planning[28].

Medical surveillance was to be added to judicial and religious counterparts, resulting in new standards of conduct expected of Inuit. The pervasiveness of the medical gaze, however, with its access to personal information, its interest in research, and documentation tremendously increased Inuit "visibility". Inuit became visible in the north as well as in the south, through the medical migrations for care of TB, birthing, and every medical intervention but the most benign. Inuit came to be perceived by the state sponsored health care system[29] as inherently "at risk" simply by virtue of *being* Inuit, in need of protection from themselves. The nursing station's role in surveillance became very important, in documenting and attempting to thwart "at risk behaviours" This process recalls Armstrong's analysis of the disciplining of the body in twentieth century England (1983). Foucault describes "political anatomy" as the process by which the medical gaze moved from the body to the space between bodies as a focus of study around the turn of the century. Likewise, northern health practitioners are profoundly interested in the configuration of Inuit social relations, as well as in their personal behaviours towards the body, that is, hygiene, and behaviours related to biomedical concepts of health and illness. The underlying rationale which stages the relationship between the northern health care institution and its Inuit "clients" has its roots in international biomedical ideology, itself often informed by WHO's expansionism, as well as Québec's health care secularisation and rationalisation.

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[28]See Renaud (1980) for a critical analysis of the health care reform in Quebec.

1.3 Methodology

This research is based on primary and secondary resources. Primary resources include non-structured interviews conducted in the field, from April 3 to May 30, 1991. Interviews were conducted with ninety-four interviewees, distributed as follow: (1) sixteen (17 percent) health policy makers in Québec City and Nunavik; (2) twelve (13 percent) health professionals practising in Nunavik; (3) twenty-six (28 percent) Inuit para-professionals and para-professionals-to-be; and (4) forty (43 percent) Inuit, including elders, students, health committee members and other persons interested in discussing this theme.

The themes discussed with policy makers and professionals included:

- what is self-determination in health care and how can it happen;
- what is the nature of the interactions between different levels of the Québec health care bureaucracy and how does this relate to self-determination; and
- how does community health articulate with self-determination.

With Inuit para-professionals, themes approached include:

- life histories and motivation to work in health care;
- experience in relation to Inuit medical culture, relation with southern practitioners; and
- the place of health care in the community.

With elders, life histories were collected, with a focus on traditional healing in relation to biomedical health care.

Secondary sources were consulted to identify links being drawn between self-determination and community health, as well as identifying what community health means at the implementation level. Since the James Bay Agreement, Nunavik health care has changed from a focus on the curative to the systematic integration of Inuit para-professionals: these particular programmes were reviewed to identify expectations in relation to concepts such as "autochtonization", "self-determination" and "la prise en charge".

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[29]as well as the Governmental Departments of Social Services, Renewable Resources, Economic Development, Justice, religious institutions...

CHAPTER 2: THE PRODUCTION OF THE COMMUNITY/PUBLIC HEALTH DISCOURSE

This Chapter focuses on the paradigms at work in the production and use of a public health discourse in Canada. Scenarios of the growth of health care in the North generally emphasize that biomedical hegemony overtook and indeed superseded traditional Inuit medicine. Analytical levels are collapsed to favour a chronological narrative recapitulating the colonial state's overpowering of Inuit society. Simply stated, Inuit "culture" is assumed to have retreated as western institutions, including biomedicine, increased in prevalence in the North: incremental structural and institutional developments are listed as evidence to sustain this argument. Paradigmatic changes in medical thinking, which might have informed the rationale for "medical development" in the North, are ignored as if irrelevant. Inuit traditional institutions are typically represented as static, monolithic and in a process of devolution rather than change, thus the claims of Inuit dependence and powerlessness. Agendas at work in the development of northern health care services are usually overlooked or glossed over.

2.1 From Oblivion to Visibility

In fact, one requirement had to be fulfilled in order for biomedical services to take the configurations they did, at the time they did: Inuit had first to become visible to the western world. The fact that Inuit were virtually ignored by first the British and second, the Canadian governments for two hundred years is significant. This situation was to change shortly after the Second World War.

> Apparently we have administered these vast territories of the North in an almost continuing state of absence of mind (Prime Minister St-Laurent, 1953, cited in Rea, 1968: 47).

This comment was made in the House of Commons, shortly after the Department of Resources and Development was re-named the Department of Northern Affairs and National Resources, an event which marks a change in northern administration and development.

Although Inuit became visible nationally early in the century, this visibility became much more significant after the Second World War, for two reasons. First, Canada's concern for asserting northern sovereignty, as well as interests in the natural resources of a newly "discovered" north, led to increased activities in that region. A second process relates to Quebec's nationalistic endeavour, pushing the provincial government to compete with the federal government for the resource-rich north. Increased activities from both the federal and provincial governments made Inuit life more visible nationally. Conversely, issues of sovereignty also made the state, in its federal and provincial forms, much more visible to Inuit. This aspect will be explored further in Chapter 3.

Medical visibility, on the other hand, was achieved through (or perhaps because of) changes in medical paradigms that led to the visualization of disease causation, the primacy of social measures promoting self control, and a renewed and focused faith in prevention. Medical surveillance, through the survey, became the primary tool of this visualization process indirectly providing fertile ground and privileged arguments for the colonial endeavour. The biomedical institution thus provided another level of visibility: much more intrusive, yet imbedded in humanitarian arguments.

2.1.1 Foucault, Armstrong and the Expansion of the Gaze

The current discourse on public health is deeply rooted in paradigms that developed in the course of this century. These paradigms, which affect explanations of the causes of mortality and morbidity, are articulations of political ideologies, reflecting western assumptions about "the nature of society, the existence of free will and the requirements of justice" (Kunitz, 1987: 402). Changing biomedical paradigms imply changing relationships between medical knowledge and professionalism, between patients and practitioners, between the state and its medical institution, and between the rights of the majority and the responsibilities of individuals. The source of these changes cannot simply be attributed to a "new medical discovery," but is inscribed in the changing relationship between the state and its constituents.

Through the notion of "political anatomy," Foucault suggests that the way the body is perceived and described by the end of the eighteenth century, is informed by certain mechanisms of power, the disciplines, which aim at improving the performance of individuals

> The historical moment of the disciplines was the moment when an art of the body was born, which was directed not only at the growth of its skills, nor at the intensification of its subjection, but at the formation of a relation that in the mechanism itself makes it more obedient as it becomes more useful, and conversely. What was then being formed was a policy of coercions that act upon the body, a calculated manipulation of its elements, its gestures, its behaviour. The human body was entering a machinery of power that explores it, breaks it down and rearranges it. A "political anatomy", which was also a "mechanics of power", was being born... (Foucault, 1979, 137-138).

Foucault demonstrates that ethics of punishment in eighteenth to nineteenth century France relaxed, changing from an emphasis on torture and death, to rationalized forms of punishment aiming at individualizing and disciplining criminals. This change is brought about by the need to rationalize relationships of power: the focus changes from punishing the body of the criminal, to evaluating the persona of the criminal and selecting disciplinary measures to hopefully reform. Context is added to crime in the judgment: it is no longer solely the criminal act which is being judged, but an action belonging to a social context in which the criminal operates as an actor. Judgment implies that both the persona and the context of the criminal must become visible to the judging process (Foucault, 1979).

In his book *The Political Anatomy of the Body*, Armstrong (1983) develops the notion of "political anatomy" to analyse the impact of paradigmatic changes in biomedicine. By the twentieth century, it is the space existing between bodies, i.e. social relations and interactions, which constitutes the focus of the medical gaze. A mechanism for extending the gaze is created to enable the state to measure, assess and document this space:

> The deployment of the new technology of the survey in the post-war medical world resulted in the crystallisation of new patterns of medical specialisation. Whereas, previously, medical specialisation had been structured around the examination, description and analysis of the body of the patient, the new specialties were deployed in the space between the people (Armstrong, 1983: 101).

Multiple factors are interconnected in the creation of this extended gaze. The germ theory led to a rethinking of the locus of disease entities, which were no longer to be found only *in* the body but

between bodies as well. The quest to control and eradicate infectious diseases was also the quest to regulate social relations and interactions.

The survey provided the ideal instrument for the objectification of social problems, thus creating a new order of reality which could be documented, analysed, and attended to[30]. Armstrong suggests that the survey not only allowed for the documentation of a spectrum of human experiences of health and illness, thus locating health and illness in a continuum rather than understanding them as a dichotomy, it also allowed for the visual juxtaposition of bodies: the new medical gaze would no longer use the "norm" as the yardstick, but rather "place the body of the patient in the context of 'other subjects' and then measure the differences" (1983: 44). A new social context is created through this mechanism, in which quantifiable social variables collected through the survey could be linked to potential pathologies through the use of statistics. While the formulation of the germ theory had the temporary effect of streamlining issues of causality to a focus on viruses and bacteria (Kunitz, 1987), the post-war extended gaze expands its reach to factors "causally implicated": certain individual and social behaviours become construed as "risk factors" (Kunitz, 1987: 386).

Compliance becomes an issue: integrated into its newly documented social context, the patient is no longer just an object to be acted upon in the isolation of the hospital, but also an actor who may chose to ignore medical recommendations. An interest develops around the doctor-patient relationship in relation to patient compliance with medical treatment. In the post-war years, the patient's personality was becoming a factor in medical discourse, as a potential obstacle to obtaining reliable histories, compliance, and as a factor to be considered in doctor-patient relationships. The patient passes from being construed as object to the status of subject (Armstrong, 1983).

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[30]Contrary to Foucault, Armstrong is more explicit as to the source of this paradigmatic change, which he locates mostly <u>within</u> biomedical ideology. Perhaps this outlook could be expanded to include, as Foucault does, "a multiplicity of often minor processes, of different origin and scattered location, which overlap, repeat, or imitate one another, support one another, distinguish themselves from one another according to their domain of application, converge and gradually produce the blueprint of a general method" (1979: 138).

In summary, changes in medical paradigms contributed to the need for extending clinical surveillance from the diseased body to the space between bodies, to the power relationships enveloping the social context of bodies. The "community" as a concept had also undergone some revision, from a mass targeted by state-driven coercions, to a mass of isolated, individualized beings in a permanent state of juxtaposition with one another.

2.1.2 On Community Participation

Community participation now plays a major role in the international discourse on public health. The change, however, is recent and linked to some of the paradigmatic changes explored above. Until the 1970s, the World Health Organization's public health policies were informed by what could be qualified as a clone of the so called "trickle down effect". This led to policies focusing on improving the health of urban populations, through relying on technologically-oriented sophisticated health care -- the focus being on the curative rather than the preventive, resulting in few being reached.

In May 1973, the World Health Organization's 26th Assembly in Geneva drew attention to the cost and ineffectiveness of on-going health care intervention, leading WHO/UNICEF to recommend a new strategy, based on Primary Health Care, which entailed:

> providing the populations with easily accessible health services that are simple and effective as regards cost, techniques and organization (Berthet, 1979: 34).

Community participation constitutes the very core of the Primary Health Care concept.

The link between community participation and better health is somewhat ambiguous. Morgan (1990) argues that this component became a pillar of the new strategy because it satisfied political-ideological needs, informed by "bourgeois principles of self-reliance and individual responsibility" (Morgan, 1990: 212). It presumes democracy, while allowing governments to reach out and extend their control over their rural country side.

> The rhetoric of participation can be a convenient way for a government to perpetuate the illusion of democracy, while large segments of the population are systematically denied access to the political process. This is not to say that government elites conspire to deceive their constituents, but the competing agendas of different social classes often result in policies that enhance elites' control (Morgan, 1990: 212).

Segall (1985) comments that

> in official mythologies of community participation, communities are portrayed as harmonious homogeneous entities, existing in an unproblematic relationship with governments and even sometimes with the wider economy (1985: 33).

He further notes that community participation often becomes a process of rubber stamping governmental predetermined plans. Local participants are subordinated to outsiders' perspective, because of their limited formal education, low literacy, political and economical vulnerability, and the devalued status of local knowledge. No criterion exists in the World Health Organization's literature which would define what "community participation" actually means. It is however an integral part of the discourse on public health.

2.1.3 Kunitz and the Discourse on Community Health

The expansion of the gaze into the community provided fertile ground for an important debate in public health. This debate occurs between two schools of thought, one attributing more importance to lifestyle factors in morbidity, and the other focusing on socioeconomic factors. Following Kunitz, the former will be termed the "voluntarists", and the latter "determinists" (Kunitz, 1987). From the voluntarist perspective, will and moral responsibility are believed to form the core of a human survival potential -- human beings are not inherently victims. Behavioural changes are considered to be the route to improved health (McKeown, 1976). This perspective conveniently, although perhaps indirectly, satisfies the need to curtail health care and other costs by locating responsibilities with individuals and avoid the unlikely aim of undertaking the major significant reforms the determinists prescribe. In all fairness, "sufficient and satisfactory" health care services are believed to be an essential pre-condition.

From the determinist's perspective, economics, capitalism, urbanization, the centralization of power, "society", alienation, military expansion, industrialisation, colonialism, cultural repression, and so on, are portrayed as the predominant causes of ill health. Pathological behaviours: smoking, drinking, self-destructive behaviours, potentially perceived by the

voluntarists to be the causes, are instead believed to be mere results. They are the coping mechanisms of the economically, politically and/or culturally oppressed.

> The sources of distress that presently affect many of the world's acculturating, migrating, urbanizing or modernizing populations have less to do with change per se and more to do with the political and economic structures which constrain individual and community attempts to construct meaningful and rewarding social environments (O'Neil, 1986b: 250).

