

**Building Community-Based HIV and STI Prevention Programs on the Tundra:
Drawing on Inuit Women's Strengths and Resiliencies**

by

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B.Sc., Dalhousie University, 2004

A Thesis Submitted in Partial Fulfillment of the Requirements for the degree of
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In the Social Dimensions of Health Program

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Supervisory Committee

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Abstract

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There is a dearth of literature to guide the development of community-based HIV and Sexually Transmitted Infection (STI) prevention and sexual health promotion programs within Inuit communities. The aim of this research project was to create a dialogue with Inuit women to inform future development of such programs. This study employed Indigenous methodologies and methods by drawing from Inuit Qaujimajatuqangit and postcolonial research theory in a framework of Two-Eyed Seeing, and utilizing storytelling sessions to gather data. Community-Based Participatory Research Principles informed the design of the study; ensuring participants were involved in all stages of the project. Nine story-sharing sessions took place with 21 Inuit women ages 18-60. Participants identified several key determinants of sexual health and shared ideas for innovative approaches that they believe will work as prevention efforts within their community. These research results build upon the limited knowledge currently available about perceptions of HIV and STI among Inuit women living in the remote north.

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List of Acronyms and Abbreviations

AHS: Alberta Health Services	NAHO: National Aboriginal Health Organization
AWHHR: Aboriginal Women's Health and Healing Group	NCCA: National Collaborating Centre for Aboriginal Health
CAAN: Canadian Aboriginal AIDS Network	NTI: Nunavut Tunngavik Incorporated
CAHR: Canadian Association for HIV Research	NWAC: Native Women's Association of Canada
CBPR: Community-based participatory research	NWT: Northwest Territories
CHDC: Community Health Development Coordinator	OCAP: Ownership, Control, Access and Possession
CHN: Community Health Nurse	PHAC: Public Health Agency of Canada
CHR: Community Health Representative	PID: Pelvic Inflammatory Disease
CIHR: Canadian Institutes of Health Research	RCMP: Royal Canadian Mounted Police
HIV: Human Immunodeficiency Virus	RN: Registered Nurse
ICAP: International Centre for Alcohol Policy	SAO: Senior Administrative Officer
ITK: Inuit Tapiriit Kanatima	SDoH: Social Determinants of Health
IQ: Inuit Qaujimagatuqangit	STI: Sexually Transmitted Infection
KT: Knowledge Translation	TCPS2: Tri-Council Policy Statement, 2 nd Edition
KTE: Knowledge Translation and Exchange	WHO: World Health Organization

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Chapter One: Introduction

This research project seeks to explore the determinants of Inuit women's sexual health, to provide information to better inform programming for Inuit women, to promote sexual health and to prevent the spread of Human Immunodeficiency Virus (HIV) and Sexually Transmitted Infections (STI) within their communities. By drawing upon Inuit knowledge as well as equity theories and methods, I will highlight the social determinants of sexual health, the strengths and resiliencies of Inuit women in this area, and the situations that place Inuit women at risk for negative sexual health outcomes.

This study is a community-based participatory research (CBPR) project. It situates Inuit women at the centre of each stage of the research process, from initial design through to 'meaning making' (i.e., analysis), and on to the translation, exchange and dissemination of knowledge. Drawing on Inuit women's stories of strength and resilience, I explore their lived experiences of sexual health as well as their perceptions of what might constitute the most effective community-based prevention and promotion programming.

The sections that follow are meant to guide the reader through my process. Within the literature review, I will strategically summarize research and scholarship related to the status of Inuit women's sexual health as well as the social determinants that most directly influence their sexual health. Following this, I will describe the methods of data collection employed, the theoretical frameworks through which the research findings were analyzed, the process of meaning making, and the dissemination plan of resulting knowledge.

Researcher Location

“To locate is to make a claim about who you are and where you come from, your investment and your intent” (Abolson & Willett, 2005, p.97).

My roots

I am from Blomidon, Nova Scotia, the traditional territory of the Mi'kmaq People. Specifically, Blomidon is the area that was home to the legendary Mi'kmaq God, *Glooscap*. I also consider Kugluktuk, Nunavut home; this is the land of the Copper Inuit. My ancestors were French and British settlers. I grew up in Blomidon, and when I was in the second year of my undergraduate degree my parents and younger brother moved to Kugluktuk, so Kugluktuk became my home away from school. I spent Christmases and summer holidays in the community and was immediately *adopted* by various families. A day rarely passed when my parents were not asked, “When is Jenny coming home?” When I did go home to visit I was asked by everyone I saw, “When did you get home?” or “How long are you home for?” Over the past 11 years, I have had the opportunity to develop strong personal and professional relationships with the people of Kugluktuk; I feel *at home* in Kugluktuk.

My career

I began my community health career on summer breaks from my undergraduate studies when I worked summer contract jobs for the Nunavut Government. After completing my bachelor's degree and working for several years in the Sexual and Reproductive Health Program at Alberta Health Services (AHS), I came to live and work in Nunavut full time in 2009. Prior to working as the Community Health Development Coordinator (CHDC) for the Kitikmeot Region in Nunavut, I took leave from my position at

AHS and completed a four-week contract in community sexual health education in the fall of 2007 in Kugluktuk. Within this project, I focused on working with the community to provide culturally relevant sexual health information and resources. Building on the success of this project, I began replicating it throughout the region when I started working as a CHDC by continuing to conduct sexual health education programs and providing training and resources for schools and communities.

This work gave me opportunities to meet with youth, adults, parents, and Elders across the region. I felt conflicted when the instructions I was receiving from upper levels of government did not consider or align with the desires and needs of the communities with which I was working. I felt the government structure did not allow voices from the community to inform directives, policy, and programming. In fact, I had been instructed by my supervisors to do things that I knew were considered low priority for communities. With these challenges and conflicts, I chose to leave my position and pursue a graduate degree focused on understanding these experiences and ways to influence the process.

Strength and Resiliency

One of the things I came to realize about the Inuit women whom I had met in Nunavut, was that they possessed a tangible strength and resiliency. These women, despite having inadequate social-structural resources to support optimal health outcomes, were raising families; they were heads of households; they were running communities. These women have been left out of the research dialogue for far too long. It is their voices and stories that are the key to working against the various disparities they experience. The

strength and resilience I have seen among the Inuit women whom I have had the honour of knowing, is articulated here:

There is a force among women, which I call âhkamêyimowak, or persistence, that provides the strength for women to carry on in the face of extreme adversity.

Âhkamêyimowak is a Cree word and embodies the strength that drives women to survive, flourish and work for change within their communities (Settee, 2011, p.III).

My graduate research focus is shaped by my experience living and working in the North, and getting to know the communities as I have. This project reflects my commitment to documenting the knowledge and insight of Inuit women's perceptions of the determinants of sexual health, and to ultimately ensure Inuit women's knowledges are documented to influence and inform programming and policy-making where it has previously been left out.

My worldview

My worldview is shaped by my family and upbringing, which includes the Western educational system, a fierce respect for the traditional Mi'kmaq territory I was raised on, and the core value that my father and mother always instilled in my brothers and me to "always treat others as you would like to be treated". My life has also been shaped by the people and places I now consider 'home'. I have a humble respect and appreciation for Inuit societal values, which resonate and align with my own values, and in turn influence my worldview.

My relations and my research

Despite my long-standing relationship with Kugluktuk, once I began graduate studies I quickly felt some discomfort as a non-Inuit conducting a research project with an Inuit community. Indigenous research literatures reflect a tension in the work around whether decolonizing and Indigenous research methodologies can be performed by non-Indigenous scholars. Being away from Kugluktuk, in the academic setting, and exploring the literature around Indigenous health research made me question whether I should pursue this research at all. I knew I had the full support of the community; however, it felt as though it would be difficult to have Inuit worldview at the forefront, because, as someone of settler ancestry, this worldview is not mine. I then discovered Albert Marshall's principle of Two-Eyed Seeing (Bartlett, Marshall & Marshall, 2012). As soon as I started to read about Two-Eyed Seeing, it was evident; I had found the framework that would fit this project.

I had the joy and pleasure of meeting and speaking about my project at length with Mi'kmaq Elder, Albert Marshall¹. I explained some of my uneasiness about reconciling what the literature says about non-Indigenous researchers conducting research within Indigenous communities and my feelings about my 'location' in the process, as well as my struggles to honour the community based and participatory nature of my study, while at the same time having an overwhelming need to go home to Blomidon in order to write. After listening to the details of my relationship with Kugluktuk, my settler ancestry, the desire to collect stories and go home to Nova Scotia, he stopped me and said:

¹ Albert Marshall is an Elder from the Mi'kmaw Nation, he is from the Moose Clan, and he is the person who, in 2004, brought forward the principle of Two-Eyed Seeing. Albert is the designated voice on environmental matters for Mi'kmaw Elders in Unama'ki-Cape Breton (Bartlett, Marshall & Marshall, 2012)

I think you're too hard on yourself! Can you not accept the fact that you have a unique gift of being able to weave back and forth between two worldviews, and you're not only accepted by this community you are doing research with, but you are embraced by them... You are a gift to this community, and they need you, just as you need them. Each of you with different capacities... that, my friend, is Two-Eyed Seeing... you are an artist, not as someone who recreates visuals, but as someone who articulates, and do you think that Picasso sat out in the hustle and bustle of a busy street where there is much commotion to do his art? Going home is your retreat, and if you need to do that, to leave Kugluktuk in order to find the peace you need to write and to do justice to the work you are doing with the community, that is what you need to do.

I believe that my close relationship with Kugluktuk, my understanding of culture, land, people and place, and the significance of storytelling within Inuit traditions are important components that influence my worldview. I believe my uneasiness, despite years of acceptance within the community, helps to ensure I will complete this research project in 'a good way'. It also reflects my learning – to be comfortable is to continue to do what you already know which is not learning; the learning happens in the discomfort and questioning and reflection. I understand now, that the uneasy feeling I carry, and the fact that I question whether I am the person that should be facilitating this project is a reflection of my critical analysis and sensitivity to settler history and privilege. All of this, however, can be challenged and mitigated through continuing to return to - and allowing myself to be led by - the community and its priorities. This orientation to the work aligns with the tenets of community-based research, which places the community as experts and provides grounding for the uncertainty of the process.

Background and Community Profile

Inuit are one of the original peoples of the land called Canada (Inuit Tapiriit Kanatam (ITK), 2004). Although Inuit have lived in Canada's north for thousands of years, for the purpose of this paper, only a brief historical glimpse of the past 100 years will be given to help frame the context of modern Inuit life.

Traditionally, Inuit lived a subsistence driven, nomadic life, directed by the seasons (Bonesteel, 2006). Until the 1950s, "most Inuit lived on the land with their extended family in small, transient camps that moved according to wildlife migrations and the seasons" (ITK, 2009, p. 6). The Government of Canada began urging Inuit to settle permanently in communities where they were provided with modern stores and medical facilities, and where permanent housing was built for them (ITK, 2009; Pauktuutit, 2006).

Today, the majority of the 45,000 Inuit in Canada live in 53 remote northern communities. These communities are located within four Inuit Arctic regions: Nunavik (Quebec), Nunatsiavut (Labrador), Nunavut, and the Inuvialuit within Northwest Territories (NWT) (ITK, 2007; Smylie, 2008). Nunavut is divided into three regions, the westernmost of which is the Kitikmeot with a population of 5,400 (ITK, 2004). The communities within the Kitikmeot include: Cambridge Bay, Kugluktuk, Umingmaktok, Bathurst Inlet, Taloyoak, Gjoa Haven, and Kugaaruk (ITK, 2004). This research project took place in Kugluktuk, the westernmost community in the Kitikmeot region.

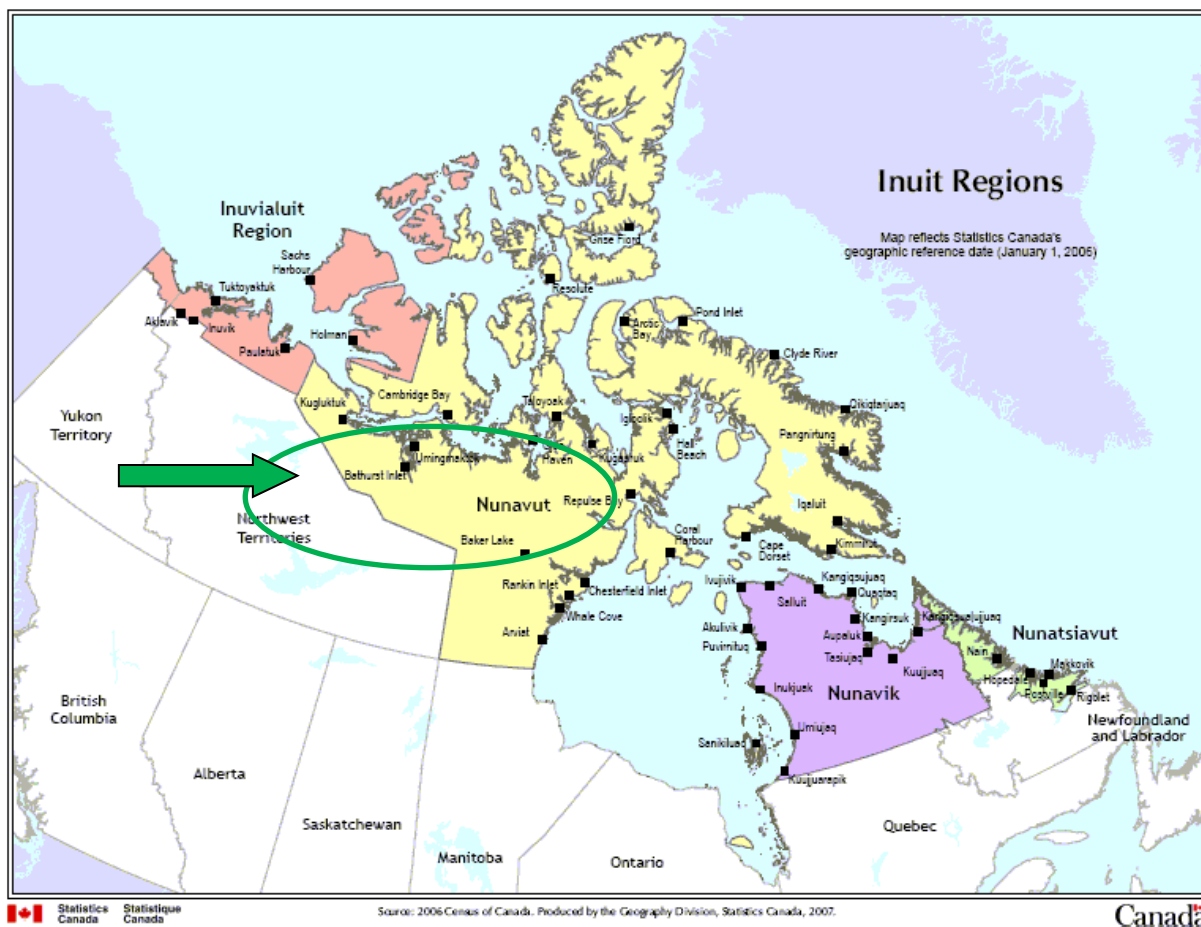


Figure 1: Four Inuit Regions, Green Circle depicts the Kitikmeot Region of Nunavut

According to the 2011 census, the population of Kugluktuk is roughly 1,450 (Statistics Canada, 2012), with approximately 92% identifying as Aboriginal, exclusively Inuit (Statistics Canada, 2007). Typical of many northern Inuit communities, Kugluktuk has a health centre, an RCMP station, three churches, two grocery stores, a hamlet (municipal) office, an airport, a local radio station, two schools, a day care, a territorial office building within which regional and territorial government departments are housed, and various community organizations (e.g., Hunters and Trappers, women's group, etc.) (Pauktuutit, 2006).