The World Health Organization's endorsement of community participation in health care planning and delivery adds another dimension to this debate. From the voluntarist perspective, individuals must recognize that they have a role to play in improving the health of the nation, either in changing their own pathological behaviours or in pressuring others to do so. Non-smoking and drinking and driving campaigns are cases in point. From the determinist perspective, community participation implies the mobilisation of interest groups or communities, in the face of domination. It is essentially a collective process of self-advocacy.

2.2 Reflections and Conclusions: The Discourse on Public Health and Canadian First Nations

In recent years, the concept of community participation has gain tremendous support in Canada, especially for ethnic minorities and "special interest groups". "Community empowerment" has followed in stride. The discourse of Primary Health Care has become enriched with such ambiguous phrases as "community empowerment through community participation". In their synopsis article entitled "*Community Empowerment: The Base for Primary Health Care*", Eng, Salmon & Mullan state:

> community empowerment and, through it, development of community competence are necessary conditions for the health of community members (1992: 7).

They go on to refer to health professionals as "midwives" to the process of community empowerment (1992: 11).

Canadian governmental health policies and programmes are often marketed and evaluated on their ability to stimulate and/or support community-based approaches and stimulate "community

development[31]" (Canada, Department of National Health & Welfare, 1988; Nicholson, 1988; O'Neil, 1990). Yet, it is the voluntarist campaign which has received the most attention at the national level.

> Future improvements in the level of health of Canadians lie mainly in improving the environment, moderating self-imposed risks and adding to our knowledge of human biology (Lalonde, 1974: 18).

In this climate of self-surveillance, individual behavioural changes became the main focus, with *ParticipAction*[32], no smoking, no drinking and driving, good nutrition and safer sex campaigns.

In the case of First Nations, however, the determinist perspective has been favoured, drawing on the colonial experience, economic dependency, anomie, cultural alienation, etc. to explain aboriginal experiences of ill health. The disparities existing between aboriginal people and Euro-Canadians have added credibility to this stance. As expected, the solution proposed has been that of a transfer of control over factors believed to be health determinants: land claim settlements, self-government and self-determination in health care:

> More quantities of health services as they presently exist are unlikely to produce a significant improvement in Indian health status. Only a major effort by Indians themselves in attacking social injustice, economic exploitation, and political emasculation can ultimately fulfill the goal of the highest attainable standard of health for the Indian people of Canada (Young, 1984: 263).

In addition to the adoption of the deterministic perspective, aboriginal communities seem to have locked onto the idea of community participation, in an attempt to regain a certain control over western institutions operating in their midst. The Four Worlds Development Project writes:

> The role of government and other agencies must be one of helping, serving, suggesting, supporting, and advising. It must never take over, or be seen to take over, the local process of development. This is because in so far as developing people lose control of their own development process, that process ceases to be development and becomes something else, such as manipulation, exploitation, or patronization (1985a: 15).

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[31]Community development is a catchy phrase which desperately needs some definition. Since it is beyond the scope of this thesis to engage in a discussion of the use and misuse of "community development", I will resolve to use the term in quotation marks

[32]*ParticipAction* is the name of a National Health & Welfare fitness programme which evolved from the Lalonde Report recommendations (1974), and which has used the media extensively in an attempt to promote physical activity

Claims of successful health care programmes have generally been attributed to their being community-based and community-controlled. Literature from the Four Worlds Development Project (1985a & b), as well as the writing of Delisle (1988) and Macaulay (1988) on health care in Kahnawake are examples of a genre in aboriginal literature that broadcasts "successful programmes" promoting local involvement/employment, favouring local values and hinging on local control. The proclaimed success of these programmes appears to revolve around community acceptance, rather than disease eradication, longer life expectancy or the improvement the health status of the community.

In summary, changes in paradigms of disease causation had tremendous impacts on the relationship between medical knowledge and professionalism, between patient and practitioner, between the state and its medical institution, and between the rights of the majority and the responsibilities of individuals. The linkage between "community development" and health has provided fertile ground for arguments favouring aboriginal self-determination and community involvement. Through this process, the "subjugated knowledge" of aboriginal societies has found a channel of expression and legitimization. This may be seen as the beginning of a process of decolonization. However, it has also provide an opportunity for the "subjugated knowledge" to become recolonized by the dominant society: this aspect will be explored further in Chapter 4, drawing from the experience of Nunavik.

The colonial encounter adds another dimension to this process: the normative aspect of medicine would provide fertile ground for the colonial endeavour, drawing on humanitarian arguments which drive a process of take-over. Before this process could take place however, Inuit had to first become visible.

CHAPTER 3: THE HISTORICAL DEVELOPMENT OF HEALTH CARE SERVICES IN NUNAVIK

> Looking at the past, as the years go, things went smoothly. When it was happening, I did not think about so many changes happening. I thought my culture was still on the same track. Today, I still feel as an Inuk. Looking back now, there has been many changes. Now I realize how dramatic it was (Interview 021-14: 40).

This Chapter will attempt to map the forces and factors shaping the contemporary relationship between northern biomedical services and Inuit, by concentrating on the development of health services in Nunavik. The historical development of biomedicine, the impact of medical knowledge on societies, as well as the relationship between medical and political ideologies have been well documented and analysed for France, Britain and the United States[33]. Canadian material is not as prevalent. Critical historical analyses of Canadian northern health care development are virtually non-existent[34]. The analysis provided is therefore intended as preliminary, and in need of further referencing to primary sources, which lies beyond the scope of this thesis. Some historical account, nonetheless, is important background to this thesis.

In the Canadian context, the nineteenth century was a time of little concern for health issues, at the national level. Graham-Cumming (1967) attributes this to a more relevant focus on developing the new world: the nineteenth century was a formative time for Canada, involving multiple "negotiations" between French, metis, and the British administration. Confederation and the building of the Canadian railway are suitable symbols of the preoccupations of the state. Accounts of native people's health status during this period tend to be informed by the assumption that native societies are simple societies living communally and healthily as long as left to themselves. "Contact" is portrayed as having played a very important role in precipitating a state of

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[33] The work of Foucault for France, of Rosenkrantz or Smith-Rosenberg for the United States, of Porter & Porter for Britain, or the comparative works of Hannaway are examples.

[34] There exists a large body of literature on the health status of northerners in historical perspective: Fortune (1968) and McCardle (1981) provide extensive bibliographies (although biased towards Alaska and the west coast of Canada) on the subject. Blake (1978), Grondin (1988, 1989 & 1990) and Vanast (1991a, 1991b, 1992a, 1992b, n.d.) provide valued insights to the relationship between Inuit medical knowledge and biomedical ideology.

social and health disarray in native societies, driving Inuit amongst others towards "degeneration" (Copland, 1978). The thesis that Euro-Canadians brought infectious diseases like measles, chickenpox and tuberculosis to the natives, with near-genocidal consequences, is well documented (Fortuine, 1965) and well accepted (Maundrell, 1941; Graham-Cumming, 1967; Young, 1988, among others). This "genetic weakness" merely adds another dimension to a polar vision of two societies coming into contact: the strong, complex, adaptable Euro-Canadian society *versus* the socially simple and genetically vulnerable native, unable to cope physically and socially with the consequences of contact although inherently healthy when in isolation[35] While this over-simplified portrayal has been challenged by Trigger (1986), a more subtle depiction of the context and consequences of contact is yet to enter the realm of northern medical anthropology

Likewise, conclusions that the state neglected native health (Copland, 1978; Frideres, 1988b; Graham-Cumming, 1967, 1969; Maundrell, 1940; Moore, 1961), or "abandoned" native people to mass epidemics (Vanast, n.d., 1991a & b), are anachronisms informed by a humanitarian vision of health services that developed only after the Second World War. Authors base their claims on such evidence as debates existing between the Indian medical administration and its medical officers working in the field in the 1920s. Duhaime (1983) proposes that these analyses are limited by a Manichean vision, in which the good native and bad colonialist are in conflict. Rather than this revisionist or simplistic perspective, these debates must be analysed as evidence of the changing relationship between the Canadian state and its constituents, as well as changing national priorities.

3.1 The Awakening of Indian Health Services Administration

> Prevailing social priorities concerning Indian affairs have changed as Canada, at the turn of the century, emerged from a pioneer economy and subsequently experienced two world wars, a devastating depression and six times were ruled by minority governments seeking to preserve their mandates (Badgley, 1973: 152)

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[35]Evidences to the effect that tuberculosis was present in North American before the arrival of Europeans (Fortuine, 1965) does not prevent theorists from focusing on a genetically weak resistance to justify the near-genocide natives experienced due to tuberculosis

Before the Second World War, churches were investing in the building of nursing stations and hospitals, especially in rural and isolated areas. While field medical practitioners employed by the Federal Department of Indians Affairs were generally opposed to the building of sedentary health services for the nomadic Inuit, the Department of Indian Affairs' administration supported a church-sponsored influx of funds for the delivery of care in the North (Vanast, 1992b). Thus, a triangular relationship between (1) Ottawa-based health administrators heading the decision-making in health care planning, (2) the churches supplying the funds and (3) the medical practitioners providing an increasingly professionalised form of knowledge, was at play in the pre-war years. Ship surgeons provided the bulk of government funded biomedical care to native people whom they came across through northern explorations (Brett, 1969), which spearheaded the fur trade. The RCMP, whose presence also preceded the governmental medical institution, often lent its premises to be used for the triple functions of guardroom, jail and "lunatic asylum" (Margretts, 1975: 422). In Nunavik, Anglican missions were settling in the region and getting involved in caring for the sick on a less structured basis. There was little governmental interest in health-related matters, except in the case of mass epidemics[36].

By the turn of the century, one basic assumption regarding the sources and impact of infectious diseases had changed in Canada. Documenting a smallpox epidemic in an Iroquoian community at the turn of the century, Weaver (1971) describes how measures were taken to prevent Indians from circulating out of the *cordon sanitaire*, presumably to prevent the spread of the disease to white communities. Interestingly, whites were permitted coming and going across the *cordon sanitaire*. Likewise, Moore writes:

> By the early 1920's it was evident that the Indian race was to survive, and also that it was in the selfish interest of the white man, for his own protection, to take steps to control tuberculosis in the red man (1961: 1013).

Graham-Cumming calls the turn of the century, the "awakening period" (1969: 527). Native populations who had been considered the victims of contact because of their high susceptibility to

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[36]This was the extend of the government's responsibility as specified in Treaty No. 6, signed by Canada and the Crees of central Alberta and Saskatchewan, in 1876 (Morris, 1880, cited in Young, 1984: 257).

"white diseases," were now perceived as the reservoir of pathologies, threatening the "white" population (Graham-Cumming, 1967; Hodgson, 1982). Moore (1961) notes that by 1933, reserves were being surveyed systematically. By 1937, a special committee to the Canadian Tuberculosis Association was making recommendations to improve medical and survey coverage as measures of tuberculosis control. Perhaps it was the pressure of epidemics that pushed the restructuration of aboriginal health services. Perhaps, it was the international trend towards the rationalization of services, a process that facilitated the expansion of the clinical gaze from the body to the space between bodies. This point requires further research. One point is clear, the consequences of this change had tremendous impact on further developments in northern health services.

3.2 Living under the Gaze

The extended gaze had not yet reached the North in the mid forties. While missionaries provided information regarding the health status of Inuit, the picture was partial at best. In 1941, the Département de Démographie de l'Université de Montréal began to systematically record the causes of death among Inuit (Choinière *et al*, 1988). However, the Inuit nomadic lifestyle, and the sporadic "white" presence in the North in no way provided the integrated picture required of this medical era. Despite this, practices aiming to deter the sedentarisation of Inuit multiplied well into the sixties[37]. Medical efforts concentrated on the evacuation of sick Inuit to southern hospitals[38]

Three processes played a major role in shaping Nunavik health services and influencing the Inuit perception of and relationship to these services. First, the duplication of federal and

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[37]Duhaime (1983) suggests that there were no formal policies aiming to deter sedentarization, but rather "attitudes" (*des comportements généralisés*) informed by the assumption that sedentarization would weaken and corrupt Inuit

[38]The number of Inuit evacuated to the South for tuberculosis alone was of such magnitude that it would eventually play a major role in changing anti-sedentarisation policies: the tuberculosis patients returning north would be required to see the nurse on a regular basis, challenging their ability to pursue the nomadic lifestyle promoted by government officials. The final turn took place in 1957-1958, and anti-sedentarisation and minimal intervention policies were replaced by policies facilitating the development of a wage economy: sedentarisation became the objective. Thus epidemics, and the delivery of health services to facilitate their eradication, acted in synergy towards the sedentarisation of Inuit. Duhaime (1983) provides a comprehensive and sensitive analysis of the sedentarisation process.

provincial health services in the assertion of sovereignty influenced the Inuit perception of Québec's intentions and their relationship with this government. Second, Prime Minister Bourassa's announcement of the James Bay project led Inuit towards the expedited negotiation of a land claim settlement, of which "self-determination in health care" was intended to be a component. Third, the Castonguay-Nepveu commission was established in 1967 to assess Québec's health services Its recommendations gave rise to the formulation of a multi-level comprehensive health care system. These processes will be discussed briefly.