Figure 2: Kugluktuk, Nunavut, May 2012

Sexual Health Services within Kugluktuk

There is no official documentation or literature that outlines the health care services available in Kugluktuk; therefore, in order to illustrate the available services and programs, information was obtained through personal communication with a long-term health professional from within the community. Donna Rand, RN, CHN, (Registered Nurse, Community Health Nurse) has worked in Kugluktuk for over 12 years in various positions including: Regional Manager of Health Programs, Supervisor of Health Programs, Community Health Nurse, and Home Care Nurse. She has an extensive knowledge of the services within Kugluktuk. The following information is a summary of the information obtained from a conversation with Donna Rand.

Kugluktuk's community health centre is staffed by five nurses, as well as a locum doctor who is available in person approximately 75% of the time and by phone the remainder of the time (D.J. Rand, personal communication, November 12, 2011). Specifically regarding STI and HIV prevention and sexual health promotion, the following services are available at the health centre:

- Routine STI testing for men and women, HIV and Syphilis testing is conducted routinely as part of follow-up for positive STI results (i.e. Chlamydia and Gonorrhoea);
- Free condoms available throughout the health centre, and at various public places within the town;
- Well-woman clinic (weekly) including: pap tests, STI tests, birth control education and prescriptions, breast health education, and breast exams;
- Pregnancy testing and counseling;
- Weekly prenatal clinic, which includes routine HIV testing.

Women are scheduled for a well-women clinic visit once a year. Prenatal appointments occur monthly for the first trimester, increasing to twice a week, and then once a week up until the woman leaves the community for confinement². Women fly either to Yellowknife, NWT to deliver at Stanton Territorial Hospital, or to Cambridge Bay to deliver at the Kitikmeot Regional Health Centre. They travel at approximately 36 to 37 weeks into their pregnancy for confinement. Women are referred to Stanton Territorial Hospital in Yellowknife for abortion services (D.J. Rand, personal communication, November 12, 2011).

² "confinement" is the actual term used within the health centre, to refer to women traveling south or in some cases east to Cambridge Bay to stay near the birthing facility for their labour.

Terminology

Given the breadth of literature presented in this paper, an explanation of terminology will be included. The World Health Organization (WHO) defines Indigenous populations as "communities that live within, or are attached to, geographically distinct traditional habitats or ancestral territories, and who identify themselves as being part of a distinct cultural group, descended from groups present in the area before modern states were created and current borders defined" (WHO, 2012, para. 1). These populations typically continue to maintain cultural and social identities as well as economic, political, and cultural institutions that are distinct from the dominant society (WHO, 2012).

In Canada, the term Aboriginal Peoples is often used to describe Canadian Indigenous populations. Established in the Canadian Constitution Act (1982), the term "Aboriginal" refers to all of the original peoples of Canada and their descendants (First Nations, Inuit, and Métis) (National Aboriginal Health Organization [NAHO], 2003). Although this research project focuses on Inuit women, much of the available literature speaks broadly about Aboriginal people in Canada. If a specific body of literature uses the terms Inuit, First Nations, or Métis, in order to stay true to that study, all three terms are used. If Inuit are included in the larger umbrella term of "Aboriginal" or "Indigenous Peoples", those terms will remain congruent with that particular research paper or article.

Given the lack of literature related to Inuit-specific sexual health research, I have approached the literature by examining literature focused on Inuit women's sexual health, then broadening the search to available literature of Aboriginal women's sexual health - to Aboriginal sexual health internationally, and in some cases, sexual health generally. I offer an explanation of this approach to avoid any misperception that I assume all Aboriginal People to share common experiences and determinants. My intention is that this widening

gaze will incorporate as much health information with reference to Inuit women as possible. As well, rather than attempting to paint all Indigenous experience with the same brush, this process acknowledges similarities that can be helpful in the absence of literature specific to Inuit women and communities.

Research Purpose and Objectives

There is a lack of research addressing HIV, STI, and the sexual health of Inuit women and families in Canada. The current rates of HIV in Inuit communities are not well known (Pauktuutit, 2010; Canadian Aboriginal AIDS Network [CAAN] 2012); though Inuit are known to have a high birth rate, as well as high rates of STIs. These two factors both indicate a potential risk of HIV infection via unprotected sexual intercourse. In fact, research indicates that among Aboriginal women in Canada, STIs are one of the leading causes of morbidity (Steenbeek, Tyndall, Sheps, & Rothenberg, 2009). Cameron (2011) asserts that Public Health officials are growing more and more concerned about determinants (e.g., travel between northern communities and the South) that increase Inuit community members' exposure to HIV and Hepatitis C infection.

According to Pauktuutit Inuit Women of Canada (2010), there are unique and challenging barriers facing Inuit regarding HIV and STI testing, treatment and care, including geographic location as well as cultural and linguistic obstacles to accessing prevention and care. The CAAN (2012) contends that, with the exceedingly high rates of STIs, limited health care access, and remoteness of communities, if no changes are made, rates of HIV in the North have the potential to increase dramatically. With the distinct characteristics of Inuit communities, there is a need for ongoing Inuit-specific sexual health promotion and education, disease prevention, and care programs.

This research project addresses the lack of available information to guide the development of programming to improve the sexual health of Inuit women and families in isolated communities in the Canadian Arctic. It gives women opportunity to contribute toward addressing one of the health issues that affects them and their communities. Specifically, the goal of this research is to establish a dialogue among Inuit women with regard to community-based HIV and STI prevention, as well as sexual health promotion programming. The project seeks to answer the following research questions:

- *What are the perceptions of Inuit women in Kugluktuk about Sexually Transmitted Infections and HIV in their community?*
- *What do the Inuit women in Kugluktuk think would benefit the community in regard to Sexual Health?*
- *What do the Inuit women of Kugluktuk perceive to be the determinants that most influence the sexual health of women and communities?*
- *What roles do Inuit women's strength and resilience play when it comes to informing them how to take care of their sexual health and that of their families?*

Chapter Two: Literature Review

Status of Inuit women's sexual health

Inuit, like many Indigenous groups around the world, view health as holistic (ITK, 2007; Loppie Reading & Wein, 2009; World Health Organization (WHO), 2007). As articulated by Loppie Reading and Wein, "Indigenous ideologies embrace a holistic concept of health that reflects physical, spiritual, emotional and mental dimensions" (p. 3). The WHO (2007) further adds that Indigenous peoples view health and well-being as a "harmony that exists between individuals, communities, and the universe" (para. 1).

Sexual health is defined by the WHO (2006) as "a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity" (p.5). This broad and holistic definition of sexual health is congruent with the holistic approach that Inuit take towards aspects of health; it is not only the absence of ill health, but a broader concept involving various dimensions. It is also useful to note that this is the definition used by the Government of Nunavut within the Nunavut Sexual Health Framework for Action 2012-2017 (Government of Nunavut, 2012).

The sexuality of Inuit and First Nations Peoples was greatly influenced by contact and colonization (Aboriginal Nurses Association of Canada & Planned Parenthood Federation of Canada, 2002). Therefore it is difficult to explain in detail traditional Aboriginal views of sexuality (Aboriginal Nurses Association of Canada & Planned Parenthood Federation of Canada, 2002). Specifically, colonial policies regarding schooling and centralized practices for childbirth has changed the way Inuit communicate about sexual health within families. It has become more difficult to discuss sexuality openly, and

in some cases, it has become taboo. Research like that of Stern and Condon (1995) depicts the differences between generational cohorts and their attitudes regarding sexual health, due to the distinct social and physical contexts of their life histories. The changes that have taken place have weakened the lines of communication and left parents and Elders (who were the primary educators of sexual and reproductive health in the past) feeling ill-equipped to teach their children about sexual health (Stern & Condon, 1995).

Inuit women experience significant sexual health issues such as high rates of STIs and difficult childbirth situations (Healey & Meadows, 2007). As reported by the Public Health Agency of Canada (PHAC), the highest chlamydia rates and second highest Gonorrhoea rates reported in Canada in 2008 were among women in Nunavut (2011). The chlamydia rates in Nunavut were 17 times the national rate in Canada (PHAC, 2011). If left untreated, gonorrhoea and chlamydia can result in serious reproductive health consequences for women, such as sterility, Pelvic Inflammatory Disease (PID), tubal or ectopic pregnancies, and chronic pelvic pain (Steenbeek, 2004). This has implications for childbearing Inuit, Métis, and First Nations women, as research shows that they are more likely to contract a STI than similarly aged non-Indigenous women (Dion Stout, Kipling, & Stout, 2001).

With high rates of STI and lack of literature specific to Inuit sexual health, this research project is needed to aid in the development of prevention and promotion programming, which may in turn help to reduce rates of STIs, HIV and other negative sexual health outcomes. Given the changes Inuit communities have gone through, and the influence these changes have had on sexual health, this study can inform future sexual

health work, and can highlight where efforts need to be focused to create positive sexual health outcomes for communities.

Social determinants of Inuit women's sexual health

The social determinants of health (SDoH) are defined as “economic and social conditions that influence the health of individuals, communities, and jurisdictions as a whole” (Raphael, 2009, p.2). These conditions are often responsible for health disparities between populations. These same conditions also “determine the extent to which a person possesses the physical, social, and personal resources to identify and achieve personal aspirations, satisfy needs, and cope with the environment” (Raphael, 2009, p.2). There are no published studies specifically examining the social dimensions of Inuit women's sexual health. Healey & Meadows (2007) identify this gap in the available literature and state that, although there are various published studies that examine the health of Inuit in Canada, there are only a few papers that discuss the social determinants of Inuit health specifically (Richmond & Ross, 2009; Richmond, 2009; ITK, 2009).

There is an urgent need to disentangle the web of social determinants of Inuit women's health to better understand their effects (Healey & Meadows, 2007). Although there is some literature regarding STI and HIV and Inuit women's sexual health, it is primarily epidemiological and quantitative. Employing qualitative research methods while utilizing an SDoH approach in the exploration of Inuit women's sexual health is useful in understanding the broader context within which health disparities exist. It is important to note that this approach is also congruent with the Inuit holistic view of health (Pauktuutit, 2010).

In support of this contention, Cameron (2011) asserts that an SDoH approach to examining Inuit public health is an important direction for future public health research in Inuit communities. She further adds that an SDoH lens considers the diverse factors influencing the health of Inuit, as well as the importance of a community based, holistic approach (Cameron, 2011). Examination of the social determinants of Inuit health identifies links between health issues facing Inuit and the social structures within which these issues exist; thus, can solutions become more applicable. Specific to Inuit women's sexual health, Pauktuutit (2010) reports that "social determinants of health such as health services, adequate housing, proper nutrition, economic opportunities, and various forms of violence and abuse are also factors that influence the sexual health of individuals and communities" (p.4).

A 2009 report entitled *Health Inequalities and Social Determinants of Aboriginal People's Health* by Loppie Reading and Wein, integrates a life course approach with a social determinants model that is organized around three categories: proximal, intermediate, and distal determinants, all of which link to health inequalities. This framework is useful for understanding the complex relationship between various SDoH and other factors that influence Aboriginal People's health. This framework can also provide insight to health outcomes throughout the lifespan (Loppie Reading & Wein, 2009).

The following sections draw on available literature to examine social determinants of Inuit women's sexual health at each of these levels. However, due to the complex nature of causation, determinants may fit into more than one level. It is also important to note that this is not an exhaustive list due to the multifaceted nature of determinants.

Proximal

Proximal determinants of health have the most direct influence on people's health. They are often the most visible when examining an individual and their health. Examples of proximal determinants of health are: health behaviours, physical environment, employment and income, education, and food insecurity (Loppie Reading & Wein, 2009).

Health behaviours. In a paper by Richmond and Ross (2009), Community Health Representatives (CHRs) from various First Nations, Inuit and Métis communities were asked to identify health determinants; they listed "life control" as one of six. Life control was defined as "one's ability to take care of him or herself" (Richmond & Ross, 2009 p. 407), which they likened to being able to make healthy decisions and choose healthy behaviours. Health behaviours are heavily influenced by structural and environmental factors around an individual.

Waldram, Herring, and Young (2006) also suggested that certain personal behaviours such as sexual behaviour are linked to the development of numerous diseases. Waldram et al. (2006) further explain that sexual behaviour is an important health behaviour, not only because of the risk of HIV/AIDS and other STIs, but of unintended pregnancies and their associated psycho-social problems. The extremely high rates of STIs among Inuit in Nunavut (Paukuutit, 2010; PHAC, 2011; Steenbeek, Tyndall, Rothenberg, & Sheps, 2006), implies 'high-risk' sexual behaviours. High-risk sexual behaviour can elevate an individual's exposure to STIs, HIV, and increased risk of unintended pregnancy, and can include: unprotected vaginal, anal or oral intercourse, having multiple sexual partners, and sex trade work (Alberta Health Services, 2014). In her study with Inuit youth in Nunavut,

Cole (2003) reported a high incidence of self-reported risky sexual behaviour such as sex without condoms.