3.2.1 Expanding the Mechanisms of Visibility

The post-war economic and political climate led to an intensification of federal activities in Nouveau-Québec, a phenomenon which coincided with (1) the creation in 1953 of the Federal Department of Northern Affairs and National Resources; (2) a soaring economy; (3) an enthusiasm generated by the end of the war, and (4) the rise of the Canadian welfare state[39]. Drugs were now available to treat tuberculosis. By 1945, the Indian Health Services were being transferred from the Department of Mines and Resources to the newly formed federal National Health and Welfare, under the Indian and Eskimo Health Services Directorate (Moore, 1961). Federal nursing stations were established in Kuujjuaq (1957), Povungnituk (late 1950s) and Salluit (1960-1)

Québec established its Direction Générale du Nouveau-Québec (hereafter DGNQ) in 1963, an agency responsible for the coordination of the northern development efforts. Rouland (1978) attributes Québec's new interest in the North to three main factors: (1) a will to stop the anglicization of the Inuit; (2) a new concern for the assertion of Québec sovereignty over its northern territory, an outgrowth of the Révolution Tranquille; and (3) Québec's quest for hydro-electric energy. To the Federal schools, justice system and health care facilities is added a series of Québec counterparts, which compete for the Inuiit attention.

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[39]It is during this period that unemployment insurance, old age security, and the first medicare plans were implemented.

> The federal nursing station was built just across here. When the provincial came to take over, they wanted to build [a nursing station] right across [the federal's]: that was where we used to dump our garbage... (Interview 205-29: 11).

Throughout the nineteen-sixties, provincial medical services proliferated, culminating in 1968 with the establishment of the hospital in Kuujjuaq. Its administration reported directly to Québec City, and benefited from a great deal of administrative and decisional autonomy compared to similar structures in the South. The hospital, located in the right wing of the Direction Générale du Nouveau-Québec's building (Bérubé *et al*, 1971), took over the administration of the provincial nursing stations. The authority of the missions in health care matters was slowly displaced, following a province-wide movement.

The French presence on Inuit land was not welcomed, by Federal employees already in place, or by the Inuit[40]. Québec's presence nevertheless intensified from 1963 to 1970, in conjunction with efforts to attract Inuit to the provincial services[41]. The Neville & Robitaille Commission[42] was set up in 1970, to consult with the Inuit with a view to solving this expensive duplication. Therrien (1979), then a teacher in one of the Québec schools, documented their opinions:

> Until we understand more fully, we will be happy with the federal government being in charge... The Québec government lacks experience... (Joe Kumarluk, Kuujjuaraapik, cited in Therrien, 1979: 101).

> We are afraid that the Québec government would not give them (our children) as good services as they are giving now (Juanisi Nalujuk, Salluit, cited in Therrien, 1979: 34).

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[40]A French trade company, the Révillon Frères, had operated in Nouveau-Québec from 1903 to 1926. It seems that the Hudson's Bay Company had actually bought the Révillon Frères, and continued operating under their name, before its closing in 1926. Inuit perceived this closure, the subsequent loss of resources and famine, as an abandonment by the French (Inuit Tungavingat Nunamini, 1983):

> Before we starved .. why didn't the Quebec government come to save the Indians and Eskimos? (Joe Kumarluk, Kuujjuaraapik, cited in Therrien, 1979: 103)

[41]Whereas the Federal Government offered schooling in English only, Québec chose to offer education in French and Inuktitut.

[42]Mr. F.J. Neville represented the Federal Department of Indian Affairs and Northern Development. Mr Benoît Robitaille was in charge of the Direction des Services Socio-Économiques de la Direction Générale du Nouveau-Québec.

Inuit resistance was at least partly motivated by a desire to retain existing gains, but also by the ambiguity felt in relation to Québec nationalistic movements. The Neville & Robitaille Commission did not lead to an agreement.

There can be no doubt that issues of sovereignty played an important role in this proliferation and duplication of services. Yet, the sudden proliferation of both provincial and federal health services in the North cannot be attributed solely to a conspiracy which would see health services as the excuse to justify the presence in the North of government-driven development agencies. The need to control infectious diseases was clear to practitioners in the field in the pre-war period. This need was documented through the clinical surveillance on southern reserves before the Second World War (see Maundrell, 1941) and the reasons why native people might have been perceived as particularly "at risk" were explored above. By the mid forties, political will and economic means were finally committed to take on the challenge of infectious disease control among Canadian aboriginal people[43]. In this regard as in others, the North remained the last frontier.

3.2.2 The Formulation of Inuit Self-Government

The idea of Inuit self-government precedes the announcement of the James Bay project. The Inuit cooperative movement introduced the idea in the sixties (Tremblay, F., 1979: 12)[44]. The cooperative movement may be seen as an attempt by Inuit to take control of the wage economy: the cooperative organizes Inuit individual endeavours and facilitates their existence by the purchasing of carving tools, the establishment of craft centres, the marketing of carvings,

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[43]Whether this delay is a sign of neglect or not depends on one's perspective. Hodgson (1982) suggests that tuberculosis among native people received little attention in the pre-war era because effectively little could be done. In contrast, Heeney, in a letter on behalf of the Privy Council, proposes that:

> Very substantial progress has been made in eradicating tuberculosis from among the white population in Canada, and the death rate, not including Indians, has been reduced fifty per cent during the last twenty years (1945, cited in Moore: 1961: 1015).

[44]Indeed it appears that the Cooperative movement was much more successful as a burgeoning political movement, than as an economic endeavour, at least by southern standards (see Riches, 1977).

pottery, duffel-made wall-hangings and prints it teaches and encourages Inuit to produce, into the lucrative southern market, and so on. By 1967, five cooperatives located in different communities united under the Federation of Nouveau-Québec Cooperatives. By 1969, there were ten cooperatives in Nouveau-Québec supplying one third of Inuit families annual income. This movement is important since it gave birth to a collective process "de prise en charge" to which is credited the idea of an Inuit Regional Government (Inuit Tungavingat Nunamini, 1983), a theme which recurs in Inuit testimonies to the Neville-Robitaille Commission. The announcement of the James Bay project by Premier Bourassa in April 1971, interfered with this collectivization process. The federal government funded the creation of a new agency, the Northern Québec Inuit Association (NQIA), to represent Inuit interests through the James Bay negotiation process. The concept of Inuit Self-Government as developed by the Cooperative Movement had to wait: both the Inuit Tungavingat Nunamini[45] (1983) and Rouland (1978) perceive NQIA as an association created to instigate dissent among Inuit[46]. From its outset, NQIA took on the defense of Inuit rights[47], rather than promoting autonomy. It is the NQIA who signed the James Bay and Northern Québec Agreement (hereafter JBNQA) on behalf of Inuit. It is noteworthy, three communities, Salluit, Ivujivik and Povungnituk, stood against the signature of the JBNQA and rejected the legitimacy of the NQIA as their representative. Although the two former eventually fell into line with the Kativik Regional Government, to-date Povungnituk still claims its opposition to the Kativik Regional Government, which evolved from the JBNQA. It is probably not a

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[45]Inuit Tungavingat Nunamini (ITN) evolved from the Cooperative Movement and, at the time of the signature of the JBNQA, represented the villages dissenting from the James Bay and Northern Quebec Agreement, (Povungnituk, Ivujivik and Salluit), which included one third of the Nouveau-Québec Inuit population.

[46]In addition, it appears that the Federal Government believed that the Inuit Tungavingat Nunamini lacked the broad extra-local support necessary to effectively negotiate the terms of the JBNQA on behalf of the Hudson Bay and Ungava Bay Inuit (Wenzel, 1993).

[47]This project threatened Indian and Inuit rights entrenched in the 1763 Royal Proclamation and later validated by the 1912 transfer of Nunavik from the Northwest Territories to Quebec. Cree and Inuit challenged the Société de Développement in court. Although they won the first round, with Judge Malouf ordering the stopping of the project, this decision would be reversed in appeal. Four days after Judge Malouf's decision, the Quebec government announced its intention to negotiate a settlement with the Cree and Inuit, in recognition that the courts will not put an end to the Federal-Provincial jurisdictional debate. Negotiations would last two years.

coincidence that the dissenting villages are located on the Hudson Bay coast, where the cooperative movement was historically much stronger.

The JBNQA, signed in 1975, validated the health care system planned for by the Québec Government, then in the process of implementing its "reform" province-wide[48]. It forced the resolution of jurisdictional debates over Québec's north, and federal offices closed their doors. The agreement entrenched Inuit institutions as public, and under provincial jurisdiction (Peters, 1989)[49]. Since 1980-81, funding for the Inuit regional and local governments has come entirely from Québec, and the Kativik Regional Government (hereafter KRG) operates regionally with powers similar to that of municipal governments[50]. These powers are curtailed by a lack of economic development which limits the potential for fund raising through taxation and by the negotiation process with provincial ministries who every year review the KRG's proposals for projects and activities and

> act upon them according to their own perception and evaluation of northern priorities, the whole being subject to the provincial government's northern policies (Rostaing, 1984: 23).

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[48]For a critical review of this process, which displaced and institutionalized community-based "cliniques communautaires" to substitute instead state owned, operated and driven "Centres Locaux de Services Communautaires (CLSC)," see Lamoureux, Mayer & Panet-Raymond (1989).

[49]In contrast to the Cree and Naskapi who established themselves as ethnic governments under federal jurisdiction.

[50]This includes three main areas of responsibility: (1) public health, sanitary conditions, water pollution and sewerage; (2) building and road standards, local police and personnel training; and (3) the regulation of the hunting, fishing and trapping support-programme, and the administration of provincial economic development programmes (Peters, 1989).

In terms of health and social services, section 15[51] of the James Bay and Northern Québec Agreement put an end to the confusion, supporting the implementation of a system similar to that defined by the Castonguay-Nepveu for the rest of the province. This system will be reviewed below.

3.2.3 The Secularisation of Québec's Health Care

The Québec Ministry of Health established the Castonguay-Nepveu Commission in 1967, to study health care services and formulate a system which represented on-going trends towards the secularisation, systematisation and "democratisation" of health care services. What resulted was the elaboration of a complex structure which influenced the balance of power in Nunavik. The "reform" officially displaced the power of northern health structures such as the dispensaries, the Kuujjuaq hospital, and the missions, and relocated it at least temporarily in Québec City

The new system recommended by the Castonguay-Nepveu Commission included the formation of:

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[51]What follows are the provincial and federal jurisdictions in health and social services matters (Canada, Quebec, 1976, in Peters, 1989: 227):

> Article 15.0.1;2 delivery of health services and social services for the area north of the 55th parallel through the Kativik Health and Social Services Council: this is a provincial responsibility
>
> Article 15 0.21 to maximum extent possible, provide employment for native people in health and social services, and budget for the impact of a northern location this is a provincial responsibility
>
> Article 15.0.19 provide funding for existing programs available to native people but not to the provincial population: this is a provincial responsibility
>
> Article 15, sh1(1) - preserve and improve the scope, extent, conditions and availability of existing health and social services: both a federal and provincial responsibility,
>
> sh1(3) - set up a working group to organize a broad range of support services a provincial responsibility,
>
> sh1(4) - improve health and social services for Aupaluk, Port Burwell, Akulivik, and any new communities established: both a federal and provincial responsibility,
>
> sh1(5) -- review health, staff, facilities and equipment at Kuujjuaq and Povungnituk: both a federal and provincial responsibility

1. Départements de Santé Communautaire (DSC) attached to University Hospitals, and charged with the formulation and supervision of regional public health programmes; thus the formation of the Projet Nord at the Centre Hospitalier de l'Université Laval's (CHUL) DSC, for Nunavik Inuit.

2. Conseils Régionaux de la Santé et des Services Sociaux (CRSSS) responsible for the administration of health dollars at a regional level and the formulation of regional priorities.

3. Centres Locaux de Santé Communautaire (CLSC) responsible for community health services and intended to be the port of entry into the health care system. Their mandate is pro-active through surveillance of "at risk" populations and reactive as out-patient clinics: the northern dispensaries and nursing stations would be rerouted to include more outreach programmes to fit this model.

4. In governmental jargon, hospitals become Centres Hospitaliers-Centres de Services Sociaux (CH-CSS).

At the regional level, the Nunavik health care system became a multi-level structure, similar to its southern counterparts. First line services are initially provided by village dispensaries and the Kuujjuaq hospital (the "CH-CSS de l'Ungava"). The hospital administers dispensaries in smaller Ungava communities. A second hospital was built in Povungnituk in 1986 (the "CH-CSS Inuulitsivik"), administering the Hudson Bay dispensaries. Both hospitals provide obstetrical, medical, minor surgical, and dental services. When specialised services are required, patients are evacuated to Montréal, this process and their stay being overseen by a team of nurses and interpreters from the Montreal General Hospital's Départements de Santé Communautaire. Public health programmes are provided under the direction of the CHUL's DSC's Projet Nord.

The only additional, albeit potentially significant, gain in terms of health and social services secured by Inuit through the James Bay and Northern Québec Agreement, is a provision for the establishment of a Conseil Régional de la Santé et des Services Sociaux, named the Kativik Regional Council of Health and Social Services (hereafter Kativik Council), in Kuujjuaq[52]. Established shortly after the signature of the Agreement, with a director, a programme coordinator and a secretary, the Council had the task of asserting its legitimacy and its ability to fulfill its mandate with both the Projet Nord of the University Laval's Département de Santé Communautaire

[52]Northern demographics would not have warranted the establishment of a CRSSS in Kuujjuaq, according to the plan of the reform

and the Kuujjuaq hospital's administration. With the former, the debate is on-going and evolves from jurisdictional and decision-making debates concerning prevention. The Projet Nord's administration does not recognize a distinctiveness that the Kativik Council would like to see acknowledged (Interviews 227, 228, 301, 302)[53]. To-date, the Kativik Council has had difficulties in enforcing its perceived mandate, and operating as a regional administration and decision-maker.

While the JBNQA proposed greater Inuit involvement in the delivery of health services, a report from the Kativik Council to the Commission Rochon[54] (Kativik Regional Council of Health and Social Services, 1986) pointed out a number of complaints: (1) excessive reliance on "imported" personnel, due to a lack of qualified personnel[55] in the region, forcing recruitment from the south; (2) language barriers, because this southern recruitment is limited to French-speaking Québec; (3) high staff turnover, among both "imported" and Inuit personnel, attributed to northern practice being limiting[56] and to a lack of opportunity for advancement. Québec is currently undergoing yet another reform. Northern concerns are not covered specifically (Québec, 1987), yet Native (not specifically northern) issues are addressed. The reform proposes to:

> reaffirm the right of aboriginal nations, long recognized in Québec, to have access to health and social services appropriate to their particular needs and way of life. The Government is in favour of indigenous communities managing their own services for themselves (Québec, 1990: 31).

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[53]It must be acknowledged that the Council has requested that its special status be forfeited when ever it perceived some advantages coming from provincial health care reforms (Kativik Regional Council of Health and Social Services, 1991). Provisions under the James Bay and Northern Quebec Agreement should in all logic take precedence over provincial trends.

[54]Created in June 1986 by the Québec Government to evaluate the health and social services system in the province. The Commission would provide the ground for the present reform.

[55]i.e. Personnel trained to take on nurse's, dentist's and doctor's positions.

[56]Outpost nurses often complain that although their role represents in some ways an extension of their traditional nurse role, it does not allow them to keep current with technological changes occurring in the South, making them unmarketable -- outdated -- if they remain in the North too long.

This will be operationalized by handing over "to the Inuit and Cree nations the mandate to manage health and social services in the Kativik and James Bay territories, respectively..." (Québec, 1990: 31). In effect, this means the dissolution of the DSCs, and the relocation of the DSC's mandate in the regions. The intention seems to be to bring decision-making power closer to the site of practice. The training of aboriginal personnel is also stated as a priority.

The proposed changes are no doubt significant: the dissolution of the CHUL's DSC means that the Kativik Council is finally given the mandate and power that it perceives it was created to have, under the JBNQA. This organism has been directed by an Inuk for at least a decade, and has, especially in the last five years, placed a strong emphasis on Inuit control of health care.

3.3 Reflections and Conclusions

In a period of fifty years, Aboriginal Health Policy went from a state of *laissez-faire* to one of implementing a multi-level provincial health care system. New biomedical concepts evolving from the community health model have facilitated and provided a rationale for the extension of mechanisms of medical surveillance into Inuit communities. The adoption of the Québec model has provided fertile ground for extending the medical gaze. The size of communities adds another dimension to Inuit visibility: in the northern context, health, social services and the justice system interlock into a network of surveillance over community members. The gaze can achieve unprecedented success in embracing nearly the whole social context of individuals at a glance.

The JBNQA has gradually allowed for greater decision-making power to be relocated in Nunavik. However, regionalism has not entirely solved the debates over the legitimacy of the decision-making structure: Québec does not yet recognize the uniqueness of the Kativik Council, itself an outgrowth of the JBNQA, and Povungnituk continues to dissent from the agreement and to reject the legitimacy of any structure which grew as a result of it.

An important provision of the agreement had to do with the health care system becoming an employer of Inuit. However, educational barriers have been a major impediment to this process.

The few Inuit working as health care practitioners are subordinated to biomedical ideology. Local knowledge remains peripheral to health care delivery to a large extent, except perhaps for maternity services in Povungnituk. While the JBNQA provided little ground for the creation of an innovative health care system, the mobilisation process inherent to its negotiation nevertheless contributed to a change in Inuit perception of this system. This will be the focus of Chapter 4.

CHAPTER 4: THE DECOLONIZATION OF THE SELF AND THE RECOLONIZATION OF KNOWLEDGE

> The white man teaches us useless things, when we can't help ourselves they mock us. Really he should be mocking himself. You don't need to know about the weather and numbers to be a social worker. To be a social worker you should just need to want to help and be respected by the community (Interview 101-59 to 61: 5).

This Chapter will provide an overview of the manner in which the community health discourse is produced and utilized to satisfy divergent interests in Nunavik. It was argued that self-determination is not a community/public health movement. In fact, the community health model offers avenues on which Inuit capitalise in their pursuit of greater control over health care. The focus on deprofessionalization through para-professionalism, itself an outgrowth of the community health model, has allowed the entry of Inuit into a structure which has been mostly impervious to their involvement. Deprofessionalization has led a greater number of Inuit to access higher levels of decision-making. While some claim that the content of the structure is slowly being "decolonized", the community health model has also favoured the recolonization of Inuit knowledge.

4.1 The Production and Use of the Public Health Discourse in Nunavik

In Nunavik, the public health discourse is called upon to represent divergent perspectives and agendas. From the "community's perspective"[57], community health means anything which strengthens the relationship between the community and health care in a positive way. This vision is coloured by the community's experience of health care, and thus differs from community to community. For the purpose of this analysis, Kuujjuaq's and Povungnituk's vision of community

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[57]There is obviously no such thing as a "community perspective", just like there is no unified "professional or southern perspective" on community health. For the purpose of this discussion, interviewees' input will be divided into two categories: 1) the "community's perspective", which includes local people who may also be health care workers, as well as long term residents; and 2) the "regional perspective", defined as the perspective of Nunavik political leaders

health will be considered in turn. These visions will be contrasted to the "regional perspective" on community health, which in this case refers to specific processes aiming at transferring to the Kativik Regional Board of Health and Social Services responsibilities and budgets controlled in Québec City.

4.1.1 Povungnituk: Community Health belongs to the Community

Povungnituk is a community of 700. It is often qualified as "traditional" by Kuujjuaq residents. It has just been provided with a proper air strip: at the time of fieldwork, however, the plane would land on ice in winter and on water in the summer. In-between seasons were problematic. Povungnituk was selected in 1982 to be the location of the regional hospital, following a consultation with the Hudson Bay communities. Its dissidence from the JBNQA probably played a role. Politics aside, Inukjuak would have been a more likely choice. The hospital is the biggest structure in town, the only governmental representation[58], and offers the most employment opportunities.

Community dynamics have played a major role in shaping Inuit involvement in health care in POV[59]. The community's political stance over the James Bay and Northern Québec Agreement seems to have contributed to maintaining and/or strengthening community identity. From the time the hospital was announced, community groups sought to be involved in the planning. The local women's group took the stance of refusing to accept the hospital unless a maternity unit was included. An objective of integrating Inuit midwives into the health team was developed shortly after (Interviews 024 & 225; see also the Povungnituk's Maternity Philosophy Statement, Inuulitsivik, n.d.). Professionals opposing this plan were slowly weeded out (Interview 024). This was the beginning of a process whereby the Board of Directors slowly expanded its control of

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[58]Social services have a small office, which is located on the first floor of the hospital. Social services and health are both under the leadership of the Kativik Regional Council of Health and Social Services.

[59]POV is the shorthand for Povungnituk.

the health care structure. This process was facilitated by some professionals. The role of the board in shaping services has grown over the years:

> The hospital was mostly the works of the white people working on it. Inuit are trappers, hunters and fishermen: they had no time, interest to get involved or nothing to compare with. The Board of Directors played a role of rubber stamping. Formed by a representative from each community, none of them had ever seen something like that, they had no experience of it. All meetings were in French. The Directeur Général was French (Interview 024-05, 06: 45).

The nomination of an Inuit director at the Inuulitsivik Health Centre in 1984 has definitely played a role in the development of para-professional Inuit involvement. Part of the general objectives of the Povungnituk hospital was a mandate to establish the hospital as a training centre for Inuit nurses (Groupe de Travail sur les Objectifs du CHCB, 1984). Multiple efforts have been made to train Inuit as para-professionals in the Hudson Bay area.

The community's relationship with the hospital is a close one. Discussions of the place of the community in health care revealed that distinctions were being made between 1) the place of Inuit knowledge in health care, 2) the role of Inuit in shaping health care, and 3) the place of the hospital in the fulfillment of local political aspirations. Each point will discussed in turn.

4.1.1.1 The place of Inuit knowledge in health care

It is readily acknowledged within the community that the hospital's functioning hinges on "white" or "foreign" knowledge (Interviews 009, 023, 024). An informant reported a discussion with a southern health professional as follows:

> Don't give us your theories, your philosophy: we don't need them. We do not need your culture, we need the facts. We are part of our culture, born in it and raised in it. We get our information from other sources as well, from the elders, from other men and women (Interview 024-23 to 24: 47).

Inuit acquire knowledge from a variety of sources. The hospital is one of them. Although it is also acknowledged that it plays an acculturating role, strong linkages with the community keep this force in check.

Inuit health care workers are thus given the task of extracting southern medical knowledge from its cultural packaging. When asked about the place of traditional Inuit medical knowledge in the new order, elders generally explain how Inuit used to help one another. Autonomy and self-reliance are emphasized. The role of the church and "white" health care in destroying the social context of healing is readily brought up[60]. Inuit employment as health professionals is perceived as an opportunity to bring back a form of subjugated knowledge (Interviews 024, 026).

> There were some Inuit which had a "special touch", that could heal. The whites did not know about it. When the white came, the Inuit tried to compromise with them, to live with them... The knowledge is still here. Now that Inuit understand the rules more, they can bring that Inuit knowledge back (Interview 023-12, 13: 44).

This is not to say that "expert knowledge" is devalued. To the contrary. Comments abound to voice the needs for more specialists:

> ...[the hospital] is an outsider institution, but one that is needed. It is not as foreign as it was 20-30 years ago when people used to be put on ships or sent south.... There are going to be more specialists in the north. Patients won't need to go south so much... (Interview 009-01: 17).

Specialists provide services which minimize community disruption when patients have to travel[61].

4.1.1.2 The role of Inuit in shaping health care

The community health care model is an extension of biomedical ideology. While the model itself challenges some of the power relationships entrenched in the curative-oriented model of

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[60]The influence of missionaries, and the role they played in paving the way to formal medical services, was considerable (Interviews 101, 203, 219). Missionaries' success in minimizing the significance of this aspect of Inuit life has much to do with their perception of the shaman, with their desire to eliminate "pagan" beliefs, as with a mission to help in critical situations. The establishment of nursing stations as well as tuberculosis epidemics and hunger, had much to do with the subsequent disintegration of the Inuit midwife role. Elders were affected by the epidemics, to which hunger made more sensitive. Many died while a larger number were evacuated south to tuberculosis sanatoriums.

> In 1941-42, there was whooping cough, measles, a lot of elders died. There was TB, lots of women loss their babies. There has not been deliveries by a midwife here for a long time. When the nurses came here, we went to them because there was a lot of dying (Interview 214-03, 11: 30-31).

Accurate figures are lacking for many communities, yet is has been estimated that 70 per cent of the Inuit population now older than 35 spent from one to nine years in southern sanatoriums because of tuberculosis. The displacement of Inuit midwifery, the curtailing of visiting the sick in times of epidemics, the substitution of medical confidentiality for group decision-making added to on-going social disarticulation due to epidemics and famine.

[61]It is also an affirmation that Inuit are entitled to the same level of services available in the south.

health care popular in the fifties and sixties, it remains faithful to a biomedical conceptualization of health. Further, it remains faithful to the investment of power in professionals. In southern communities, Boards of Directors usually share the class culture of professionals. In the north however, the professionals and Inuit[62] constitute two distinct groups which do not share a common culture. This provides Inuit with a mechanism which can be called upon to shape northern health care via the knowledge acquired by Inuit health care workers and the power of the Board of Directors.

> The nurses in the nursing stations have a lot of autonomy because they were let to have it. But we have to work so that the Board of Directors and local committees get more involved. We have to make the Board of Directors responsible for the care provided in the community: they have to ensure that she works for the community. Inuit must provide the nurses with a framework to support the nurses in their involvement/work in the community. We have had nurses in the north for 40 years, Inuit have had services in their communities for 40 years: the government is very proud of this. Someone has been on call 24 hrs a day here for 40 years. Where is our health in 1991? 1. highest teenage pregnancy; 2. highest tooth decay; 3. highest cause of death is through violence/ accidents. Why? Because the health system has never been structured to meet our needs. It focused instead on clinical. There was no information going to the people, no information about good food, no information about caring for children. It is for us to ensure that the health system is working for us (Interview 024-27 to 32: 48).

Services are deemed "not Inuit-like". The reason for this is attributed to powers outside the reach of Inuit:

> This organization was given, no, introduced by whites. We should be able to give services the Inuit way. Because POV was dissident of the JBNQA, changes here were gradual rather than sudden. In other communities, they were suddenly given a lot of power, but no direction. In POV, it happened slowly. At the level of services, we should have as complete control first, but we will never have control, we will always be caught in between (Interview 009-07 to 08: 17).

Informants generally qualify "the Inuit way" as a non-institutionalized approach to caring.

While the mechanisms called upon to address the shortcomings of the system are mechanisms provided by the health care structure, comments emphasize the community's role in providing direction.