Another significant health behaviour identified by Inuit that affects communities in Nunavut is substance abuse and misuse (ITK, 2009; Mancini Billson & Mancini, 2007). Specifically, the rate of heavy drinking in Nunavut is three times that of Canada (Mancini Billson & Mancini, 2007). The Nunavik Inuit Health Survey conducted in 2004 revealed that "communities, governments and regional organizations have identified drinking as a serious social problem among the Inuit" (Muckle, Boucher, Laflamme, Chevalier, & Rochette, 2007, p.2). However, they add that there is very little data specific to alcohol consumption by Inuit. What literature there is available tends to pathologize alcohol use among Inuit and Aboriginal populations. Mancini Billson and Mancini (2007) suggest that the social problems that occur due to Inuit alcohol misuse are "even more devastating because the Inuit are geographically isolated and especially vulnerable during this period of exceedingly rapid social change" (p.186). ITK argues that substance misuse and addictions intensify life situations leading to more substance usage, and make linkages to "poor housing, low income, unemployment, and single parenting" (p.14). This illustrates the linkage between various determinants of health, and highlights the larger socioeconomic inequalities within Inuit communities.

Richmond (2009), in her paper on social support as a determinant of Inuit health in the Canadian Arctic puts forward that addictions are a determinant affecting not only individual, but also community health. Loppie Reading and Wein (2009) propose that over-use or misuse of alcohol is among one of the most relevant health behaviours among

Aboriginal peoples. This is directly “related to increases in all-case mortalities” (Loppie Reading & Wein, 2009, p 6). CAAN (2004) reports addictions including alcohol and other substances lead to behaviour that are high risk for STIs, HIV and Hepatitis C. They further contextualise addictions within Aboriginal communities and put forward the link of personal histories that increase the likelihood of alcohol and drug use such as “growing up in a violent home, sexual abuse, poverty, loss of loved ones to suicide or violent death” (CAAN, 2004,p.1). These personal histories are said to be rooted in colonization, specifically the residential school system, loss of culture, and systemic discrimination and racism. These linkages suggest personal health behaviours (alcohol and drug use), and the resulting effects on sexual health, are influenced by a variety of intermediate and distal determinants of health.

Physical Environments. Among all Aboriginal peoples in Canada, overcrowding is felt most profoundly by the Inuit (Loppie Reading & Wein, 2009). In fact, the most urgent public health priorities within all Inuit regions in Canada are housing shortages and poor quality housing (ITK, 2007). Problems associated with inadequate housing such as overcrowding, as well as sanitation and ventilation deficiencies, can promote the spread of infectious diseases, personal stress, and violence (ITK, 2007). For example, Inuit women who experience family violence often have no safe place to escape an abusive situation, due to a lack of housing and shelters (ITK, 2007; Nunavut Tunngavik Incorporated [NTI], 2008).

Food security or food insecurity is said to be a major determinant of health affecting Aboriginal communities in Canada (ITK, 2007; Loppie Reading & Wein, 2009; Richmond, 2009), affecting Inuit at an alarming rate (ITK, 2009). Loppie Reading and Wein

(2009) state that “Aboriginal people living in remote rural and reserve communities face considerable food insecurity related to challenges acquiring both market and traditional foods” (p.8). Food insecurity as a social determinant of health is strongly linked to other determinants; for example, ITK (2007) identifies income level and education as major factors that inhibit access to food. Beaumier and Ford (2010) add to this list by including: lack of access to full-time hunters, the high costs of hunting, and addictions as factors that influence Inuit women's access to food. They argue climate change is leading to a decline in hunting and therefore declining accessibility of traditional food within Inuit communities. Inadequate access to sufficient quantities of healthy foods leads to a variety of mental, social and physical health issues, including malnutrition, infection, chronic health problems, and psychological stress (Beaumier & Ford, 2010; ITK, 2007).

For Inuit women, access to adequate food is an important part of maintaining overall health, including sexual health. Food security is an issue for all Northerners, however, as Healey and Meadows (2007) assert it is especially of concern for Inuit women, as they often are solely responsible for children, and often have many to feed. If Inuit women are unable to access healthy foods for themselves and their families, their overall health suffers, which includes their sexual and reproductive health.

Education is an important proximal determinant to consider when discussing sexual health. ITK (2007) provide evidence illustrating the connection between education and well-being among Inuit, and suggest higher levels of education leads to improved health status among Inuit, much as it does among other populations worldwide. School-based sexual health education is a proven intervention for improving the sexual health of

adolescents (WHO, 2010). The WHO further suggests that the key to improving sexual health through sexual and reproductive health education programming is a solid educational foundation, which includes literacy, language and critical thinking (WHO, 2010). Richmond and Ross (2009) include environmental knowledge, cultural knowledge, access to high-quality educational institutions, and health promotion programming when referring to education as a determinant of Inuit and First Nations health.

The gap in educational attainment between Aboriginal and non-Aboriginal people in Canada has been increasing over the last decade (National Collaborating Centre for Aboriginal Health [NCCA], 2010e). This gap is especially striking for Inuit, who are the most disadvantaged with regards to educational achievement. It is important to note, that although these gaps exist, Aboriginal women are more likely to graduate than men (Loppie Reading & Wein, 2009; NCCA, 2010e). While examining education as a determinant of sexual and reproductive health among women, it is clear there is a close relationship. Specifically, there are fewer unintended pregnancies, fewer low birth weight babies, and lower rates of infant mortality among women with higher levels of education (Health Canada, 1999). Lower levels of education in adults are also linked to early sexual activity, and lower rates of birth control use (Health Canada, 1999).

With regards to sexual health education, there is a general lack of culturally relevant resources in the north to address sexuality education and “[u]ltimately, a structured, creative and culturally acceptable sex education curriculum needs to be developed, supported and taught widely if the high rates of STIs and adolescent pregnancy are to come down in Nunavut” (Cole, 2003, p.273). This sentiment is echoed elsewhere in the

literature, stressing the importance of Inuit-specific prevention education within communities and schools (Cameron, 2011; NTI, 2008; Pauktuutit, 2010). Although there is a need for sexual health education programming within the schools, it is also important to provide support for community education for parents and grandparents (Steenbeek et al., 2006).

Employment and Income. Authors use a variety of terms for employment and income within the context of Inuit or Aboriginal Peoples. Richmond and Ross (2009) use the term *material resources* and participants in their study referred to this as “the importance of work, the opportunity to earn a salary and to provide for his/her family” (p.407). ITK (2007) use the term *productivity*, which they assert to be “an important Inuit-specific social determinant of health and as a more accurate term for Canadian Inuit, as opposed to employment, since many Inuit men and women still work ‘informally’ by harvesting country food, producing goods for their families and providing voluntary services to their communities” (p. 8). When specifically looking at Inuit women and employment, the NCCAH (2010a) suggests Inuit women are more likely than Inuit men to be employed. Regardless of which terms are used to describe employment and income, they are linked to socioeconomic status, which is linked directly to mental and physical health and wellness (ITK, 2007; Loppie Reading & Wein, 2009; NCCAH, 2010a).

Aboriginal women in Canada are disproportionately affected by poverty (NCCAH, 2010g; PHAC, 2010; Varcore & Dick, 2008). The Aboriginal Women’s Health and Healing Research Group (AWHHR)(2005) report that First Nations, Inuit and Métis women in particular experience Poverty of Sexual and Reproductive Health. This particular type of

poverty, as they suggest, takes the form of inadequate access to contraception, lack of control over fertility, lack of recognition of Aboriginal girls as sexual beings, sexual abuse and STIs.

Social supports, also known as social resources or social safety nets (Richmond & Ross, 2009; ITK, 2007), are defined as “the breadth and quality of one’s social ties, and the abilities to rely on friends and family in times of need”. (Richmond & Ross, p. 407). In her 2009 paper on social support as a determinant of health in Inuit communities, Chantelle Richmond proposes that, “friendships, intimacy and supportive social networks are strong predictors of health at home, in the work environment and in the wider community context” (p. 474). The findings of her study suggest that certain sub-groups within the Inuit population (i.e. Men, Elders age 55 and up, and Inuit who are unmarried) are more likely to report lower levels of social support. Richmond also identified Inuit-specific factors that contribute to higher levels of social support, such as traditional language and participation in traditional harvesting activities.

Social safety nets have been weakened through dramatic changes in family relations and the changing social conditions for Inuit over the past 50 years (ITK, 2009). Specifically, issues such as addictions and family violence, as well as involvement with the justice system have been detrimental to social safety nets within Inuit communities. However, ITK contends that despite substantial shifts, there is evidence that strong networks do exist as “most Inuit live in small communities where the extended family is still a relatively strong social unit, and children are often shared between homes, living with grandparents or other relatives in the community” (p.18). NTI (2008) emphasizes the importance Inuit

place on social support of each other, as well as on family relationships and participation in traditional activities. They further suggest Inuit today very much think of traditional activities as part of their identity, and key to overall well-being. Social supports are important for sexual health, because having access to and using social supports has been shown to be associated with safer sex, lower rates of substance use, and later sexual debut among youth (Barker, 2007). Having the ability to seek and find support through formal (i.e. health centre) and informal (friends) sources improves overall health outcomes.

Gender power relations. Traditionally the roles of Inuit men and women were well established and clearly defined (Condon & Stern, 1993). Survival was essentially a shared responsibility and the complementary roles of men and women in traditional Inuit societies were imperative to ensure survival (Mancini Billson & Mancini, 2007). Prior to colonization, Indigenous men and women experienced more egalitarian gender roles (King, Smith, & Gracey, 2009; Mancini Billson & Mancini). These traditional roles situated Inuit men/husbands as primary authority outside the home - responsible for food, tools, shelter and the family's safety, while Inuit women/wives were the primary authority inside the home and were responsible for the bulk of childrearing, preparing food and water, as well as sewing clothing, tents and boat materials (Pauktuutit, 2006). Of all the changes Inuit societies have faced, gender role shifts are perhaps the most complex and synergistic.

Traditional egalitarian gender roles changed dramatically after Inuit moved into permanent settlements. Women learned English, attended available schooling, and attained wage-earning jobs more easily than men (Mancini Billson & Mancini, 2007). As well, during settlement, women were often able to bring their sewing supplies and small tools

whereas men left their dog teams and hunting equipment behind in camps (Mancini Billson & Mancini). Thus, men lost their role as primary provider of sustenance and security, as women gained more of this responsibility. "Higher rates of substance abuse, depression, and violence among males" (Mancini Billson & Mancini, p. 211), are, according to many Inuit, tied "directly to role reversal and male loss of the provider role" (Mancini Billson & Mancini, p. 211).

Examining gender relations is important to understanding dramatic increases in HIV and STI rates among Aboriginal women (Ship & Norton, 2001). When the roles and responsibilities of men and women within a given society are rapidly and dramatically changed, this can cause an upset in power, which can result in increased gendered violence. Often the "more powerful and independent women become, the more likely powerful males will abuse, ignore, ridicule or physically harm them—as a way to rebalance their real or perceived lost power" (Mancini Billson, 2006, p.79).

Intermediate

Intermediate health determinants directly influence proximal determinants, as they represent larger systems that shape environments within the realm of proximal determinants. For example, a lack of available health care services directly affects one's ability to access services and perhaps learn about health promoting sexual behaviours. Examples of intermediate determinants of health among Aboriginal people include: health care systems, educational systems, community infrastructure; resource and capacities, environmental stewardship, and cultural continuity (Loppie Reading & Wein, 2009).

Education Systems. Possessing higher education can be thought of as a proximal determinant of health, whereas an educational system might be considered an intermediate determinant of health (Loppie Reading & Wein, 2009). Education determines health in various ways. It is directly linked to employment and earnings, as well as to the literacy and skills needed to acquire sexual health information (ITK, 2009). Unfortunately, most Inuit youth across Nunavut (75%) drop-out before completing high school (NTI, 2007). In order for formal education to be useful for Inuit, it needs to be meaningful and relevant to students (NTI). There is a need for improved educational infrastructure especially with early childhood programming, secondary, and post-secondary curricula and programs in Inuit communities (ITK).

Inuit are known to be the most educationally disadvantaged people within the Aboriginal population (Loppie Reading & Wein, 2009). According to ITK (2007), the root of Nunavut's problems is a broken school system, suggesting there is a "lack of comprehensive, well-designed bilingual education system that can produce graduates who are competent in both Inuktitut and English" (p. 14). This is echoed elsewhere in the literature. NTI (2007), in their report on grade kindergarten to twelve education in Nunavut, encourage a fundamental change in Nunavut's education system by entrenching Inuit society, language and culture into all levels of the education system.

Health care systems. Accessible, safe and effective health services are key components for positive sexual and reproductive health (Health Canada, 1999). Yet, access for Inuit to comprehensive health care services is limited. Most Inuit communities only provide primary services, and community members have to travel to regional centres or

cities in southern Canada to see specialists, have surgery and deliver babies (ITK, 2009). NTI (2008) reports that, “the distance between communities and referral hospitals in Nunavut’s health care system are the largest in Canada, perhaps in the world” (p.12). Nunavut relies on more extra-provincial hospitals in more provinces than any other province or territory in Canada (NTI, 2008).

CAAN (2009) proposes that isolated northern regions of Canada face great barriers to HIV prevention programming and education due to cost and distance. They state that, “health care is limited to nursing stations that may not see a doctor for months at a time. Patients must travel to larger communities to receive specialized care such as surgery and child birth” (p.6). They emphasize the importance of gaining political support and integrating services in order to meet the challenges of HIV/AIDS work.

The Native Women’s Association of Canada (NWAC) (2007) advises there are major barriers to reproductive health care for Aboriginal women due to lack of access to health care providers, specifically the lack of access to health care providers who are Aboriginal. The importance of Aboriginal health care providers working within Aboriginal communities is also emphasized by ITK (2007), which states that educating and training Inuit doctors, nurses and mental health professionals is key to improving health care services for Inuit.