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[62] An implication of this comment is that Inuit communities are unified and homogenous. That is not necessarily the case. Regional centres such as Kuujjuaq are clusters of communities, each defined by the community of birth of residents. Smaller communities like POV are less liable to this phenomenon because of the scarcity of employment. Also, northern communities including POV are stratified, although not necessarily on the basis of wealth.

4.1.1.3 The place of the hospital in the fulfillment of local political aspirations

Under the community health model, the hospital's role is to assist communities in achieving/maintaining its health status. In POV, the hospital is part of a community process which is specific to this community. POV's rejection of the JBNQA, signed in 1975, has been empowering yet costly. It has focused the community on a common goal of resistance. The hospital, the largest employer, has been enlisted in this struggle:

> The hospital has a very important role to play in the community...: it has to work and build at the grassroots. It can't afford to alienate people. We do not need another institution that alienates our people.... There is little linkage [between Povungnituk and the Kativik Regional Government] -- we used them very little, unless sometimes for training funding They are "disconnected", disoriented. We keep to ourselves as much as possible so that they can interfere as least as possible. All they want is money, KRG, KSB, Air Inuit, Avataq, Land Holding Corporation[63]. If they start seeing us as having money, they'll walk all over us. They destroy everything they touch, for money. Nobody has been able to stand up to them. They don't think that people are more important than money. We will keep health separate as long as we do not have a fair and equitable government. The hospital is a mean to train Inuit, to increase their self-confidence, to create a front which will be able to stand up to KRG. Nobody has been able to stand up to them yet When they come for us, we will be ready. We will have 30-40 people ready to stand up. The hospital is a way to prepare tomorrow's leaders (Interview 024-26 to 39, 47-49).

In summary, the hospital as an institution is a vehicle for the community's fulfillment of its political aspirations. It was shown earlier that Inuit employment in health care is perceived as the way for Inuit to end a dependency on southern knowledge. Inuit health workers are given the task of learning southern medical knowledge which they will then integrate with Inuit knowledge. Inuit leadership see this type of structure as providing a framework to ensure that health professionals are responsive to community needs and wants. One question remains: what is the linkage between these aspirations and the community health model?

Povungnituk's perception of the role of health care does not fit neatly into the community health model. It includes more specialists providing services locally, to minimize the social disruption experienced as a result of medical travel. It includes the assimilation of biomedical knowledge, a precursor to the creation of a unique "Inuit" medical institution It also includes the

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[63]KRG stands for Kativik Regional Government, KSB stands for Kativik Regional School Board The KRG, KSB and the Land Holding Corporation are all Kuujjuaq-based institutions which evolved from the JBNQA. Avataq (the Northern Quebec Inuit Cultural Institute) is an exception, being based in Inukjuak

integration of the hospital into the political life of the community. In reference to Kunitz's distinction [64], the orientation here is definitely deterministic, although it goes beyond that model as well. Rather, it is a model in which the community is the core, in which "subjugated knowledge" may find its expression once the structure becomes decolonized in terms of human resources. Finally, it is a model whereby the hospital is part of a larger context which includes Povungnituk's self-determination.

4.1.2 Kuujjuaq: Community Health Means Community Oriented Services

When asked about the transition from Inuit medicine to nursing stations, elders from Kuujjuaq generally relate the role of epidemics in promoting this change:

> The whites had more knowledge. If people had problems that elders could not solve, they'd go to the doctors. Also with the new diseases, they started going to the American doctors (Interview 214-09: 30).

The establishment of an American Army Base in Kuujjuaq in 1947, in times of famine, played a role in entrenching a process already under way. Kuujjuaq was already a well established, albeit seasonal, settlement, and had been for a number of years. The army base formalized its role as a regional centre. Both the federal Department of Indian Affairs and Northern Development and the provincial Direction Générale du Nouveau-Québec established their offices in town.

Kuujjuaq was first to receive its hospital, in 1968. It offered the best schooling opportunities for both coasts. It was a logical place to locate the Kativik Regional Government, and the Kativik Regional Council of Health and Social Services. This point is important: opportunities for wage employment were always better in Kuujjuaq and literally boomed after the signature of the JBNQA, with young high school (or less) educated Inuit being deterred from pursuing higher education by the prospects of well-paid stable positions within the new political structure (Interview 224).

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[64] I am here referring to the distinction between the voluntarist and the determinist explored in Chapter 1.

Situating health services within Kuujjuaq's community context is complex. Both the Kativik Council and the hospital have their own place, mandate, philosophy and history. This difference is evidenced by the tense relations which exist between the two (Labbé, 1987b). From the time of its opening, the Kativik Council was under the leadership of a Board of Directors formed by a representative from each community. The executive director was and still is an Inuk. Although the Council has had to rely on professionals for some of its programme planning, Inuit involvement has been considerable. Further, the Council's activities have generally been informed by community consultations. Aside from the director and the Board members, Inuit representation within the organization has been mainly at the level of clerical support, although this staff generally heads community consultations, and is included, involved and consulted in programming and delivery, in recognition of their roles and knowledge at the community level.

The hospital, however, is a different picture. Established through provincial involvement, its orientation was essentially curative, and it relied heavily on professional staffing. Inuit employment at the hospital has remained at the level of non-skilled, janitorial positions. The hospital has never played a leadership role in promoting local employment (Singer, 1990).

Following the Québec model, Boards of Directors are expected to provide direction to northern health institutions. In reality, unless provided with training and staff willing to keep the control in the hands of the Board, Boards cannot play that role. Biomedical institutions are complex and strategies can be used successfully to ensure that Boards' involvement remains peripheral to critical issues. In Kuujjuaq, the predominant use of French[65] at the hospital enabled administrative and professional staff to by-pass the Board until the community opted to nominate a trilingual president to secure more control. This event, however, is relatively recent.

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[65]It is a policy of the Quebec Government that health professionals must be proficient in French to qualify for licensing. This in effect eliminates most professionals who have a proficiency in English. English remains the primary second language for Nunavik Inuit, despite repeated efforts to provide French education. There exists now a generation of high school students educated in French, but their fluency is generally limited by the fact that students have few opportunities to practice their skills outside the school. Their competency remains generally too limited for even the most mundane conversation.

One may wonder why Ungava communities tolerated being literally excluded from the hospital's decision-making for over 20 years The answer is related to community dynamics. The establishment of the Kativik Regional Government in Kuujjuaq caused a major drain of skills in this community in favour of political-economic types of employment. Health was not perceived as a high profile institution, its reliance on professionalism being an additional deterrent. Board members are either already involved on a number of other Boards which monopolize their energies and they might, therefore, be grateful for a lighter load, or involved Board members were satisfied to wait for the day when they would be invited to contribute more significantly, provided that a per diem[66] be provided. Another reason may be that as a regional centre, Kuujjuaq has a number of government agencies and the community has a higher tolerance and acceptance for "institutionalized relationships", which are perceived as more southern or white, than the communal approach of smaller communities which are qualified as more "traditional".

From the community's perspective, community health seems to mean anything which addresses current hardships experienced because of health care. It is therefore not surprising to hear requests for more professionals and specialists to be located in the north, as was the case for Povungnituk. After all, the social and family disruption experienced because of repeated travel due to sickness is considerable (Interviews 215, 216, 222).

But community health also means breaking the barriers between the community and the hospital. This theme is reiterated in various ways described below.

[66]An alternative form of employment practised in the north is that of professional Board member, where some individuals will cumulate a number of assignments to different Boards to support their families and supplement their income. Few, usually low profile, Boards require voluntarism.

4.1.2.1. A Desire for a sharing of knowledge between professionals and the community

Until recently, the hospital's mandate has focused on curative services. Although one Department, "Hygiene" was supposedly dedicated to outpatient care and prevention, the perception remains that health professionals do not inform but dictate treatment:

> It is a question of lack of choice. You go there and they give you the prescription, and tell you what you have to do. There is no explanation, no choice. For example, I was told my tooth had to be pulled. I came back here, and talked to [a friend], who suggested that a root canal may be a possibility. When I went back and asked -- sure enough it was possible. Now I still have my tooth -- but I would have lost it if I had listened to them (Interview 202-11: 3).

Informants readily shared multiple examples of perceived discrimination and incompetence when accessing health services, as indicative of the poor quality of treatment they were getting: a "white" who has woman married into the community wanted to deliver her child in Kuujjuaq. Her doctor was discouraging her from doing so. When she asked why she should go to Montreal to deliver, she was told: "Inuit do not sue". She was finally convinced to deliver in the south (Interview 224-03: 47). An Inuk was prescribed a medication which was substituted at the pharmacy for something cheaper. She had an allergic reaction to it. It was interpreted as a case of "whites" giving cheap medicine because they know Inuit do not pay for their medication (Interview 224-04: 47).

The relationship between the hospital and the community took a turn for the worse some time ago[67]. The climate is that of a deep lack of trust on the one hand, and of a lack of understanding which some would call lack of respect, on the other.

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[67]Informants seemed to recall that the relationship between professionals and the community was very positive before the construction of the hospital in 1968. Services were then offered by Federal (most likely anglophone) staff, in a small nursing station. The hospital brought a large number of mostly French speaking professionals at once.

> ... people used to use the medicine from the land. They never bothered after that [after the nurses came]. Old people were young when the nurses came... There are not many elders now. Then they used to live until 80 or 90, because they ate fish, meat, seal. Now the meat they eat is like paper, it's low in blood. So we are weaker. People get liquor and they are not eating enough. Kids are not eating enough because their mothers are not looking after them properly with food. Kids now are eating sweets, and they are jumping all the time, because of the sweets. Hospital workers, interpreters think that they are smart, but they are not. They are not teaching enough the young people. We used to work together -- they don't know now.... Services were better with the nurses because we used to go around, all over the place with the X-ray[68]. It was better than the hospital (Interview 205-31 to 36: 11).

4.1.2.2. A Desire for a greater integration of the hospital with community life

> In POV, they do a lot of things as a community, they get involved. We are not really together here. We have to start getting together, acting as a community. We can't just leave it to certain people.... One thing is sure, we have to make the community aware. We have to hold public meetings, to get the information out to them. We need to get the people involved. Only then can the hospital become what the people want (Interview 216-03 to 07: 34).

Kuujjuaq acts as a magnet for other communities; it is a place where individuals seeking wage employment collect. This Inuit population is often transient, coming and going between smaller settlements and the metropolis, or on a north-south axis. For more than 30 years, Kuujjuaq also has the largest non-Inuit population -- Cree, French and English Canadians. Kuujjuaq is in fact a number of stratified communities, living side by side, and interlocking at some levels while conflicting at others. It is hardly surprising to see this loosely woven community having difficulties reclaiming control over 20 year old institutions. Given the example of Povungnituk, it seems that a strong sense of community is essential to promote the integration of the hospital and its staff into the community. Other factors at play will be reviewed below.

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[68]The older generation still attaches a great deal of power to the X-ray machine in diagnosis, and a great deal of value to mobile clinics.

4.1.2.3. A Desire for health care which reaches out and provides care in the actual community

> People lost control over themselves. Social services came in. They told the people if you have any problems, we are here to serve you. It took responsibilities away from the people. Now people feel that they have no control over their themselves. The organizations do not promote [autonomy]. We have to look at the individual and the families. But all the programmes from the south are taking so much energy and time away so I can't do it. The people with knowledge are caught up with family and work, and have no time left. If life skills was offered at adult education maybe they can learn that they <u>can do</u> whatever they want. That is the only way to make a difference with drug and alcohol. In the past, there was no such thing as abuse[69] -- no word for it. People learned from experience. Things happened but people considered them part of life. Now by talking about it, it gives people an excuse to say "poor me, I was abused". Getting a woman's shelter[70] is another way of taking away people's responsibility. It's another group of people now interfering in your life. The problem now is that the community does not want to get involved in other people's lives. They say "there is the police, social services, the women's shelter, so it is not our problem". These have removed people's responsibility for each other. We are now separated from the caring we should have for other human beings. I don't believe that institutions are the answer. Caring must come back Now we felt that we need a computer, another building, and this and that to stop these problems People are not being asked what they want in their community (Interview 207-09 to 17: 13-14).

Health care, as with other institutions, promotes a disjointed approach to caring: individuals are extracted from their daily lives, and caring is provided by strangers. Further, health care is isolated from the larger needs of the community:

> Le "Board" vient de se prendre en main. On vient de changer la direction de l'hôpital. We now have different goals. The Board wants Inuit people to be able to come within the organization. We want the jobs to be taken by local people We pay lots of money in benefits, trips to southerners. Northerners don't get those benefits. Southerners get everything they want when they come here. Between 1979-82 we trained auxiliary nurses which ended up being treated as interpreters. Only four of the 14 remain in the structure and they never had the chance to become Registered Nurses. The Board must take the chance to have a say in what happens. We want to focus on training and that is urgent Something like 60% of our population is below 20 years old. They are going to need jobs. In 10-20 years, we want to have the Inuit people working here instead of having southerners running the hospital. The hospital here is oriented towards curative medicine. We want to emphasize preventive medicine now. We want home visits. Older people are not getting care because they are not mobile enough to get to the hospital. In a sense we are

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[69]Not that spousal and sexual abuse did not happen, but it was not considered as much an issue as it is today, perhaps because of the necessities of interdependence.

[70]The shelter is a community-based, non-governmental initiative initiated by an elder Inuit man

> going along with the reform[71], towards community health. We have a high reliance on southerners, we have a booming population, and not enough funds for building houses. There is a housing crisis here. Hiring locally would solve this housing problem (Interview 215-01 to 09: 30-32)[72].