NCCAH (2010b) specifically examines access to health services as a social determinant of First Nations, Inuit, and Métis health. They point out that access to health services is determined by factors such as socio-economic status, geography, lack of infrastructure and staff, jurisdictional ambiguities, and language or cultural barriers, all of

which may be shared among Aboriginal groups, but also vary depending on one's status and home. A notable barrier for Northern Canada's health services is the geographic remoteness (NCCAH, 2010b).

Cultural continuity. Chandler and Lalonde first published their seminal research on the concept of cultural continuity in June 1998. Cultural continuity represents a community's cultural and social cohesion (Loppie Reading & Wein, 2009). This continuity is linked to numerous factors from land title and self-governance, through to traditional connectedness, and in particular, generational connectedness (Loppie Reading & Wein, 2009). Chandler and Lalonde's research showed that First Nations in British Columbia, "that have taken active steps to preserve and rehabilitate their own cultures are shown to be those in which youth suicide rates are dramatically lower" (p. 192).

It is therefore not surprising that "the declining participation in traditional activities and the health and social well-being of the Inuit are related" (Richmond, 2009, p. 472). Richmond further suggests that, "[t]he shift in their way of life, from traditional to market economy, has had considerable consequences for the social, cultural, economic, and physical health of the Inuit" (p. 472). Connection to land, culture, and community is particularly important for the health of Inuit. Participants in Richmond and Ross' study defined environmental/cultural connections as a specific health determinant and described this determinant as "a process of defining people's abilities to draw resources from the environment in the maintenance of culture and way of life" (2009, p. 407). This is echoed in a NCCAH (2010d) report, suggesting that within Aboriginal cultures, the physical environment (traditional lands) and culture are intimately linked.

NCCAH (2012d) reports that culture and language are imperative to improving the health outcomes of Aboriginal Peoples in Canada, stating “Cultural continuity can build individual and community resilience and mitigate poor health outcomes” (NCCAH, 2010d, p. 3). Given the holistic approach Inuit take towards health in general and sexual health specifically, cultural continuity plays an important role in Inuit achieving positive sexual health outcomes. It is clear from the literature that cultural continuity, and the availability of culturally relevant and safe sexual health services and information is imperative in creating sexually healthy Inuit communities.

Environmental stewardship is a widely recognized intermediate determinant of health among Aboriginal Peoples (Loppie Reading & Wein, 2009). For example, Richmond and Ross (2009) stated that, “The land is a fundamental component of Indigenous culture, and central to the health and wellness of Aboriginal societies” (p. 404). Threats to the Arctic environment affect Inuit in a variety of ways, including traditional food security, and with respect to their spiritual and cultural values (ITK, 2007). Aboriginal cultures are intimately linked to the natural environment; the health of a community and the health of the land are synonymous (NCCAH, 2010d). The connection to traditional lands and environment is also tied to a community's spiritual, social, economic, and political foundation. Loss of land is one of the most significant cultural stressors among Aboriginal communities (Richmond & Ross, 2009; NCCAH, 2010d).

Through colonial policies, Indigenous people have been denied access to their traditional lands, they have been displaced, and forced to move to lands allocated by colonial authorities (Loppie Reading & Wein, 2009; Richmond & Ross, 2009). This, as well

as environmental contamination, has left Aboriginal peoples at a loss, displaced and far from their natural traditional environments of which they were once stewards. CHRs have emphasized the effects of reduced access to environmental resources, and how shifting culture and land practices have had a negative influence on other health determinants (Richmond & Ross, 2009).

Although the connection of Inuit women's sexual health to the land and environment may not be immediately apparent, Inuit have very close connection to their lands, and therefore their health is intimately linked to that of the health of the environment of which they live (Inuit Tuttarvingat, 2014). As Danforth (2014) articulates,

Our bodies as Indigenous youth are grounded in our cultures, communities, histories and lands, which cannot be separated. When these connections are recognized as related to our bodies as rights that must be respected and protected, [this] supports our ability to access to justice. Justice over our bodies goes beyond just sexual health; it involves a myriad of expression of self-determination over our bodies and the spaces they are in as Indigenous youth.

This exemplifies the intimate connection Inuit have to the land, and this connection to sexual health and self-determination of an Indigenous youth's body is linked to land, culture, history and community.

Distal

The most profound determinants of population health are often those most distant from the individual. Distal determinants of health are the political, economic and social environments that shape the intermediate and proximal determinants (Loppie Reading &

Wein, 2009). Some examples of distal determinants that influence the health of Aboriginal People include: colonialism, racism, social exclusion, and self-determination (Loppie Reading & Wein, 2009).

Colonialism is defined as "the policy or practice of acquiring full or partial political control over another country, occupying it with settlers, and exploiting it economically" (Oxford Dictionaries, 2014). Aboriginal communities in Canada are still recovering from the impacts of colonial legislation and structural influences, and many argue that colonialism has never ceased; linking historical colonialism with current policies and historical events (Czyzewski, 2011). Colonialism affects Aboriginal people's health by creating inequalities in social, political and economic aspects of their lives (Reading-Loppie & Wein, 2009).

Historically, the political agenda of the Canadian government was to "assimilate and acculturate Indigenous peoples into the dominant culture" (Reading-Loppie & Wein, 2009, p. 21). The remoteness of the North delayed colonization of the Inuit and until the 1940's and 1950's Inuit continued a traditional lifestyle until increasing exposure to southern Canada and American military, who were stationed in the North (during World War II and the Cold War)(Bonesteel, 2006). The American military criticized the Canadian government for neglecting the Inuit, specifically regarding housing, education, and healthcare. This criticism combined with the government's interest in the resources of the Arctic caused the government to act. The Canadian government no longer believed the Inuit could continue to be self-sufficient, and as a result adopted programming to acculturate and assimilate Inuit. Examples of such programs were Inuit housing, education and healthcare, as well as urging Inuit to participate in wage labour (Bonesteel, 2006).

It was hoped that housing developments, economic development, and education for children would improve health (Bonesteel, 2006; Mancini Billson & Mancini, 2007). However, the results of resettlement changed all aspects of Inuit life. It was difficult to continue traditional subsistence from within the communities due to length of travel to find animals and the need to earn a wage through employment (Bonesteel, 2006). Increased exposure to southern lifestyles increased alcohol and drug misuse, family violence, welfare dependency, criminal acts, and divorce, all concepts that were virtually unheard of in traditional Inuit camps (Mancini Billson & Mancini, 2007).

One of the most powerful examples of programs seeking to assimilate Inuit into Canadian culture, and which has had devastating, long lasting effects was the residential school system. According to the ITK (2009):

While boarding at the schools run by missionaries, located hundreds or thousands of kilometres from home, for nine months per year, many Inuit children lost their familial, communal, and socio-cultural connections. They had no opportunity to eat country foods; were banned from speaking Inuit languages; and were forced to follow southern norms. Physical and sexual abuse of pupils was also common in addition to the emotional, mental and cultural abuses. Cultural repression, assimilation and abuse combined to make some feel ashamed of their identities, alienate and disconnected from their families (pp.5-6).

According to McCall, Browne, and Reimer-Kirkham (2009), “[a] direct link can be drawn between the challenges that Aboriginal women face and the historical impact of colonization” (p.1770). They suggest the subordination that has resulted for many

Aboriginal people due to colonization places Aboriginal people in situations of multiple individual and institutional discrimination and disadvantage. Regarding Aboriginal women specifically, Moffitt (2004) argues that, not only is colonization a “determinant of health affecting all peoples of the North” (p.328), but that it “produces serious social consequences on the everyday lives of pregnant Aboriginal women, which results in lower health outcomes” (p.323).

Colonization is said to have contributed to high rates of family violence within Aboriginal communities (NCCA, 2010c). Some researchers contend that within Aboriginal communities, there are strong relations observed between sexual behaviour, sexual abuse, and feeling disconnected to family (Devries, Free, Morison, Saewyc, 2009). This points directly to the results of colonization, and in particular, the residential school system, which was a major community trauma that affected and continues to affect the health and well-being of Inuit (ITK, 2009). There is also evidence that when a child witnesses or experiences abuse, he or she may be more likely to experience various health problems later in adolescence or adulthood, as well as high risk sexual behaviour leading to STIs (Devries et al., 2009; Wynne & Currie, 2011). PHAC (2010) reports that for Aboriginal people, racism along with the effects of colonialism and the residential school system for multiple generations are distinct factors increasing their vulnerability to contracting HIV.

Racism and social exclusion have existed for most Aboriginal peoples since their first contact with the Europeans (Loppie Reading & Wein, 2009). Specifically for Aboriginal women’s health, there is evidence that gendered racism, a form of double marginalization (Dion Stout, Kipling & Stout, 2001) affects Aboriginal women in a variety of ways - with

their health being the most important (NWAC, 2007). Although it is difficult to untangle the factors within a web of causation related to high rates of STI in Aboriginal populations, Wynne and Curry (2001) suggest “a common underlying theme appears to be social exclusion” (p. 115). They define social exclusion as “the structures and processes that limit the full participation of certain groups or individuals in society due to inequalities in access to social, economic, political, and cultural resources” (Wynne & Currie, 2001, p. 115). Ship and Norton (2001) agree, and add that Aboriginal women’s high risk for HIV is linked to social factors such as racism. Interviews with Inuit women living in Montreal suggest that racial discrimination from healthcare providers is among the reasons they did not keep their appointments to be tested for HIV. Other reasons were the lengthy waiting period for results, as well as lack of pre and post counseling (Ship & Norton, 2001).

Institutional social exclusion of Aboriginal people in Canada is also an important distal determinant of health closely aligned with racism. Specifically, a well-studied aspect of this is residential segregation (Wynne & Curry, 2001). Williams and Collins (2001) assert that, “racial residential segregation is a fundamental cause of racial disparities in health” (p. 404). They define this as the physical separation of races in residential contexts. Although their research examines health inequities within African American communities within the United States, they suggest American Indian reservations are another example of residential segregation that requires further examination. They suggest health challenges, and health disparities faced by American Indians and Alaskan Natives relates to residential segregation (Williams & Collins). Evidence of Inuit residential segregation for Inuit can be seen in imposed settlement and housing policies by the federal government.

Specifically linking residential segregation to sexual health, Wynne and Curry (2001) put forward, that residential segregation has been identified as a primary determinant of STI rates. They add many of Canada's Aboriginal people live in socially isolated communities, either in rural or northern regions. This in turn creates conditions that make it difficult to access health services and participate in health promoting activities.

Self-determination is referred to by ITK (2007) as "the road back to health" (p. 21). Loppie Reading and Wein (2009) note self-determination has been said to be the "most important determinant of health among Aboriginal Peoples" (p.23). Indigenous Peoples' self-determination has been defined as the right of a people to participate in processes that influence their own future, politically, socially and culturally (International Work Group for Indigenous Affairs, n.d.). Self-determination influences all other levels of health determinants, and is vital for addressing health conditions within Inuit communities. Self-determination improves the health of communities because it provides them with community control over resources, services, and programs specific to their needs (ITK, 2009).

Historic trauma and intra-generational grief are described as "psychological baggage being passed from parents to children along with the trauma and grief experienced in each individual's lifetime" (Wesley-Esquimaux & Smolewski, 2004, p. 3). This means that unresolved historic trauma continues to have a negative impact on individuals, families, and communities, and will continue, until mental, emotional, physical, and spiritual resolution takes place (Wesley-Esquimaux & Smolewski, 2004). Historical trauma and colonialism have made it difficult for many Indigenous families and individuals

to discuss sex and sexuality (Danforth, 2014). There are also many barriers to accessing "traditional and modern forms of contraception and culturally relevant sex education for many Indigenous nations" (Danforth, 2014, p.6). Self-determination influences all aspects of Inuit health, including sexual health.

Self-determination is a vital approach that allows Inuit to address the socioeconomic inequalities affecting their health (ITK, 2007). Canadian Inuit are making great strides toward self-determination (ITK, 2009). An exceptional example of self-determination and resiliency among Inuit is the formation of Nunavut. The first proposal for a Nunavut land claim was submitted to the Federal Government by Inuit Tapirisat of Canada (ITC) in 1976 (Hicks & White, 2000). Over the course of the 15 years of protracted negotiations and overwhelming obstacles the Inuit were unwavering in their stance that upheld their fundamental principles including a comprehensive land claim ensuring Inuit use of their lands, and compensation for past and future use by non-Inuit, and a new government in Eastern and Central Arctic that would be equipped to advance language, culture, and social-wellbeing (Hicks & White, 2000).

The Nunavut land claim was ratified in November 1992; this began the process of forming the Nunavut Territory; and in April 1999, Nunavut Territory and the Government of Nunavut were inaugurated (Hicks & White, 2000). Although the creation of Nunavut would not solve all Inuit problems, having a government that can relate to its people, and speak and understand their language, culture, and priorities, will lead to relevant solutions (Hicks & White, 2000).

Resilience and Strengths

It is important to note the strengths and resilience of Inuit women when discussing health determinants and the current state of inequities in Inuit women's sexual health. Resilience has been defined as "positive adaptation despite adversity" (Fleming & Ledogar, 2008, p.1). Historically, "Inuit resiliency", has referred to their "persistence, resourcefulness, endurance and adaptability to the unpredictable Arctic environment" (Kirmayer, Dandeneau, Marshall, Phillips, & Williamson, 2011, p. 88). The Arctic environment is recognized as one of the most challenging habitats in the world. However, in relation to this research project, it is not this resilience to the physical environment that is addressed. Indeed, "for Inuit today, resilience is not so much about adaptation to the Arctic environment as ongoing efforts to adapt to a daunting social environment created by the incongruent and often conflicting policies and institutions introduced by southern administration" (Kirmayer, et. al, 2011, p.88). This is the type of resiliency that this study will explore, the modern version of Inuit resiliency to outside factors affecting their health.

This 'modern resilience' is what Dickson (2000) depicted in her qualitative study with Aboriginal Grandmothers. She spoke of their "resilient approach to live" (p. 202) that came from a "lifelong struggle to protect themselves and their families" (p. 202). Dickson understood this inner strength of the Grandmothers, and said, "Their innate and acquired strengths were many, yet the traumas in their lives were numerous and daunting" (p.190). Examining Inuit women's strengths and resiliencies is an important approach when looking at their health and wellbeing. This study is not 'resiliency research' per se, which is an entire field of research inquiry; instead, this study takes a strengths-based approach, which provides space to reflect on Inuit women's resiliency. Additionally, resiliency is a

western concept; I have yet to find words to describe what I have witnessed in my time spent in Kugluktuk. Therefore, my use of the word resiliency is not tied to the entire field of resiliency research. It is meant to reflect the tangible feeling of strength and perseverance I have been witness to.