To summarize, in Kuujjuaq, health care planning has been in the hands of Inuit Council members since its inception, but delivery had been provided mainly through francophone professionals. The local experience of health care has been one of patron-client (Dufour, R., 1991; Morissette & Tourigny, 1986; Tremblay, F., 1991), resulting in a gulf between health professionals and the community. The situation in which early health care was implemented, at a time of epidemics and famine, by means of provincial involvement, facilitated the establishment of a curative-oriented institutionalized health care system which has been difficult to control. All Inuit interviewed were critical, almost vehemently so, about the limited quality of care and the racism they experienced when seeking care. No Adult Education student viewed the hospital as a suitable employer, despite the fact that some had worked at the hospital for years. Inuit employed as health care givers were also very critical of the situation.

Questions of the place of Inuit medical knowledge were understood very differently in Kuujjuaq than in Povungnituk. Povungnituk residents perceived the hospital as either a possible vehicle or as a definite avenue to "bring back" this "subjugated knowledge":

> Inuit used to help one other. Maybe it is time to bring this knowledge back (Interview 026).

In Kuujjuaq, the same question was treated as irrelevant: "there is not much we can do", "the knowledge is lost", "biomedicine is more effective". While Povungnituk informants placed an emphasis on autonomy and self-sufficiency, Kuujjuaq residents placed an emphasis on the

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[71] The reform referred to is the process outlined in:
Québec, Ministère de la Santé et des Services Sociaux, 1990, A Reform Centred on the Citizen, Québec: Ministère de la Santé et des Services Sociaux.

[72] This interview, with a long term resident, was carried out in both English and French, and is transcribed verbatim.

technical aspects of medicine. Kuujjuaq's reliance on biomedical knowledge may be the sign of assimilation or acculturation that some health professionals and theorists have been waiting for. Or it may be a mix of different components: it is possible that Kuujjuaq residents do not perceive the hospital as a vehicle for cultural self-actualization The presence of the Kativik Regional Government, the Kativik School Board and the Kativik Regional Council of Health and Social Services may detract from the potential of the hospital. Further, Kuujjuaq residents have experienced an individualizing curative technologically-oriented form of health care for over 20 years. It is possible that Kuujjuaq residents do not see the relevance of integrating a more Inuit form of health conceptualization with a biomedical institution: perhaps both systems of thought remain distinct, in contrast to Povungnituk. This point requires further fieldwork. Nevertheless, the local concept of community health remains dramatically different from that of biomedicine, with its fitness, good nutrition and non-smoking campaigns. In Kuujjuaq, community health is the antithesis of the services offered at the hospital[73]: informants proposed that health professionals should provide home services rather than have patients making appointments at the hospital. The meaning of community health is thus the provision of community based and driven, caring **services** to **individuals** in the community: "tender loving care" (Interview 215: 11). This contrasts sharply with Povungnituk, where health is a **collective political** process. In Kuujjuaq, the hospital is not a vehicle through which Inuit can achieve greater collective autonomy. Debates over the relationship between autonomy and health were encountered, but only among the Kativik Regional Board of Health and Social Services' leadership. In Kuujjuaq, it appears that the political debates over health and autonomy are not community based but institution based.

[73]Again, a dramatic change was under way at the time of fieldwork, leading to a great deal of hope in the community. The analysis provided here is based on interviews where informants were drawing from their past experience.

4.1.3 Community Health and the Regional Discourse

> ...les Inuit en [ont] assez. Il leur répugne d'être forcés, sur leur territoire, de s'adapter aux mentalités du «sud» et d'être obligés, pour avoir des services, de se plier aux caprices d'une culture qui n'a rien à voir avec leur façon de vivre[74] (La Presse, 1986a: B1).

The discourse on public health plays a major role in defining Inuit vision and understanding of health care. It also feeds into planners' decisions regarding policy and programmes. The use of this discourse, however, differs from coast to coast, which has impacts on community involvement and the understanding of services, as well as planners' perception of processes and historical contingencies the development of health services.

Health planners' use of the discourse of public health hinge on a number of assumptions which inform the argument, namely that holistic, global, systemic approach or "l'approche communautaire" is better adapted to address northerner health care needs. A first assumption is that the north in general, and traditional Inuit society in particular, are more communal, a characteristic lost or altered by modern life or through contact (Bédard & Baillargeon, 1981; Bérubé *et al*, 1971; Choinière *et al*, 1988; Sampath, 1988). This assumption is used to justify a community health model (Labbé, 1981b; Tremblay, F., 1979).

A second assumption is that Inuit/northerners are assumed to be the only/preferred/sole legitimate providers of truly effective and/or culturally appropriate health care, as opposed to *Qallunaat*, Whites, Allochtones, Euro-Canadians, Outsiders[75], the Government(s) (Dufour, M.-J., 1983; Kativik Regional Board of Health and Social Services, 1990, 1991; Tremblay, F., 1979; Tremblay, N., 1978). Again, holistic, global, systemic approaches, "l'approche communautaire" are presented as superior alternatives to biomedicine because the former opens doors to "lay"

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[74]This statement was made to La Presse (in English) by Mr. Paulusie Padlayat, Mayor of Salluit and representative of this community to the Board of Directors of the Inuulitsivik Health Centre (Povungnituk).

[75]These words are being used in the literature as if synonymous.

practitioners and is believed to be closer to Inuit traditional concept of health and illness (Dufour, R., 1979; 1990a; Tremblay, F., 1979; Tulugak, n.d.).

It is through these oppositions that power and control over decision-making are negotiated:

> The need for a Community Health Department is evident but, it must be determined whether or not the needs of the region are met by an establishment based in the South Dynamic community health programs are a necessity if the goal of optimal wellness through increased self-reliance is to be achieved.
>
> The Kativik CRSSS [Kativik Council] feels that the expertise of various establishments and organizations in the South should be used to establish priorities or to implement the required emergency measures [in case of epidemics] But responsibility for the development of program (*sic*) policies and objectives must be kept within the region (Kativik Regional Council of Health and Social Services, 1986: 13).

The above comment is part of an introductory statement made during a presentation to Mrs. Thérèse Lavoie-Roux requesting that control over services be relocated in the north and that services be expanded. The arguments called upon here are utilized over and over again:

> In our own way, we are professionals and believe that it is time to start applying Inuit theory and perfecting it with southern technique, which has so much more influence than our own (Kativik Regional Board of Health and Social Services, 1988: 1-2).
>
> As you are aware for a number of reasons specific to our situation, (our specific culture, the size of our territory, and the distance between villages, the lack of development of our health and social services; the dependence in which we are maintained in regards to health and social services delivery; the importance of specific health and social problems such as suicide, alcohol and drugs, violence); we have been requesting the Ministry the means to assume more and more our own destiny in matter of health and social services While we feel that the attitude of the personnel at the Ministry is more opened, we have often heard that we should demonstrate our capacity to assume our responsibility first and then be given the means. That is contradictory. How can we demonstrate that we have the abilities if we do not have the means (Kativik Board of Health and social Services, letter to Marc-Yvan Côté, Minister, Ministère de la Santé et des Services Sociaux, July 30, 1990).

From some planners' perspective, however, the allocation of control and power are also negotiated in terms of results: power and control will be passed on when results start to occur. Inuit must first demonstrate their abilities:

> Du côté des Inuit, on a pas une volonté de se prendre en charge, on est tellement gâté Pour qu'il y ait une prise en charge, il faudrait qu'on les laisse faire leurs erreurs -- on l'a jamais fait... Les Inuit, de toute façon sont de grands parleurs, et de petits faiseurs (Interview 301)[76].

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[76] The overtone clearly indicate that Inuit are considered as big children.

Southern institutions involved in northern health care sometimes assume a role for experts who must "safeguard the Inuit and northern planners against themselves". A cultural argument is utilized, but control and resources are safeguarded until "the Inuit are ready". Northern professionals' ability to make appropriate decisions are even disputed on personal and professional grounds: "they could not get a job in the south".

> Kuujjuaq c'est une société d'Inuit et de blancs. Les blancs vont là pour l'argent et le pouvoir... Ce n'est même plus *un sacrifice* que d'aller au nord (Interview 301-19: 4).

From the planners' perspective then, the discourse of community health serves to define distinctions between inadequate and ideal planning, and to determine successes and failures. Their perception of community dynamics[77] may be utilized to explain community involvement, or the lack of, within an institution: the nature of the institution itself, its rapport with the community and the larger context of health politics become somewhat secondary. Professional involvement is stressed over community involvement in successes. In cases of failure, Inuit lack of commitment, northern politics and individual's personality are blamed.

While communities appear to rely on community involvement in health care as a measure of success, the strengthening of a regional order will not necessarily lead to a strengthening of community involvement. The linkage between the regional administration and the Ministry, together with the control mechanisms involved in the provision of budgets, place limits on the Kativik Council's flexibility. Five or ten year plans are not likely to represent communities' diversity and be responsive to spontaneous mobilizations:

> L'administration est souvent en retard sur les initiatives venant du terrain, des professionnels et de la communauté. On sent peut-être le besoin de se serrer les coudes, se sentant pris de cours, confronté ou mis devant un état de fait. Maintenant, on sent l'omniprésence de l'administration au nord. Avec le CRSSS, il n'y a plus moyen de bouger sans avoir un gestionnaire dans son lit. Les professionnels sont scrutés à la loupe, pour identifier les initiatives du terrain. Pour être efficace, l'administration devrait supporter les élans de la base. On tend plutôt vers le contraire... On demande... de faire une étude, qui serve de base au CRSSS pour établir ses objectifs et orientations. A partir de cela, on va établir un plan quinquénal. Pis les projets de base qui ne colleront pas se feront dire: concentrez-vous sur nos objectifs, votre projet n'est pas une priorité, veuillez respecter la grille ci-présente... En subordonnant les problèmes identifiés localement à des

[77] Inuit culture, gender relations, family relationships, political processes, etc

> grilles d'analyse, on ralentit le potentiel de changement. J'ai peur que la techno-bureaucratie reproduise le système de gestion. Au lieu d'un colonialisme blanc, c'est un colonialisme régional. On assiste maintenant à la formation de classes sociales, de stratification des collectivités. En essayant de standardiser les approches, on bureaucratise et subordonne les initiatives et besoins locaux à des plans quinquénaux. Le paradoxe du discours sur la santé communautaire, c'est qu'il conduit à la formation de gestionnaires à l'écoute de leur grille, pas du milieu (Interview 225-49: 53).

To summarize, the community health model provides interesting possibilities for the integration of communities' perspective into health care planning. However, the usefulness of this association is limited. Communities are diverse and see the role of health care in light of their experience and own aspirations. POV and Kuujjuaq share a need for an out-reach form of health care, which is integrated with community activities. But POV also sees the hospital as having a role greater than that of "health care": as an instrument that the community can use in its struggle for autonomy. At the regional level, broader political-cultural arguments are favoured to support relocating decision-making in the north. Regional entities, however, appears to be fighting for the expansion of their own power[78] and are not necessarily able to and/or interested in being responsive to community needs. Nevertheless, the underlying themes called upon in regional debates over self-determination in health care: culture, autonomy and self-responsibility, were given greater legitimacy through the community health model. It appears that the agendas at work at both the community and regional levels go beyond the confines of the community health model: the health care system in the north is absorbed into political debates relating Inuit to the dominant society.

4.2. Operationalizing Self-Determination in Nunavik Health Care

Debates in the discourse on self-determination in aboriginal health care were examined in Chapter 1. It was argued that while self-determination is called upon as a cure-all for disparities in health and problems encountered in or because of health care, the operationalization of self-determination in health care is rarely ever explored. In Nunavik, para-professionalism and Inuit

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[78] This is often justified by the apparent necessity of having one unified voice communicating and negotiating with the Quebec Ministry of Health

employment are prized avenues through which Inuit hope to take control over a foreign structure. In POV, these avenues allow the community to fulfill its independence from the regional government.

The next sections will review the context of operationalization of self-determination in health care in Nunavik. While a commitment has been made to hire and train Inuit for para-medical and medical professions, educational obstacles have contributed to the reification of the complexity and perceived superiority of biomedical knowledge. This reaffirms Inuiit dependence on and submission to outside expertise. Yet, the community agenda in pushing for a midwifery run by Inuit midwives in POV has led to a very different process, where communities of the Hudson Bay now see the hospital as a vehicle to bring back forbidden/forgotten knowledge. These two examples will be discussed in details.

4.2.1. The Symbolic Dimension of Health Professions

The Kativik Council was established after the signing of the JBNQA, with the mandate to train Inuit to gradually take over the health care structure. The Kativik Council took on the task of promoting the Inuitization of health care in Nunavik. Expectations were conveyed to the younger generation: *they* were the future. This resulted in creating a perception of new opportunities as well as transferring a great deal of pressure onto the shoulders of the more promising students. Expectations came from local politicians as well as the communities. Some families already engaged in local people in power started dreaming of their child becoming the first Inuit doctor or nurse in the country. While expectations from the structure, the communities, some families and the students themselves were high, education remained a major obstacle.

The northern school system has developed considerably in the past fifteen years, but a number of communities offer neither secondary 4 and 5[79] (grades 11 and 12) nor science programmes. Students wishing to pursue higher education found that they must take one or two years of upgrading after the completion of their high school degree, because northern schools tend to be more lax and unstructured than their southern counterparts. Further, northern education focuses on preparing students for higher education, rather that providing technical training which could find immediate application in northern communities (Groupe de Travail sur l'Education au Nunavik, 1991). It is not surprising then to find only a few students interested in finishing high school: the majority await the legal age, 16 years old, to leave school permanently. Of these, some will come back to Adult Education, although this programme has yet to produce a graduate. The Kativik School Board established a Task Force on Education in 1991, to identify ways of solving these problems[80].

Difficulties are compounded in POV. While the hospital has pushed for greater Inuit involvement in health care delivery, achievements remain at the para-medical level (although some Inuit trained in para-medical roles have been successful in securing administrative and upper level management jobs within the structure). Because POV maintains its opposition to the JBNQA, its school has not benefited to the same extent as schools in other communities from the influx of funds. While the school in POV can depend on the community for support and on the dedication of its staff, science curricula, the most expensive to deliver, remain beyond the school's

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[79]The Québec education system differs considerably from that of other provinces. Primary school, termed elementary school, is similar to other provinces. elementary schools offer kindergarten and grades 1 through 6. Compulsory grade 7 was abolished in the early seventies and now serves the purpose of a "catching up" grade for students with learning difficulties. High school, termed secondary school offers Secondary I through V equivalent to grades 8 through 12. There is no grade 13. CLGEP, which stands for Collège d'Enseignement Général et Professionnel, offers two year mandatory programmes for students wishing to pursue university education, and three year professional programmes, such as nursing, dental hygiene and so on. Finally, Québec university programmes are generally three years degrees instead of four as in other provinces.

[80]Although the objective of the Task Force was initially as stated, its membership led the door open for it to be coopted to fulfill other agendas. The Task Force's preliminary report offered little else but non-constructive criticism of the School Board administration and program planning. See Gauthier (1989) for a detailed discussion of the limitations of northern education.

capacity[81]. This results in students perceiving the possibility of employment opportunities being high, while educational barriers remain overwhelming.

In communities where there is no hospital, involvement remains at the level of interpreter or janitor, positions with lesser status than the more technologically-oriented roles. In these communities, the drive to be a nurse may be that much more accentuated, because there are no in-between options. At the same time, the possibility of realizing such an objective is that much more remote, since students have less access to science programmes and para-medical training.

At the time of fieldwork, twelve Inuit students were trying to further their education with a view to getting involved in health care: most had been involved with the Povungnituk hospital as *nunalini aaniasiurnapitt*[82], thus trained to operate within the biomedical health care system. Only two never had direct contact with health care. All, except for two, wanted to be nurses. All had encountered difficulties in being admitted to a nursing or pre-medicine programme.

> I decided [to be a doctor] when I was very young. When I was 8 years old or something, a doctor showed me how to put a cast on a woman who had a broken leg. Then I worked in all kinds of jobs at the hospital as a volunteer, a nurse assistant, a nursing aid. But now that is all over, because I don't want to be in an environment where I am told that medicine is so much hard work. That it is a long process. Also I don't want to be in an environment where people are expecting so much. Today, I am [studying to be a doctor] because I want to do it, not because they need an Inuit doctor. I am doing it because it will make me comfortable, and it will make my people more comfortable. I know I can do it... I used to be nervous, very anxious. Now I want to take it day by day. I am tired of them telling me I'll have no social life, that it will be hard work. I don't want to be in that environment. I have done so many jobs already. I am only 22 and I have done 10 jobs already. I have been a reporter, an information officer, a researcher, a translator, a teacher. I have no regret at all. I could say now I wish I had finished my education. But the past does not matter (Interview 209-01 to 07: 17).

> Before high school was offered here, students were sent south to Ottawa. I went south to Ottawa too. I did not know what I wanted to do either until I was hired to be an interpreter at the nursing station... Then, I only had a grade nine education, so I decided to go back. When in Ottawa, I was a grade A student, until I was given an apartment with a friend, as a reward for being grade A. I got into trouble, drugs, so they sent me back. When I wanted to go back... 2-3 years later, they refused to take me. I still did not know what to do with my life. Then I got hired to be an interpreter... Some nurses would teach me what to do, and they would get to know me and let me do more and more. I got to know a lot, and I

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[81]Such was the case at the time of fieldwork, in the Spring of 1991.

[82]"who are concerned with the health of the community". Their role corresponds to that of auxiliary nurses or "préposés" as indicated on their job classification

> realised that I could do better than some nurses, some were very lax. I realised that I could do it. I started to take adult education..., while working After being away for 10 years, I finally went back for one semester... Then alcohol started being a problem, building up from when I was young. I went for treatment in a treatment centre. It is hard in the south: it is too money oriented, you always need money. People seem ashamed when you ask for money. Here, I just say "I'm hungry" and they give me food. . In CEGEP, I got frustrated with education in the north. The education is very lax, they hide behind culture. We expect the kids to do something, but the education is very lax. Now I have to go back: it's my last chance to do something with my life[83] (Interview 008-01 to 12 16)

The scenario is typical: professional pursuits are hampered by multiple attempts at fulfilling the science requirements, compounded with difficulties in adjusting to a southern academic life. A number of students have been working towards their goal for five to ten years, with limited success.

Students can return north with an "incomplete education" and be met with excellent employment opportunities[84]: as a result of the JBNQA, Inuit employment is favoured at all levels of each institution[85] and on-the-job training is possible in most cases Any high school graduate can find employment (Interview 224-06). What drives students to pursue dreams of becoming nurses or doctors for years, despite multiple defeats, is not the scarcity of employment, neither is it the economic aspect. While most students have privileged access to para-professional positions in the health care structure that are well-paid even for the north, easing access to housing, and providing them with freight allowances and travel assistance, the focus remains on traditional western health care roles: nurses and doctors. Only one student aimed at becoming a midwife through the POV programme: this student had unsuccessfully attempted to be admitted to a nursing

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[83]This comment must be brought in context After three failed semesters, students attending CEGEP are asked not to return At the time of fieldwork, three students were "on their last chance": they were attempting to accumulate CEGEP science credits to qualify for admission to nursing, and one failed course, because of previous failed attempts would mean definite expulsion

[84]Students will not be stigmatized by their families or the community for "dropping out". this is perceived as a matter of personal choice and respected

[85]It is significant that the Federally funded Canadian Employment and Immigration Centre's human resource development programmes have assisted most institutions, businesses and political agencies with on-the-job training funding for Inuit Health, however, falls outside of these programmes' criteria

programme for at least three years and had already spent the same amount of time taking science courses in the south.

Involvement in health care as nurses and doctors has taken on a deeper meaning than that of a career in the southern sense. It appears to be linked with self-perception and self-definition within the new political order. Traditional biomedical roles have taken on a symbolic dimension, for a generation who is looking for a way to integrate itself within the new order. They are looking for a role which will be meaningful in both worlds[86]. Para-medical roles, often perceived as "discount health care"[87] by Inuit, do not have the same appeal: they are jobs, not goals. The roles themselves, however, deserve close attention, since it is through them that the new socio-political order becomes negotiated.

It appears that the structured and restricted contemporary health care giver role is largely an outgrowth of outside influences on Inuit culture. The same can be said of the para-medical roles mentioned above. the crystallization of socially meaningful (and powerful) roles through an educational process divorced from the social context, is foreign to Inuit culture[88]. Para-medical roles have had different levels of successes in integrating Inuit and local knowledge into the health structure. Further, some roles have been able to achieve both local and professional recognition, while others have been disconnected from the spirits in which they originated and reintegrated into more technocratic and servile roles.

With the JBNQA, Inuit were expected to take over the delivery of health care. Emphasis was on training: the gap had to be bridged. On the Ungava coast, initial attempts at involving more Inuit in the structure were, however, incomplete and ill-planned, resulting in much dissatisfaction. A first class of auxiliary nurses graduated in 1976, in Kuujjuaq. This course was attempting to

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[86]Some entertain the goal of leaving the north and are looking at nursing as a way to reach that goal.

[87]"La santé à rabais"

[88]This is of course an anachronism: I am talking of Inuit culture in terms of the past to bring meaning to a current process. The assertion should be rephrased as: it is doubtful that this process would have evolved if Inuit had led this process

address the problems of high nursing staff turnover by training an indigenous staff who would assure continuity and facilitate the integration of nurses as collaborators. It appears that the training offered was quite extensive, aiming at relieving some of the burden of the regular nurses. An evaluation carried out two years later showed only a partial integration of these auxiliary nurses into the structure, the main reason being that this integration had not been planned for. Dufour (R., 1979), who evaluated the role of the auxiliary nurses demonstrated that only a few were given the opportunity to take on significant responsibility: the tasks they could perform were not delegated to them. Dufour concluded that in effect, the auxiliary nurses essentially performed the task of interpreters[89].

In POV, the recognition of a difference in cultural approach to health and illness and an acknowledgment of the educational gap pushed planners towards the creation of para-medical roles to operate within the health care structure. Most of these roles do not exist per se in the south. Except for midwifery which will be discussed below, none of the para-medical roles have any resonance in Inuit culture. The results have been mixed, depending on whether a particular role was comparable to something existing in the south: comparable roles have been the least successful. For example, the *nunalini aaniasiurtiapiit* (POV) are generally utilized by nurses and doctors as "préposés"[90], with the burden of bed making, emptying bedpans as opposed to teaching patients, translating and gradually taking over a larger part of the nurses' role. While their training aimed to allow these graduates to take on more of the nurses role over time, hospital dynamics, staff rotation as well as a southern emphasis on professionalism have defeated these intentions. A number of trained Inuit have lost confidence and left, others are holding on with

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[89]A number of factors contributed to the limited success/failure of this project. No training had been offered to nurses in order to prepare them to share their role with these new health professionals, no role had been established for the auxiliary nurses in the health care structure. The high staff turn-over compounded the problem: in the dispensaries, six out of eight nurses were replaced twice in six months in 1976. In Kuujjuaq, the average stay for nurses was of four to six months. These factors contributed to limit or prevent the integration of the Inuit auxiliary nurses into the structure. Further, although monies for indigenous staff training are available through a number of avenues, jobs remain limited. Until very recently, capitalizing on local health-trained staff was not a priority. Accordingly, recent promises by the Minister of Health that a nursing course would be offered in the north were received with scepticism (Interviews 213, 216).

[90]Auxiliary nurses

frustration. Another group has realized that the only way to secure the place they want is through formal education and are pursuing this avenue, with modest success.

While there was hope that Inuit working as *nunalini aaniasiurtiapitt* and nursing assistant would be able to integrate Inuit knowledge into health care delivery, this has not been the case. Again, a number of factors are at work, but perhaps the most significant is linked to the dynamics of a generation that was recruited for these roles:

> I am of the generation who knows nothing of the culture. My mother died before I could have a chance to ask her to teach me. I am also married to a white, and his culture is more dominant, because it is all around me. I would like to learn about the old ways, now. I would like to see that knowledge in the hospital, but is that what the people want (Interview 216-11 to 12: 34-35)?

Other roles have been more successful in generating recognition: the hearing specialists are the best example, for a number of reasons. They are addressing a critical problem: otitis media has a much higher prevalence in indigenous populations around the world (Dufour, 1989b, 1990b), it is a chronic problem which often leads to significant hearing loss. Hearing specialists are Inuit who use portable equipment to do screening, some treatment, preventive teaching as well as prosthetic fitting. The approach is unique because it is community-based, and is the envy of a number of agencies and other countries[91]. Its success lies in the fact that from its inception onward, the trained candidates were to be "the specialists" and operated as such. When the need for referral for treatment or interventions runs beyond their abilities, audiology services are assured by a team from the Montreal Childrens Hospital who travel north as needed, but are not in a position to subordinate the local specialists. Hearing specialists have been able to secure some professional recognition among other health professionals. Their role however, does not appear to be distinguished as special by the community. Of all para-professional roles created, Inuit midwives enjoy the most recognition by both Inuit communities and southern professionals working in POV. The factors at play require close attention.

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[91]See Crago, Hurteau & Ayukawa (1990) and Tourigny, Couture and Joubert (1991) for a review of this programme

4.2.2. Culture, Community Ownership and Midwifery

> The grandmothers, the mothers and the daughters got together. It was illegal, but we did it: we build our maternity (Interview 004-12: 5).

The Povungnituk midwifery programme[92] has been the most documented, discussed, filmed, studied and envied of all the local training programmes (Dufour, 1989a; Gagnon, 1989; Native Women's Association, 1989). No doubt, it was the existence of some commonality between Inuit and "southern" midwifery that made this project feasible, successful, and so visible[93]. Inuit midwives enjoy both professional and community recognition. The community seems to perceive midwifery as evidence that professionals are willing to give back the tradition they destroyed/displaced (Interview 101).

> They came and took over everything, even delivering. We did not need the nurses but they insisted. For TB, it was different. But they took for granted that we could not look after ourselves because we needed pills for TB. They took over birthing... It was not the first time that white people started coming in. The first time was around 1920. People then used to share. They did not take everything. Only the nurses did. White people in the 1920 used to share, help people with their home remedies. Earlier than 1960, white people helped with what they could and what they had. We hardly have home remedies any more -- we lost a lot of things because [foreigners] started coming in. Now white people are starting to give our tradition back, i.e.. Inuit midwives, and that is positive (Interview 101-15 to 20: 2).

> Having a maternity in our own community has given us a chance to make up our own goals. And for us right now, sharing information is a very big priority We do it in our own language. We, as Inuit midwives, know our own people. We know things Qallunaaks (*sic*) can't know. We are being trained and we are bringing the knowledge back to our community (Qumaluk, 1988: 2).