Conclusion

As can be evidenced in this literature review surrounding the determinants of Inuit women's sexual health, much of the available information takes a deficit-based approach, focusing largely on the negative health outcomes, poor living conditions, and challenging (and often hostile) political and social environments. This study, however takes a strengths-based focus, and is grounded in Inuit cultural values. As suggested throughout the literature, women are showing strength in the face of a long list of determinants that are seemingly insurmountable. This can be seen in the numbers of Aboriginal women employed as well as the numbers of women attending and completing schooling compared to that of men. Another example is illustrated with the correlation between women's participation in government and community wellness, specifically lower suicide rates (Chandler & Lalonde, 1998).

This review of the literature revealed there are various complex challenges and determinants with regards to influences on Inuit women's sexual health. Paying particular attention to the strengths and resiliency of Inuit cultures in general, and women within these cultures, in particular, can provide insight into strategies that may change these inequitable conditions. Strength and resiliency are crucial for Inuit women's sexual health because these form the foundation upon which effective health promotion interventions

are built – despite the lack of resources and the presence of numerous challenging SDoH women face in their communities.

In conclusion, it is clear that more research is needed to untangle the web of the social determinants of Inuit women's sexual health. The health of Inuit women is a crucial part of the health of their communities (Healey & Meadows, 2007) and therefore research in this field is needed to provide much needed direction to improve the health of their communities as a whole.

Chapter Three: Methodology

The term methodology refers to the theoretical and philosophical models a researcher uses to frame a research project. As defined by Hesse-Biber and Leavy (2010), it is the researcher's "theory of how knowledge building should ensue" (p. 13). This chapter will explain the conceptual approach (theoretical and philosophical models), study design, methods of data collection, and ethical considerations for this study, which are all part of the methodology. Dissemination activities that have already taken place and plans for future dissemination of results will also be discussed.

This research project aimed to address the lack of information available to form the basis of programming to improve the sexual health of both Inuit women and their communities in the Canadian Arctic. It provided the opportunity for women, in the Hamlet of Kugluktuk, Nunavut to voice their perceptions about how to address one of the health issues that affect them and their communities at alarming rates. Specifically, the goals of the research questions were to establish a dialogue among Inuit women with regards to community based HIV and STI prevention and sexual health promotion programming. I employed a participatory design along with a qualitative research method, both of which align with Inuit epistemology, to answer the research questions detailed below.

Research Questions

- What are the perceptions of Inuit women in Kugluktuk about sexual health, sexually transmitted infections and HIV in their community?
- What do Inuit women in Kugluktuk think would benefit the community in regard to sexual health?
- What do Inuit women of Kugluktuk perceive to be the determinants that most influence the sexual health of women and communities?

- What role does Inuit women's strength and resilience play when it comes to informing how to take care of their sexual health and that of their family?

Conceptual Approach

Although Aboriginal Peoples have always done research as a way to update and adapt knowledge as a tool for survival within changing environments (Brant-Castellano, 2004), academic research itself is a Western concept (Kovach, 2005; Smith, 2012). Therefore, the idea of 'Indigenous research' within academia creates contention within itself. Linda Smith (2012) links the term 'research' to European imperialism and colonialism, she goes so far to as say "the word itself 'research', is probably one of the dirtiest words in the [I]ndigenous world's vocabulary" (p. 1). This perception comes from a long history of oppressive and abusive research practices *done to* Indigenous communities. This being said, a slow shift is occurring within the academic landscape. There is a debate about whether or not Indigenous research methods can be considered 'formal academic practice' and movement toward the emergence of Indigenous research frameworks and knowledge systems within the academy (Kovach, 2009). This combination of research frameworks and knowledge systems informed by distinct ways of knowing is moving away from the homogeneity of the past, and is transforming academia (Kovach, 2009, p.12).

Researchers sometimes rely on theories to provide an understandings of concepts that are otherwise difficult to articulate; these concepts can include the way societies operate, the inner workings of organizations, and why individuals interact the way they do (Reeves, Albert, Kuper, & Hodges, 2008). Theories provide a framework for analysis by

presenting researchers with diverse "lenses" with which to view complex issues and social problems and guide researchers to focus on the characteristics of their data (Reeves et al.).

There are various critical methodological theories such as critical feminist and critical race with tenets that could be helpful in guiding this research project. They recognize different ways of knowing, and acknowledge the need for social justice, empowerment and self-determination. Critical theories emerged out of the social justice movements of the 1960's and 1970's such as the women's, civil rights and gay rights movements. These theories are grounded in the principle that societies exist within power-laden contexts, and that we live within power-laden constructs (Hesse-Biber & Leavy, 2011). Another belief common throughout critical theories is the rejection of a universal and absolute truth. For example, Feminist theory emerged after the long exclusion of women and girls from knowledge construction, and this theory puts forward that gender is historically and socially constructed and fights to seek social justice for women and girls (Hesse-Biber & Leavy). Similarly, critical race theory, which emerged from the intersections of feminism and civil rights, seeks to create a more just society for racially marginalized people, and strongly values experiential knowledge. Critical race theory also strives to include voices that have been excluded (Dunbar, 2008). Feminist theory is helpful in its goals of bringing women's voices forward into the discourse, as this research project seeks to do. Critical race theory can also provide guidance in its goals to bring forward the voices of Inuit women (a marginalized group within Canada).

However, these critical theories fall short for Indigenous health research. Feminist research theory, as Bagele (2012) suggests, is understood within a Western mainstream,

marginalizing voices of non-Western women, as it carries a definition of empowerment from a Western worldview. And Denzin and Lincoln (2008) assert that, "critical race theory, without modification will not work within [I]ndigenous settings" (p.5). This is due to the fact that "critical theory's criteria for self-determination and empowerment perpetuate neocolonial sentiments while turning the indigenous person into an essentialized "other" who is spoken for" (Denzin & Lincoln, 2008, p.5).

In order for critical theory to be applicable within an Indigenous community, it needs to be "localized, grounded in the specific meanings, traditions and community relations that operate in each Indigenous setting" (Denzin & Lincoln, p.6). Despite feminist theory being helpful in its goals of bringing women's voices forward into the discourse, as this research project seeks to do, it is not suited for this project. Similarly, Critical race theory can also provide guidance in its goals to bring forward the voices of Inuit women (a marginalized group within Canada), but is not suited for this project. A framework that is more relevant to the participating women is needed for this project. Concepts that resonated and could be discussed in a language they understood.

The importance of grounding this research in local realities, in a theoretical framework that is relevant to the participants was more appropriate than imposing a research theory from the existing literature onto the research project. Inuit women in this study did not identify with feminist theories, nor does critical race theory seem to be a theory that would have provided adequate relevant guidance for this study.

More closely suited to this project was decolonizing research methodologies. These methodologies do not follow a particular method and have no one agreed upon definition.

They exist because non-Western (e.g. Indigenous) knowledge forms are excluded and/or marginalized in mainstream research paradigms (Swadener & Mutua, 2008). Decolonizing methodologies focus on the best way to acquire and interpret knowledge (Denzin & Lincoln, 2008). This research project favoured Indigenous (Inuit) ways of knowing, and ensured Inuit women were central and their input guided the research process - i.e. the acquisition and interpretation of knowledge.

An Indigenous research process has recently emerged as its own methodology. It borrows tenets from interpretive and critical/emancipatory theories, but does not necessarily fit into any of the Western research categories (Kovach, 2005; Wilson, 2001). It is difficult to strictly define an Indigenous methodology, as "it is a methodology that shape shifts in the form of theory, methods, and ethics" (Kovach, 2005, p. 32). Denzin & Lincoln (2008) state that Indigenous research inquiry "must be ethical, performative³, healing, transformative, decolonizing, and participatory. It must meet people's perceived needs. It must resist efforts to confine inquiry to a single paradigm or interpretive strategy" (p. 2). This speaks to the idea that the Indigenous research process is more than just collecting information and sharing it. It is much larger than that; it encompasses all aspects of past, present and future for the people involved. One of the most important components is that Indigenous methodologies are adaptive, and this, as Barton (2004) points out, allows one to employ the methodology "in a cultural context, preserve the perspectives of Aboriginal

³ The Merriam-Webster's dictionary definition of performative as: " being or relating to an expression that serves to effect a transaction or that constitutes the performance of the specified act by virtue of its utterance <a *performative* verb such as *promise*>" Performative, with regards to Indigenous research this means it is interlaced with activism, and works on the promise that the research must advocate to end oppression and seek action for social justice (Swadener & Mutua, 2008).

peoples, maintain the holistic nature of social problems, and value participation in respectful ways” (p. 525).

As a researcher conducting Aboriginal health research, it was important to carefully consider a variety of existing research theories. The aforementioned research theories all have components that relate to this project; however none of them align completely to be the sole theory to ground this research upon. The conceptual approach that forms the Indigenous methodology for this research project drew on several frameworks. The first was Inuit Qaujimajatuqangit (IQ): Inuit ways of knowing, the second is Postcolonial Research Theory, and the third is Two-Eyed Seeing. These concepts, how they connect to form this framework, and how they align with the research design will now be discussed further.

Inuit Qaujimajatuqangit

“Inuit Qaujimajatuqangit (IQ) is the term used to describe Inuit epistemology or the Indigenous knowledge of the Inuit” (Tagalik, 2012, p.1). Tester & Irniq (2007) suggest the definitions of IQ parallel the more commonly known concepts of Indigenous knowledge and traditional knowledge. For instance, as Arnakak (2002) explains IQ “tries to capture past, present, and future experience, knowledge and values of the Inuit” (p.35). This is also echoed by Nunavut Tunngavik Incorporated (NTI) (2002, cited in Tagalik, 2012) who note that, although IQ is often thought of as specifically Inuit Traditional Knowledge, it is more accurately “Inuit ways past, present and future” (p.2).

IQ has great potential to be a guiding tool when undertaking research with Inuit communities in Nunavut. There are strong parallels between these guiding principles and

participatory research frameworks. They also share similarities with broader Indigenous methodologies. IQ aligns with Indigenous research frameworks that emphasize cultural context and Aboriginal Peoples' perspectives. Specifically, "being grounded in IQ ensure[s] cultural continuity, stability and wellbeing" (Tagalik, 2012, p.2).

The following are IQ principles as defined by the Government of Nunavut's human resources manual:

1. **Pijitsirniq.** The concept of serving (purpose or community) and providing for (family and/or community);
2. **Aajiiqatigiingniq.** The Inuit way of decision-making; comparing views and taking counsel;
3. **Pilimmaksarniq.** The passing on of knowledge and skills through observation, doing and practice;
4. **Piliriqatigiingniq.** The concept of collaborative working relationships or working together for a common purpose;
5. **Avatittinnik Kamattiarniq.** The concept of environmental stewardship; understanding that the human community is part of the greater earth or land community;
6. **Qanuqtuurniq.** The concept of being resourceful to solve problems and seeking solutions;
7. **Tunnganarniq.** Fostering good spirit by being open, accepting and inclusive;
8. **Ikpigusuttiarniq.** Caring for others; taking their situations and who they are into account;
9. **Inuuqatigatiitsiarniq.** Respect for others and treating all equally are practices the leaders have always stressed in their words of advice (uqujjuusiat). Government practices should promote impartiality.

(Government of Nunavut, 2006, pp. 1-2)

The Government of Nunavut officially adopted IQ as a guide to develop practices and policies that are consistent with Inuit culture, language and values (Pauktuutit, 2006; Tagalik, 2012). IQ was used throughout the inception of Nunavut, as it was employed while forming the territory's foundation (Arnakak, 2002) and continues to be used as the territory evolves. The importance of incorporating IQ into a research framework comes

from the voices of Elders in Nunavut, who advise that there is “a need to rebuild institutions grounded in Inuit Qaujimajatuqangit” (Tagalik, 2012, p. 4).

Tesster & Irniq (2008) recommend more effort be made in designing social processes and spaces that “help Western scientists and Inuit understand each other’s historical, cultural, and political contexts” (p.59). This underscores the value of Western trained researchers working with Inuit to form strong research partnerships. Drawing on IQ principles to guide the methodology of this research project ensured the research process represented the people this research project engaged. Many of the academic protocols that take place within University based research approaches are irrelevant to Inuit women in Kugluktuk; incorporating the ways in which Inuit acquire and apply knowledge into this research framework was key to conducting research that is relevant and respectful of Kugluktukmmuit. IQ created a comfortable research environment for participants as it is a concept that is familiar and relevant to them. IQ informed many aspects of the initial design of the research project, and was considered throughout all phases of the project. For example, the participatory design of the project reflected the IQ principle of collaborative working relationships and working together for a common good known as Piliriqatigiingniq. The concept of Aajiiqatigiingniq, decision making together by taking counsel and comparing points of view, is also recognized in the participatory aspects of the project. For instance, participatory research designs encourage shared decision making between researchers, community partners and participants and consultation with stakeholders in a research project. In the development of this research project, an advisory group was formed and consulted, as was the Hamlet's Senior Administrative Officer (SAO), the Mayor, Hamlet Council and the wellness committee. The advisory committee as well as

research participants were involved the decision making process related to data collection, analysis, timelines, and knowledge translation.

Pijitsirniq, the concept of serving a purpose and serving your community as well as providing for family and community was present in this research project on multiple levels. For instance, pijitsirniq aligns with the long-term goal of this project of informing programming and policy in the aim of improving the health of the community. Additionally, this principle may be related to the women's interest (or motivation) in sharing their knowledge and experiences as a contribution to improving the health of their families and community.

Storytelling, the primary data collection method used in this research project, was congruent with IQ principles. Pilimmaksarniq which is the passing knowledge and skills through observing, doing, and practice, was encouraged through the storytelling sessions which allowed for women to take part in sharing and learning from one another. Within these sessions, there was a sense of reciprocity that women received from one another, and gave to one another, as they healed and learned together. Also, the participatory analysis approach reflected this concept, and as we participated in analysis groups, we learned by doing, and by observing one another.

Tunnganarniq, which is linked to fostering good spirit by being open, accepting and inclusive, was an approach I took when communicating with the community. After my initial consultations with the community, I held a feast for the entire community, and involved as many people as possible, being inclusive of everyone who showed their interest in the project. I invited, by creating space for, diverse and conflicting opinions to be shared

and ultimately I believe that this is linked to both the richness of the data (or perspectives) and strengthened the impact (or uptake of) the findings of this research by decision makers in the community. Through this process, the Kugluktuk Wellness Committee, Health Centre, RCMP, Social Services, Elders at the Elder's Centre, Hamlet Council, Mayor, SAO, as well as all community members were involved with sharing information about the research study.

Qanuqtuurniq describes the concept of being resourceful. In this case, we used resources available within the community, and through community support the research project was successful. Additionally, we utilized available resources from the Hamlet such as meeting spaces and administrative tools such as photocopiers and printers, and we were creative in determining what honorariums are relevant, and we were flexible in meeting spaces and times.

The concept of Ikpigusttiarniq, which means caring for others; taking situations and who they are into account, aligns with the focus in this research project to examine the social determinants of sexual health. Taking time to explore the aspects of people's diverse backgrounds, like structural and environmental and factors that are beyond them as individuals, truly considers each person's situation. The structure of this project created a space for participating women to share, heal and care for one another, and this reflected Ikpigusttiarniq.

The concept of Inuuqatigatigiitsiarniq, respecting all equally, can be seen through the use of a participatory research approach. This approach aims to be respectful of all the member of the community, inviting diverse opinions and multiple community members in various roles, and shared decision-making processes. Additionally, the participatory

research approach values participants as experts in their own lives. Avatittinnik Kamattiarniq or environmental stewardship recognizes that the human community is part of the greater land community and is important to consider as it is integral to every aspect of Inuit life and culture. This principle was considered throughout this project as it is linked to daily life within this Inuit community. For instance, the logistics of this research project took into account the times when families are typically unavailable because they are out on the land, fishing, hunting and camping.

Postcolonial Research Theory

Postcolonial Theories are defined by Young (2001, as cited by Browne, Smye, & Varcoe, 2005), are “a family of theories sharing a social, political, and moral concern about the history and legacy of colonialism – how it continues to shape people’s lives, well-being and opportunities” (p. 19). Postcolonial theories differ from other critical theories as they focus on changing the historical way of thought regarding race, as well as structural inequities formed through colonization and today’s neocolonial systems (Anderson, 2004). They provide a useful and relevant framework for approaching research within Indigenous communities in Canada. This is supported by Browne, Smye, & Varcoe (2005) when they propose that, “given the extent to which the health and health care of Aboriginal peoples have been shaped by social relations rooted in Canada’s colonial history, these [postcolonial] perspectives are particularly applicable in the area of Aboriginal health” (p.19).

Given Browne et al.'s point about postcolonial approaches being especially applicable with Aboriginal Health research, utilizing a postcolonial lens when looking at the

social determinants of Aboriginal Health is also useful. Colonization as a distal determinant of health, does affect the social determinants at intermediate and proximal levels. Although this study did not specifically examine, for example, the effects of colonization on Inuit women's sexual health, postcolonial research theory can provide a lens to ensure the influence of colonial systems and programming as well as neocolonial institutions is at the forefront of the research methods throughout this project. Postcolonial theory provides a rationale for considering a largely traumatic event that should not go unexplored within this project.

As a non-Indigenous researcher, it was not appropriate for me to solely adopt an Indigenous methodology for this project. Since this study was participatory, and the co-creators participating in this project are Inuit, it was also in no way appropriate to have a completely Western methodology. Drawing on postcolonial research theory enabled me to locate Inuit health within the social conditions created by historical and structural colonial and neocolonial programming and policy. It was a way to stay reflective of the deep-rooted power dynamics as well as attitudes that can be present in research environments. Given the history of negative research experiences within Aboriginal communities, drawing on postcolonial research theory has allowed me to be conscientious and respectful in my reflection of the research process. It is my responsibility as a researcher to be critical of the colonial /Western/dominant knowledge systems and drawing from postcolonial research theory enabled me to keep these ideas in the forefront of my mind within this project.

Critics of postcolonial scholarship suggest that Indigenous researchers often are resistant to the narrative of post-colonialism (Smith, 2012). Linda Smith argues that, "this

is because post-colonialism is viewed as the convenient invention of Western intellectuals which re-inscribes their power to define the world” (p.14). It is important to explore alternative frameworks, and acknowledge the criticisms of postcolonial theories. Clearly defining the theory, and what it works toward, is important in ensuring it is applicable within a particular framework.

McConaghty (2000, cited in Anderson, 2004) offers that postcolonial theory does not specifically represent a certain time in history. He asserts the ‘post’ in ‘postcolonial’ does not refer to ‘after colonialism’ but rather refers to a concept that is unbounded by time or place, and of working against colonialism. Postcolonial theories emerge from Western epistemologies, and although Indigenous knowledge can and perhaps should inform postcolonial theories, Indigenous epistemology "represent[s] different intellectual endeavours" (Browne, Smye, & Varcoe, 2005, p.23). However, Browne et al., suggest the two (Indigenous epistemology and postcolonial theories) can be drawn on together, and often are used in parallel. Accordingly, this research project does not solely draw upon postcolonial research theory, but instead utilizes the strengths from this theory to ensure I remain reflexive along with the strengths from IQ to ensure the project is carried out in a good way.

Reimer Kirkham and Anderson (2002), within their exploration of postcolonial theory in nursing scholarship, argue that the most challenging task is “the translation of its theoretical tenets into a method for research” (p. 9). They further add that, when bringing together theoretical perspectives and research processes, researchers often receive little guidance in how to conduct the research (Reimer Kirkham & Anderson). It is important to

consider these ideas when employing a postcolonial framework. However, in this study postcolonial research theory was used alongside the previously mentioned IQ principles. This multi-pronged approach provided a thorough guide for this research project. This combination of these two concepts utilized the strengths from each, and avoided the disconnection between theoretical perspectives and research process that Remier Kirkham and Anderson caution is a challenge to postcolonial research.

Two-Eyed Seeing

Given that Inuit women's voices have been largely ignored throughout the history of health research, as evidenced by the lack of data reflecting their experience, the centralizing of their perspectives in this study is critical. A useful approach to consider when working with two concepts, one from an Indigenous worldview (IQ) and one from a Western view (Postcolonial research theory), is that of Two-Eyed Seeing which "neither merges two knowledge systems into one nor does it paste bits of Indigenous knowledge onto Western" (Iwama, Marshall, Marshall, & Bartlett, 2009 p. 5). This concept reflects a pluralistic approach that brings Indigenous and Western theories together, thus promoting the strengths from each.

Two-Eyed Seeing, as Bartlett et al. (in press, cited in Iwama, Marshall, Marshall, & Bartlett, 2009) articulate, "adamantly, respectfully and passionately asks that we bridge together our different ways of knowing to motivate people, Aboriginal and non-Aboriginal alike, to use all our understandings so we can leave the world a better place..." (p. 5). Hatcher & Bartlett (2010) explain Two-Eyed Seeing as seeing "from one eye with the

strengths of Indigenous ways of knowing, and from the other eye with the strengths of Western ways of knowing, and to use both of these eyes together” (p.16).

This research project brought together the strengths of postcolonial research theory and IQ, and gained strength from each. Two-Eyed seeing encourages multiple ways of knowing be considered for scientific inquiries. In this study, postcolonial theory and IQ were used to ensure that the diverse strengths of each are emphasized and aligned with a participatory design. Iwama et al. (2009) note, in reference to their idea of Two-Eyed Seeing, that “some might describe our efforts as Indigenous (or First Nations, community-based participatory action, decolonizing, or Aboriginal) research” (p.6). Yet, the inclusive concept of Two-Eyed Seeing, allowed for both the principles of IQ and postcolonial research theory to work together, and allowed for weaving between two worldviews throughout the project.

Research design

Participatory research is a valuable approach to consider when working with Indigenous populations because it “is intimately linked to many Indigenous philosophies through the value of local participation, learning through action, collective decision making, and empowerment through group activity” (Loppie, 2007, p. 278). Such frameworks, by design, ensure that respect and equity is upheld, and make certain that Indigenous Peoples are full participants (Bird, Wiles, Okalik, Kilabuk & Egeland, 2009). As is the case when undertaking research with and for other marginalized populations, within Indigenous research it is of utmost importance that the participants are involved throughout the

research process (Smith, 2012; Denzin & Lincoln, 2008). The overarching conceptual approach of this research project (Two-Eyed Seeing) calls for a participatory design.

CBPR is much more than simply a collection of research methods; it is “an orientation to research that focuses on relationships between academic and community partners with principles of co-learning, mutual benefit, and long-term commitment and incorporates community theories, participation and practices into the research efforts” (Wallerstein and Duran, 2006, p. 312). Edwards, Lund, Mitchell, Andersson (2008) suggest that the driving force behind the advance of CBPR is the development of theories, approaches, and methods related to Indigenous ways of knowing. Given these origins of CBPR, and the emphasis this design places on the community as a meaningful partner throughout the research process, CBPR encourages multiple ways of knowing. Thus, the conceptual framework of Two-Eyed Seeing aligns well with the CBPR design.

Gesink Law, Rink, Mulvad, and Koch (2008) maintain that its strength as a framework comes from its ability to link skilled researchers with resourceful local knowledge systems and traditions. CBPR is said to be a promising framework when working with Indigenous Peoples in regards to sexual health research (Gesink Law, et al., 2008). This lends support to CBPR being an appropriate approach to exploring the social determinants of Inuit women’s sexual health. Given the sensitivity of sexual health as a topic of inquiry, ensuring women who are participating have input in how the research proceeds is helpful for their comfort in participating. The use of a CBPR design enabled the participating women to gain skills in research, as they were involved at each stage of the process, and this process is also promising for influencing community change.

These are the nine principles of CBPR as defined by Israel, Eng, Schulz, and Parker (2013):

1. CBPR recognizes community as a unit of identity
2. CBPR builds on strengths and resources within the community
3. CBPR facilitates collaborative, equitable partnership in all research phases and involves an empowering and power-sharing process that attends to social inequalities
4. CBPR promotes co-learning and capacity building among all partners
5. CBPR integrates and achieves a balance between research and action for the mutual benefit of all partners
6. CBPR emphasizes public health problems of local relevance and also ecological perspectives that recognize and attend to multiple determinants of health and disease
7. CBPR involves systems development through a cyclical and iterative process
8. CBPR disseminates findings and knowledge gained to all partners and involves all partners in the dissemination process
9. CBPR requires a long-term process and commitment to sustainability (pp. 8-11)

They advise that these principles vary depending on the research project, and all may not necessarily be present in every research process. They also note that the principles are very much interwoven, even though they seem to be distinct from one another (Israel et al., 2013). These principles are also meant to serve as a guide not as a rule, that is, they are not to be imposed on partnerships and are not claiming to be completely applicable in all situations, cultures and communities. Local contexts are needed to help these principles to be relevant and useful.

In reviewing the principles of CBPR, there is a strong parallel between these and the IQ principles. Both sets of principles centralize community, encourage co-learning/ learning from one another's distinct approaches, and stress the importance of working collaboratively to attain mutual benefit. The two sets of principles also value equity and

decision - making that is achieved through open communication among the parties involved.

Using a study design that was rooted in IQ principles was important for this study to be relevant to participants, as well as culturally congruent within their lives. CBPR was well suited for this study, because of its alignment with IQ through the process outlined in the principles of CBPR. For example the fact that CBPR recognizes community as a unit of identity, is important for this project, because it is community-based, and drew from the geographic community of Kugluktuk, which is also further defined for this project as the project involved Inuit women from Kugluktuk.

Throughout the project we drew from and built upon the strengths and resources within the community. We were supported by the health committee and hamlet council provided us with various meeting spaces. The participating women represent strengths within the community, and they acted as experts in their own lives, came together to share their stories, support one another, and as a result of participating, built their own research capacity to approach future research projects.

The beginning stages of the project drew guidance from the advisory group and the collaboration continued throughout the project as more partnerships were formed. Advisory group members, participants and supporters (Hamlet Council, Mayor) all had an equally important role in the project. The design of the project also provided opportunities for co-learning and capacity building both for myself as a new researcher, and for participants who were new to participatory research. The storytelling sessions allowed women to draw from one another's experiences and learn from each other.

The goal of this research project was action, in the form of informing programming and policy that will ultimately benefit the community. This relationship of mutual benefit between community and researcher is also clear in this study when considering the immediate benefit for participants. An environment for healing and support was created through the storytelling sessions. The principle of CBPR emphasizing public health issues of local relevance, and attending to multiple determinants of health is achieved through grounding this study in IQ, and through the focus on examining social determinants of sexual health.

The dissemination of findings at conferences was co-created with participating women, and will continue to take place in this way. My visits to community as well as conference presentations and meetings are done in collaboration and consultation with participating women and the advisory group.

The commitment to sustainability and long-term process is evident considering my relationship with the community that extends beyond this project, pre-dating it by 10 years, and my continued commitment forward to doctoral studies and my career dedicated to Inuit community health.

Community and researcher engagement.

Community support for this research project was evidenced in the form of letters of support for funding applications and once the project was undertaken, collaborative planning. Inuit Nipingi (2009) notes that "the planning stage of research is a very important chance for communities to work with researchers and to help shape a research project right from the beginning" (p.2), which is what took place with this project.

In February 2012, I travelled to Kugluktuk to meet with community members (six women attended) and form a preliminary advisory group for the proposed research project. I collaborated with two Community Health Representatives (CHRs) and the Acting Wellness Coordinator to invite women to attend meetings to discuss an opportunity to be involved in this sexual health promotion and STI/HIV prevention research project for women. The meeting was held at the Wellness Program office in the wellness building.