This project has achieved what no other programme could: its role extends beyond the health centre and addresses the needs of a population as defined by it. Its impact has been much deeper than that of midwifery: it appears to have brought back a desire to integrate local knowledge into the health care structure.

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[92]It is beyond the purpose of this section to present a comprehensive evaluation of the Inuulitsivik maternity. Such an evaluation, however, is available and very informative. See Meyer & Bélanger (1991) and " urigny, Ross & Joubert (1991a, b & c).

[93]No doubt, the resurgence of this profession amongst a cross-section of professionals at a provincial level, and to the influence of feminism on the biomedical institution, were essential components in the success of this programme.

What is being "given back", however, differs from what was "taken". Historically, there was no "standard practice" for Inuit medical practice: every camp seemed to have its own pattern for decision making and its own treatments. In some camps, decision making for treatment was made by the whole group, in others, it was the privilege of elders. In some camps, helpers for delivery involved only women who had children themselves, where in others, youths including young men were invited to attend (Interviews 021, 022, 025 & 219). Visiting the sick was a social expectation. Inuit interviewed on their traditional medical knowledge generally emphasize the social context of healing, with regrets. The treatments themselves are given less importance.

The history of this project was briefly discussed earlier: the newly formed hospital included a perinatal programme established in 1986, under the leadership of the local Native Women's Association and with the support of other community organizations (Dufour, R., 1989a). Its objectives were to:

1. keep as many deliveries as possible in the north;
2. encourage the reintegration of cultural know-how into obstetric and perinatal care; and
3. offer support in the prenatal -- postnatal periods.

This programme evolved from the Povungnituk hospital's orientation, which apparently aims at facilitating an Inuit take-over of health planning and services. The perinatal committee is formed by doctors, dentists, pharmacists, professional and student midwives (the latter are Inuit who will replace white midwives upon graduation). Dufour suggests that these Inuit student midwives take an active role as part of the committee, in planning strategies and interventions (1989a). The learning process is through apprenticeship. Strategies and interventions are also shared with the community in meetings, which aim at what Dufour describes as a "communication symétrique et complémentaire" (1989a: 9) where knowledge is exchanged between all parties, including health care workers, nurses, social service employees, maternity workers, school age children, elders, pregnant women, the community council, etc. The programme is to be extended to other communities located on the Hudson Bay, although an actual time frame has not yet been defined.

It is however a priority, because of the importance given to birthing and to the community of origin:

> White man took away the most important thing, we used to deliver our babies, it used to be a joyful thing. It's not the same now, when they arrive by plane... Even when they go to Inuit midwives at POV, it is not the same as when the delivery was at home. Family and friends all used to visit when the new baby came. Now it does not happen any more. They don't see the baby any more. They don't even visit when the new baby comes back Inuit simply don't want to mislead the white man to think that they don't appreciate everything that they have done for us. The white man does not trust us on our own efforts (Interview 101-20 through 26: 2-3).

The place of local knowledge in midwifery and in the spatial arrangement of the clinic can be considered as indicators of the difference between what was "taken" and what is "being given back". This is done consciously, in an effort to "improve" what existed traditionally and to answer to perceived and expressed wants and needs from the women in the community:

> Southern midwives introduced the concept of the uterus, why women get pregnant, a concept of the body. We have extended the role of the midwife, we are giving more than what the traditional midwife used to give (Interview 002-17)[94].

Asked about the place of local knowledge in midwifery, an informant replied:

> You are right to be concerned about this. But the qallunaat are outnumbered here: 99% of patients speak Inuktitut, 75% of the care is in Inuktitut. Midwives are constantly bombarded by the community. Now their information is mostly white, but one day they will outgrow this. They will be in charge and it will be up to them to decide where the maternity should go (Interview 024-25: 47).

The spatial arrangement of the maternity, although very familial, is "southern":

> We have the dream birth centre from the south, now we need more Inuit physical prop, ropes, the box to squat, different positions. It is not that it is forbidden, but the [double] bed takes a lot of space and there is no incentive for anything else. The woman that started this had a strong focus on "techniques". Now we need to move on, to relax this and let women decide what they want, to give them options (Interview 007-02, 03)

Maternity care is soon to face a new challenge imposed by a southern tradition In western institutions, literacy is essential to leadership. In small governmental departments, it is customary for the coordinator, or the head, to do the administrative duties (the paperwork), because through it

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[94]It is doubtful that southern midwives introduced the concept of the uterus and pregnancy to Inuit culture, although it is a common attitude among southern professionals that Inuit culture had little knowledge prior to contact. The role of the midwife has however grown under the influence of southern midwifery, to include the promotion of biomedical precepts of prevention and post-partum care.

decision-making is made: paperwork is power. This means that the most competent people are taken away from their field of expertise to carry on administrative duties, a fact which will challenge Povungnituk:

> I am now the coordinator, which means a lot of paperwork. If [the Inuit midwife] who is now ready to graduate, although she still needs some direction with the paperwork, becomes coordinator, she will be plagued with paperwork. We will effectively take her away from what she is best at: being a midwife (Interview 007-06: 13).

4.3 Reflections and Conclusions

Community health discourse is a vehicle which Inuit utilize in their pursuit of greater autonomy. It allows for cultural, geographical and political arguments to be formulated in a way which imbues them with an aura of legitimacy. Povungnituk's resistance to the regional government, the integration of Inuit knowledge into the biomedical system, attempts to bring back the social context of healing, regional self-determination, the relocation north of resources and budgets now administered in Québec City, are examples of agendas which are being legitimized through the manipulation of this discourse. The aims, however, go beyond the usual boundaries of health care. What is at stake and what is being negotiated through the discourse of community health is the place of Inuit in the face of the dominant society, and Povungnituk's place in the face of the Kativik Regional Government.

The James Bay and Northern Québec Agreement has indirectly, through the mobilization it necessitated, initiated or at least facilitated a process whereby Inuit see and use the northern health care institution as a vehicle for cultural self-actualization. The provision of a hospital in Povungnituk, and the northern commitment to promote Inuit employment in health care were elements which were secured through the JBNQA. Despite current obstacles to Inuit employment, Inuit perceive that they are beginning to recover some of the elements of their culture which was taken away by colonialism:

- A first which is readily mentioned is midwifery;
- A second, more subtle perhaps, is the community's reclaiming of northern institutions.

The same mechanisms, however, also allow for the recolonization of Inuit knowledge: traditional Inuit midwifery, which was "taken away" differs considerably from what is being "given back".

Still, the recolonization of Inuit knowledge is perceived as temporary, and as a step in the process of Inuit self-determination in health care. The health care system must first be decolonized in terms of human resources for decolonization in terms of knowledge to happen. Informants in both Povungnituk and Kuujjuaq agree that the former is ahead in this process. As the Kativik Council slowly succeeds in securing greater control over community health budgets and resources through the use of community health arguments, individual communities may find themselves faced with a new challenge: that of maintaining a voice in the face of what one informant called "regional colonialism" from both "whites" and Inuit representing regional organizations (Interview 225).

CONCLUSIONS

> From time to time we get calls from the south, to adopt Inuit children. I brought the matter to the community. The answer was clear: we will accept that whites adopt our children when white will allow us to adopt theirs (Interview 217-15: 37).

Sixteen years have passed since the signing of the James Bay and Northern Québec Agreement. Community health theorists, anthropologists and health care planners are still relying on concepts such as dependency, social disruption and cultural assimilation to formulate arguments to address issues of control and power over decision-making in northern health care. A second James Bay project is now under way. The Kativik Regional Government has just announced its wish to negotiate a "comprehensive land claim settlement" with the Government of the province of Québec (CBC, March 1993). And Québec is undergoing or at least attempting yet another reform of its health care system, this time "centred on the citizen" rather than on the structure, with a commitment towards decentralization, the answering of special interest groups' specific needs, and on the curtailment of costs (Québec, 1990).

Within the confines of this reform, community/public health is intended to be strengthened through the creation of regional directorates of public health, which, under the direction of Deputy Ministers of Health, will develop strategies of intervention which regional entities, such as perhaps the Kativik Council will be mandated to implement (Québec, 1990). This contrasts with a regional discourse which aims at relocating decision-making in Nunavik, and a community discourse which wants to break down the barriers between the community's wants/needs and the northern biomedical system. These wants and needs often go beyond the usual mandate of health care. The discourses of community health in Canada are diverse.

The real test of the reform lies with its implementation. the terms of implementation will specify whether Inuit will be able to work with and/or maneuver through the prescribed policies and procedures issues from the reform to respond to the (perceived) needs/wants of Inuit

communities and society. A study of the mechanisms and strategies utilized in this process would constitute an interesting follow-up to this thesis.

In some ways, the context of health care in Nunavik has undergone dramatic changes. Substantial gains have been secured:

- Inuit employment in health care has grown beyond interpreting to include upper level management, paramedical roles, finance, support staff and janitorial;
- resources, dossiers and budgets long administered from Québec City are now controlled from Kuujjuaq;
- Hudson Bay Inuit women are no longer expected to travel to Moose Factory (Ont.) to give birth, but can do so in a northern (initially illegal) pilot maternity project.

The JBNQA created a momentum whereby Inuit now assume a considerable part of decision-making with regard to the northern biomedical system.

Perhaps the major change in Nunavik since the JBNQA with regard to health care is in the way Inuit formulate their demands The Agreement created an opportunity for Inuit to learn and master a powerful discourse: the discourse of community health. The way in which the discourse of community health developed in Canada over the past sixteen years has offered new avenues for Inuit to justify their wishes The resurgence of welfarism in the nineteen-fifties paved the way to the development of the community health discourse, facilitating its association with basic human rights. The aboriginal rights discourse allowed Inuit self-determination in health care to become embedded into a broader and powerful context.[95] In a way, this convergence of discourses acted synergetically to facilitate a process of self-determination: arguments favouring para-medical employment opportunities, community involvement in health care, the reliance of cultural arguments in justifying regional relocation of decision-making are now invested with an aura of humanitarian legitimacy which has been utilized widely in all these discourses The development of para-medical roles is associated with a process whereby Inuit believe that their traditional "subjugated" knowledge can be brought back and integrated within the northern health care

[95]Perhaps it is the larger context which made self-determination in health care conceivable

system. Povungnituk's midwifery is perceived as the beginning of a process whereby southerners are "giving back" Inuit their culture. It is fair to say that the changes brought upon through the JBNQA facilitated:

- the decolonization of the Inuit self, whereby Inuit see the biomedical institution as their own, and capable of being shaped in their pursuit for cultural self-actualization; and
- the recolonization of Inuit knowledge, where the biomedical institution in turn shapes the knowledge Inuit integrate within this institution.

The two processes are, at least for the time being, complementary. From one informant's perspective (an Inuk health administrator), this situation is temporary: Inuit working in health care may have to replicate a foreign system for the time being. The influence of the community, their own culture, and the power of numbers is expected to change this situation over time. If this vision is accurate, than the operationalization of self-determination in health care in Nunavik may be a multi-phase process, where Inuit must first master the foreign knowledge to be able to enter the field of health care, second ensure that Inuit employment in health care is facilitated, and third accede to the decision-making level, to finally see the decolonization of health services. In this process, knowledge may be temporarily recolonized or perhaps permanently modified. While it is difficult to assess whether significant decolonization is taking place, informants seem confident that a process of decolonization had begun and would eventually lead to true self-determination.

There can be no doubt that the mobilization inherent to the process of negotiating the JBNQA opened a door for Inuit to begin the decolonization of the northern health care system. The community health model has provided a mechanism allowing Inuit unprecedented gains in securing more control over their health care system. Communities perceive the (potential) role of the biomedical system in a way which goes beyond its usual boundaries: Povungnituk is a case in point. Inuit midwifery is being reshaped through the medical model. The local push to "bring back" midwifery was motivated by the hope of bringing birthing back to all Inuit communities. This has proven to be a slower process than what was anticipated/wanted by the communities.

In Nunavik, health practitioners, bureaucrats, political leaders and community members all capitalise on the discourse of community/public health to formulate arguments supporting or opposing Nunavik in securing greater control and autonomy over its decision-making in matters of health care. Yet, what regional and community leaders are seeking goes beyond what the community health model has to offer. There are grounds to wonder if the integration of a political process into a model which evolved from biomedicine may be double edged What will happen to Inuit aspirations as new biomedical paradigms develop? While the deterministic discourse of community health has favoured aboriginal societies' quest for self-determination, one may wonder about the future of this discourse. Land claim settlements are not as generous as they used to be, social programmes are eroding: the fundamental social reforms this discourse demands may be a thing of the past, given current trends in an economically depressed Canada.

Still, in sharp contrast to the current claims of Inuit dependency, acculturation and apathy, the analysis provided in this thesis shows how the northern biomedical system is becoming absorbed into the life world of Inuit, and is in fact becoming part of the process of a people's reclaiming of its perceived rightful place in the new Canadian society. Inuit are actors and consumers of various paradigms. This may not be a recent phenomenon, but it is certainly a requirement of self-determination:

> I have black in my sputum now. An elder told me to tie my finger like this96. If I went to the nurse, they would put a tube down my nose, and I feel that the finger works better Some Inuit medicine works better. I'll try this one first. If it does not stop the bleeding, I'll go to the nursing station (Interview 103-07 to 09: 8).

96A red string was tied around one of her fingers, keeping it folded

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