Ideas discussed at the meeting were:

- Funding applications
- Methods of data collection
- Honorarium to be provided to participants to pay respect for time
- Timeline of research project
- Who else should be involved, how we should communicate with other participants, how recruitment should take place

I also met with the SAO of the Hamlet to discuss the project, and obtain his input. The mayor was not in town at that time, but the SAO said he would discuss the project with the mayor, and was fully supportive of the community-based project. After the meetings in February, we applied for funding that would help pay for the research project. We were successful in our application to the CIHR Social Research Centre in HIV Prevention, and I received the LaVerne Monette student Award (\$15,000).

I returned to Kugluktuk in mid-May 2012, to check in with the advisory group and further discuss funding and future project plans. At this time, I met with the mayor, the Community Wellness Committee, and the SAO, as well as with various advisory group

members. The mayor articulated his full support of this project, and asked that I write a letter so he could present it to Hamlet Counsel, as is community protocol (see Appendix A for letter to the Mayor of Kugluktuk).

During initial meetings with the Advisory Group, we discussed methods of recruitment and decided that data collection would take place in the fall (October-December) of 2012; during the fall visit recruitment would be undertaken, following an information session and community feast. Together we decided to advertise for the information session/ community feast on the local radio, by posting flyers on the community bulletin boards, as well as through commonly used social media within the community (such as Facebook).

We also discussed the level of involvement for each stage of the project, and decided this would be an ongoing discussion as we reached each new stage. This equitable and flexible partnership-building process also included determining the best way to communicate information regarding the research project between myself, the Advisory Group, participants and the community. We decided that there would be regular contact with the CHRs, and if they needed to share information with others they would do so.

Method of Data Collection

Indigenous research methodologies lend themselves well to certain methods of collecting information, as Liamputtong (2010) asserts, “qualitative research relies heavily on ‘words’ or stories that people tell researchers” (p. 11). Data collection for this research project used the qualitative research method of storytelling. Kovach (2005) suggests that storytelling aligns with Indigenous perspectives and ways of knowing. In a study that

examined the emancipatory potential of group storytelling for women of African descent, Banks-Wallace (1998) defines storytelling as the process or interaction used to share stories. She further explains that people sharing the story are the storytellers, and the people who are listening are story-takers. Banks-Wallace concluded that not only do group storytelling sessions provide answers to the research questions in her study, but they also provide participants with the opportunity to learn from one another, and to grow.

Thomas (2005) notes that critics report that storytelling is subjective and biased and should not be deemed a legitimate research method. However, he suggests we must take into serious consideration the cultures and traditional ways of life based on oral tradition. Oral tradition is a cultural value found in many Aboriginal communities and thus should be recognized as a valid research method (Bird, et al., 2009; Thomas, 2005). Bird, et al. (2009) asserts that narratives and storytelling practices can be used to better understand the health status of Inuit communities. They also offer that Inuit have a strong oral tradition of storytelling and highlight this as an important means of communication and learning. Banks-Wallace (2002), in regards to such traditions, reveals that, “oral tradition assumes that everyone present is actively involved in story construction as either storytellers or listeners” (p.421).

The advisory group in Kugluktuk agreed that storytelling groups were an appropriate method of data collection. Storytelling is a common practice in Kugluktuk, and it fits within community customs of sharing information, as well as aligning with IQ principles. It was important that women felt comfortable within their storytelling sessions; therefore, careful consideration for privacy and comfort was made when setting up the

sessions. Neutral places were available, such as community meeting spaces, and women were given the opportunity to participate in the storytelling session in their homes or in the community meeting spaces provided.

Storytelling, as the method of data collection, was not only chosen because it was culturally relevant to the participating women, but for its ability to add a personal narrative to the current available literature. The type of information that is gained from this method is equally important to consider, as it adds stories of lived experience to what is currently an epidemiological body of literature. This mainly epidemiological literature provides information about sexual health among Inuit women, yet fails to address the real life situations that influence the epidemiological data. The rich dialogue and anecdotes that storytelling elicits is an important component that fills in the situational details of women's lives. Sharing stories can also be healing, supportive, and celebratory (Banks-Wallace, 1998).

Participant Selection

Hosting a feast is an ideal way for researchers to gather community members in Kugluktuk and is seen as a respectful way to communicate to the entire community about a project. Hosting a feast can also facilitate recruitment. Early in my third community visit, I hosted a community feast at a community hall in Kugluktuk. I promoted the feast by posting a flyer (see Appendix B for feast flyers in Inuinnaqtun and English) on all the community bulletin boards, and at grocery store checkouts. The Kugluktuk High School Graduate Committee catered the feast. We began with a Prayer by an Elder, and I presented information about the research project.

The project information handouts (see Appendix C for project information handouts in Inuinnaqtun and English) were handed out to community members who attended the feast. Although the feast did not directly yield any volunteers, this does not mean that it was unsuccessful. The feast helped to communicate the intentions of the research project throughout the community and sparked interest, which led people to inquire further about the project. The information provided during the feast was also posted on community bulletin boards, the community website (Facebook), community programs (Canadian Prenatal Nutrition Program & Brighter Futures Elder's and Youth Program), and the community bazaar. I visited workplaces during coffee breaks to discuss the opportunity with women and distributed copies of the project information handout.

I attended the women's sewing group as a participant, which would prove to be one of the most important experiences of this project for me, personally. This provided me with an opportunity to sit and visit without an agenda. I did not "present" what I was in town for in this setting; however, women asked me when I had returned to the community, and what I would be doing while I was home. Sewing was an opportunity to spend time in the evenings with women (some of them did participate in the project, and many others did not). Regardless of their status within the project, this was an easy way to communicate, while sewing and drinking tea, and was an opportunity for natural knowledge translation and exchange KTE about the ongoing project.



Figure 3: Two pairs of toddler Kamiks that I sewed with the sewing group

After being in town for over a week, women began approaching me at the stores, on Facebook, and at the sewing group to volunteer for the project. The following table illustrates the way in which each of the 21 participants volunteered to participate in storytelling sessions.

Table 1

Recruitment activities

Recruitment Activity	Number of Participants Gained
Grocery Stores	2
Work Places	8
Sewing group	2
Feast	0
Facebook	5
Community Programs	4
TOTAL	21

Storytelling sessions

Nine storytelling sessions took place with a total of 21 women aged 18-61. The sessions lasted between 30 and 75 minutes. Some of the sessions were individual, with one woman and me, and others were groups ranging in size from 2 to 6 women. The sessions were semi - structured, in that the topics to be discussed were suggested at the beginning, and stories were shared based on the topics in the guide (see Appendix D for Storytelling Topic Guide).

The storytelling sessions took place at a variety of locations, based on convenience for participants. The SAO provided access to two Hamlet locations: the Elder's Centre, and the Prenatal Nutrition Program meeting space. Sessions also took place in a boardroom, and at individual women's homes and the Mission house. Each of the locations worked well for the groups and individuals, as they were familiar spaces and provided comfortable seating. We began each session with food and tea.

Informed consent was explained when we set up a time and place for the storytelling sessions, and all participants were read the informed consent out loud before the sessions began. The informed consent form was provided in both English and Inuinnaqtun; however all of the women chose the English copy. All participants were asked permission to have the session audio-recorded, and all of the women consented (see Appendix E for participant consent forms in English and Inuinnaqtun).

Interview notes

Notes were recorded during all sessions and consisted of: seating arrangements, any interruptions, points of particular relevance to research questions, any recurring

themes, and areas to be readdressed later in the conversations. At the end of each day, interview session notes were typed up in point form, highlighting some of the phrases women used as they were speaking. These notes proved useful while working to transcribe the interviews in ATLAS.ti, as they drew attention to discussion points that were often repeated. Notes taken during the sessions captured data I thought was particularly rich. The notes illustrated particular thoughts that were expressed by some of the women, or an idea that struck me as being particularly relevant to the research questions. These notes were congruent with my reaction while listening to the tapes and reading through the transcripts.

Diary

Keeping daily diary notes proved to be a useful way of keeping track of daily events, meetings, and plans for the upcoming weeks. It was also a useful means of reflecting back and retrieving memories of the time spent in Kugluktuk. Included in this diary were meeting notes, daily schedules, notes about ice-fishing trips, as well as sewing groups I attended during my time in Kugluktuk. I also felt inclined to keep track of the time of the sunrise and sunset, and the temperature. I was in Kugluktuk for the data collection visit at the end of November through the beginning of December. This was nearing the shortest day of the year, and Kugluktuk was losing 10 minutes of sunlight a day. This is quite a contrast to the daylight in 'Southern Canada', as was the temperature. This was mainly to keep me organized and keep track of my thoughts and reflections on the experience, and was not a direct source of data for the research process.

Data Management and Analysis

Data Management

The data management system I used helped to ensure confidentiality and was useful as an organization tool to aid in analysis. All storytelling sessions were audio-recorded with a digital audio recorder. The files were transferred to a password - protected laptop, and then deleted from the recorder. The files were uploaded through a secure electronic connection to the transcription company, Transcription Divas, and transcribed verbatim. Before the files were sent to Transcription Divas, they signed a confidentiality agreement (see Appendix H for Transcription Confidentiality Agreement). Once the transcriptions were complete the text files were returned via a secure internet connection. Thus began the process of listening to the audio to check for inaccuracies and replacing real names with pseudonyms. Throughout this process, the audio files and original text files were kept on a password - protected computer. The next step in the process was entering the text transcripts into the qualitative analysis software program, ATLAS.ti. Copies of the audio files and original transcripts have been kept for reference and remain on a password - protected computer. These files will be destroyed one year after completion of the research project.

Analysis (Meaning Making)

Inductive thematic analysis was selected as it aligned with the goals of the research project. This project aimed to gain knowledge and information that can help inform future policy and prevention programs. Since "the output of an applied thematic analysis is not

necessarily a theoretical model but is often recommendations for program or policy" (Guest, Namey & Mitchell, 2013, p. 13), this approach fits well within this project.

I began the data analysis process by reading through the transcripts line by line, and completing some initial description and conceptual coding. At this time, I also wrote memos linking several of the codes, and noting any specific points I thought were important. Coding as defined by Hesse-Biber and Leavy (2011) consists of "identifying 'chunks' or 'segments' in your textual data and giving each of these a label (code)" (p.330). They further add that it is an analytical strategy researchers use to "locate key themes, patterns, ideas, and concepts that may exist within their data" (Hesse-Biber & Leavy, 2011, p. 330). Once I had reviewed all of the transcripts three times, I began condensing related codes. From this process, themes began to emerge and I grouped several codes together. At this point in the data analysis process, I returned to Kugluktuk to conduct participatory analysis groups with the participating women.

The participating women had previously agreed that they would like to be contacted in order to take part in data analysis. Women were notified that I was 'in town' again and interested in meeting for analysis groups. Each woman who participated in the participatory analysis signed a community analyst confidentiality agreement (see Appendix F for community analyst confidentiality agreement). All identifiers were removed before the data were presented to these groups, which ensured an extra level of confidentiality. Three participatory analysis groups were held, with 13 women who were representative of the participants in terms of age and socioeconomic status. These groups took place at the Prenatal Nutrition program meeting space, as well as at a community boardroom.



Figure 4: Participatory Analysis 1

We began each group with tea and a meal. The process began with sharing the data in its current state. This consisted of collections of quotations with codes and memos attached and the list of codes in print form. Women shared in reading various sections, and examples of codes and related quotations were shared out loud. We collectively worked through the data - discussing the rough codes and the quotes linked to them. After sharing codes, they were listed on sticky-notes, placed on a board and rearranged in thematic groupings. When the group felt that we had covered enough of the materials, we ended the meetings. The participating women in all three of the analysis groups said they felt I would represent their stories in the right way, and they gave permission for me to further organize and analyze the data we did not have time to cover. The analysis groups provided me with an opportunity to directly ask participants how they think themes and subthemes should be framed.

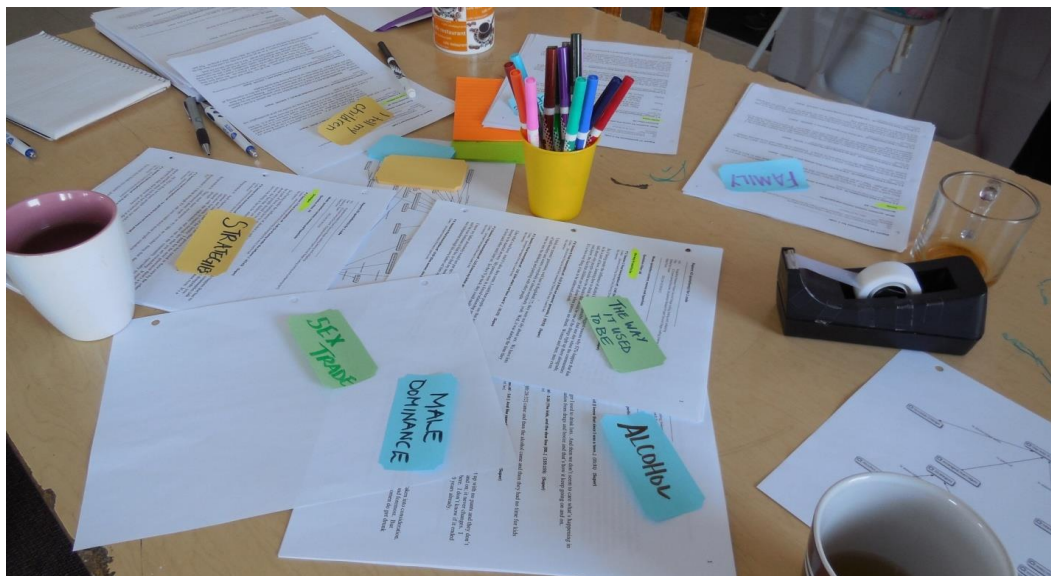


Figure 5: Participatory Analysis 2

Five major themes emerged and were comprised of several sub-themes. The five major themes emerging from the data were:

- 1 - The way it used to be
- 2 - Change
- 3 - Family
- 4 - Relationships
- 5 - Holistic strategies

These will be explored at length in the findings chapter.

The participatory analysis groups ensured that I continued to work within the research framework. It was also an opportunity to ensure that I was interpreting the messages appropriately, that I was able to ask the women about how I should frame certain

themes, and that I obtained permission to continue writing to meet my academic deadlines before I return to Kugluktuk for more KTE. The women who participated in the analysis groups were happy to be a part of this phase of the research project, and expressed their excitement at seeing the stories they shared becoming a part of something bigger.

The participatory analysis groups also helped put together an academic poster that was presented at the Canadian Association for HIV Research's (CAHR) 22nd annual national conference in Vancouver, BC (see Appendix G for Conference Poster). When asked what they might think if they were to see this poster at a conference, one group of women said that they would be proud to have taken part in this project.

Ethical Considerations

It is an unfortunate fact that, “Inuit communities in Canada have seen many researchers come and go. In the past, Inuit have been subjected to bad research practices and have often wondered what happened to the information they provided to the researchers” (Inuit Nipingi, 2009, p.1). An example of 'bad' research is one in which the community never receives the results or in which they have no say in how the information is shared. This project is mindful of the history of colonial research projects that have taken place in Indigenous communities across Canada and the world. There are various guidelines and principles along with the specific theoretical framework of this project that can help ensure the project is conducted ethically.

The ‘OCAP Principles’ (Ownership, Control, Access and Possession) were created as a response to colonial approaches toward research activities in First Nations communities and serve as “self-determination applied to research” (Schnarch, 2004, p. 80). These

principles have been articulated as a political response to the negative approaches to research within First Nations communities in Canada. Despite the origins of OCAP being First Nations focused, “many of the insights and propositions outlined are relevant and applicable to Inuit...” (Schnarch, 2004, p. 81). OCAP was considered throughout this project. Another document that served as a guideline to ensure ethical procedures throughout all stages of the project is the *Tri-Council Policy Statement, 2nd edition: Ethical Conduct for Research Involving Humans* (2010) (TCPS2) (particularly Chapter 9). Guidance was also sought from Inuit Tapriit Kanatami and the Nunavut Research Institute's (2007) *Negotiation Research Relationships with Inuit Communities: A Guide for Researchers*.

Community Protocol

The research project was put on the docket for the May 22, 2012 Kugluktuk Hamlet Council meeting and council members voted in favour of the project. This acted as the community's protocol for approving community research, as the Hamlet Council is the community governmental board comprised of elected officials.

Ethics and Research License

An ethics application was submitted and approved by the University of Victoria's Ethics Review Board (ethics protocol # 12-432) (see Appendix H for Ethics Certificate). This application was in accordance with the TCPS2. Also submitted, was a proposal to the Nunavut Research Institute, and a Scientific Research License was granted (License # 04 065 12N-M) (see Appendix I for Research License). These approvals were obtained before any recruitment or data collection activities occurred.

Preparations

Given the sensitive nature of sexual health as topic within the storytelling sessions, support services were made available for all participants. The Social Services program, Elders, and the Wellness Centre (which provides counselling services within Kugluktuk) were notified about the details of the research project and were readily available to provide support following the storytelling sessions. It was made clear at several stages throughout the data collection process that all participants could withdraw from the project at any time and that support was available to help deal with any issues that may arise from their participation. Although it is difficult to ensure strict confidentiality within the storytelling groups, we discussed confidentiality, and, as a group, identified that all of our conversations should be kept confidential.

Compensation

Women were given their choice of honorarium equivalent to fifty dollars. Honorarium options varied from fifty-dollar gift cards, to fifty-dollar donations to the upcoming “Christmas games”, an account controlled by the Hamlet. Women could also receive fifty dollars’ worth of sewing supplies such as embroidery floss, moose hide, and beaver pelts.

Informed Consent

The informed consent process began when I set up the date and time for the storytelling session. I explained that participation was completely voluntary, and that they had the opportunity to withdraw at any time. All participants signed a consent form at each storytelling session. The forms were provided in English and Inuinnaqtun (See Appendix E for consent forms). The option for verbal consent was available if needed.

Insider/Outsider Researcher Status

Highlighted within the literature on Indigenous methodologies, as well as other anti-oppressive methodologies, is the importance of researchers identifying their relationship with, and intent regarding, the research and the community research partners. Absolon and Willet (2005) stress that one of the most important principles within Aboriginal methodologies is for a researcher to locate him or herself. If identified immediately, this informs where the voice of the researcher comes from and strengthens researcher accountability.

This leads to an examination of the insider/outsider status of the researcher, in regards to the community where research is taking place. Insider or outsider status refers to the similarities or differences present between the researcher and participants (Hesse-Beiber & Leavy, 2011). There is debate among qualitative researchers and sociologists regarding the benefits and drawbacks of researchers being members of the same community as the communities they study (Kerstetter, 2012). Critics of insider research warn that an insider's close proximity to the research can lead to biased findings (Innes, 2009). Outsider researchers are said to be neutral detached observers, which helps in analyzing data objectively. Insider researchers may have difficulty clearly analyzing something in which they are immersed (Kerstetter, 2012). Also, insider researchers may have difficulty separating their own personal experiences, thus causing bias. There may also be issues with confidentiality if the researcher and participant are from the same community (Kerstetter, 2012).

Proponents of insider research argue that those who hold insider status possess greater contextual understanding (Innes, 2009). Moreover, researchers with insider status

are able to "challenge preconceived notions of their communities and expand scholarly knowledge" (Innes, 2009, p. 440). Hesse-Beiber and Leavy (2011) agree, suggesting the matching of a researcher with a participant based on certain characteristics can take advantage of insider status, which can increase access and the success of an interview. If the researcher is seen as an "insider" having commonalities with the participant, it can increase the chance of obtaining permission to conduct the interview as well as achieving cooperation and rapport when the interview is taking place (Hesse-Beiber & Leavy). It may be more difficult for an outsider to gain access and fully understand the perspective of the participant. It has also been argued that outsider researchers are not able to fully understand something they have never experienced or been a part of, be that a culture, or event. However, the participatory nature of this research project is helpful in ensuring the project is conducted in a manner that considers input of all those involved.

James Banks (1998 as cited in, Liamputtong, 2010) discusses four types of cross-cultural researchers. These four types are 1) Indigenous insider, 2) Indigenous outsider, 3) external insider, and 4) external outsider. Each category is based on where the researcher is socialized in comparison to the group/ population and their relationship to the culture. For this research project, I am considered an external insider, as I was "...socialized 'within another culture' but acquires the beliefs, values, behaviours, attitudes, and knowledge of the culture with which he or she is carrying out the research" (Banks, 1998 cited in Liamputtong, 2010, p. 110). I have had ties in the community of Kugluktuk for over a decade, and when I am there, members of the community refer to me as being "home". I am thus considered an 'adopted insider' by the local community where the research is being undertaken" (Banks, 1998 cited in Liamputtong, 2010, p. 110).

It is important to discuss my insider status within the Ethical Considerations of this thesis. As a non-Inuit woman, conducting research with Inuit women, it is especially important to discuss how the research community views me. I know that the women I work with in Kugluktuk consider me an insider. This research project has provided opportunities for explicit conversations with participants about my insider/outsider status within the community and they have clearly indicated that I am considered an insider. For example, I have been told, “but, you’re not a Kablunak (white-(wo)man), you ARE from here, this is your home... You know us, you’ll do it right, who else would?” I have also been told, “of course you are doing this with us, you taught my Bunnick (daughter) about puberty”.

Liamputtong (2010) warns that, “conducting cross-cultural research is rife with ethical and methodological challenges” (p. 4). This is in part due to the lack of literature on cross-cultural research methods. As a result, researchers who are working within this context have very little information about how to deal with difficulties as they occur (Liamputtong, 2010). Liamputtong also emphasizes that it is imperative that researchers conduct their research ethically by considering cultural implications. I appreciate this cautionary message; however, I believe that challenges were avoided by involving participants within each stage of the research project, grounding the project in IQ, and the fact that I have a long-standing relationship with the community.

Strengths and Limitations

All research projects have some limitations that need to be acknowledged. I have attempted to be explicit about my location as a researcher within this project and in this community. I have made decisions about what to include and what not to include in this

thesis, and I acknowledge this is based on my worldview, as well as that of the participating women. This inevitably means that there are gaps and biases.

Although I acknowledge the possibility of gaps and biases, it is important to counter this with the fact that the participating women's voices have remained central to the process. This is one of the strongest elements of this study is that those with whom I engaged with, shaped it. Literature about CBPR supported the design; however, the participants and I shaped how the process occurred. Centralizing the participating women grounded this study, and achieved its goals, which were to engage Inuit women, as experts in their own lives and communities, to find out what they think their community needs for sexual health promotion and HIV and STI prevention, and what they believe determines sexual health. The participatory design of the research project also allowed for ongoing, integrated knowledge translation (KT) with the community throughout the research process. As well, the women-centered process allowed for iterative decision-making and KT to take place.

My dual role as community insider and academic researcher represents a potential limitation. My insider status could be viewed as a limitation from a positivist paradigm, in which I might be seen as too close to the data to be objective (Innes, 2009). Yet, knowledge of the culture and workings of this particular community are a major strength. Participants knew me, as well as my background as a community sexual health educator. Through that role, I had taught their children, grandchildren, or themselves. This established trust allowed them to feel comfortable sharing their stories with me. Moreover, my long association and relationship with this community ensured my access to this information,

and also means I have a thorough understanding of the context of these stories, which could be misunderstood by an outsider.

Research in the Canadian North is often limited by budget, due to the expense of travel, food and accommodation. The strong community involvement and support, combined with the strong researcher-community relationship, resulted in the project being well funded. My relationship with the community also provided me with free accommodation and discounted airfare. This enabled me to travel to the community numerous times before and after the data collection trip.

Many of the storytelling sessions were with multiple participants. This limited the possibility of confidentiality. I took steps to ensure confidentiality of the participants; however, within a group setting this is not always possible. This limitation was discussed during the informed consent process at the beginning of each storytelling group, and we discussed keeping what was said in each group private. Women were respectful of this idea and agreed. This may also influence what women felt comfortable sharing, however many women who reflected on the research process said how good they felt after sharing stories that they had never talked about before. Some woman may have been reluctant to share personal information; however, the group setting proved to be a positive experience of sharing and for the most part, women felt comfortable discussing the issues within the group, resulting in the collection of rich data.

Another perceived limitation is the small sample size and thus lack of generalizability. This study took place in a particular place (Kugluktuk, Nunavut), within a particular time (November 2012 - April 2013); with a particular group of people (21 Inuit

women age 18-61). Consequently, generalizability of the research results is limited. Hesse-Beiber and Leavy (2011) claim that, although qualitative research cannot be generalized across populations, qualitative research has a different aim. The aim of this project was not to generalize, but to capture these women's experiences and their ideas, in order to have a deeper understanding of their perceptions. Although this small sample size and purposive sampling limits generalizability to an entire population, the information gleaned through this study adds greatly to a field where there is little existing literature.

Ongoing Dissemination

Within Community: Community Knowledge Translation was an ongoing process throughout the research project. Participants aided in the creation of a poster for the 22nd Annual Canadian Association of HIV/AIDS Research held in Vancouver, British Columbia. I traveled to Kugluktuk in September 2013 to report progress on my thesis writing to the women, and to discuss the final print report each of the participants would receive. We decided that each participant would receive an 'executive summary' style document, which will be completed when the thesis is complete. In addition, a few copies will be made available to the Hamlet in both English and Inuinnaqtun. These executive summary documents will be given to participants and the Hamlet during my final research project visit to the community. This will take place after the oral examination, and the thesis is finalized and bound. We will hold a community feast, and I will present the findings and give the community the thesis and executive summary to the community. A bound copy of the final thesis will be offered to the Hamlet of Kugluktuk, and will be housed at the Wellness Program.

External: To date, the methodology and process of this project has been presented in a variety of settings. The following list includes the academic conferences where abstracts have been accepted:

Conference/ Meeting Presentations:

Rand, J. R. & Kadlun, S. (May 2014). Inuit specific community-based HIV prevention: Research grounded in Inuit Qujimaiatuqangit (IQ). [Oral Presentation]. 23rd Annual Canadian Association of HIV/AIDS Research; St. John's, Newfoundland.

Rand, J. (November 2013). Community engaged research: Inuit Community-Based Participatory HIV prevention research. [Oral Presentation]. OHTN 2013 Research Conference: Changing the course of the HIV prevention, engagement and treatment cascade. Toronto, Ontario.

Rand, J. (September, 2013). A story of Two-Eyed Seeing on the Tundra: HIV prevention research with Inuit women. [Oral Presentation]. At Wise Practices IV: The Role of Research in Getting to Zero HIV/AIDS Community-Based Research (CBR) Capacity Building Conference; Saskatoon, Saskatchewan.

Rand, J. (April 2013). Building community-based HIV and STI Prevention on the Tundra: Drawing on Inuit women's strengths and resiliencies. [Poster Presentation]. 22nd Annual Canadian Association of HIV/AIDS Research; Vancouver, British Columbia.

Rand, J. (August 2012). Social Determinants of Inuit Women's Sexual & Reproductive Health: Community Based Research on the Tundra. [Oral Presentation]. International Congress on Circumpolar Health 15 – Call to Congress; Fairbanks, Alaska, USA.

Rand, J. (May 2012). Strengths, resiliencies and social determinants of sexual health in Inuit women: Informing HIV/STI prevention and sexual health promotion programs. [Oral Presentation]. ASPSH's 10th Biennial Western Canadian Sexual Health Conference – Building Sex Positive Communities: Inclusion for All; Vancouver; British Columbia.

Published Abstracts:

Rand, J. R. & Kadlun, S. N.(2014). Inuit specific community-based HIV prevention: Research grounded in Inuit Qujimaiatuqangit (IQ). *Canadian Journal of Infectious Diseases & Medical Microbiology*. 25(Supplement A), 14A.

Rand, J. R. (2013). Building community-based HIV and STI prevention on the tundra: Drawing on Inuit women's strengths and resiliencies. *Canadian Journal of Infectious Diseases & Medical Microbiology*. 24(Supplement A), 138A.

Rand, J. R. (2013). Social Determinants of Inuit women's sexual & reproductive health: Community-based research on the tundra. *International Journal of Circumpolar Health*. 72(Supplement 1), 599-600.

Future journal articles as well as conference abstracts will be submitted to share the findings with a broader research and health professional audience. Funding has been secured through the SRC KTE training award to facilitate KTE activities. Three separate KTE events are planned with these funds. They include a KTE event in partnership with the Canadian Aboriginal AIDS Network, to be held in Nova Scotia; another event will be held in partnership with Pauktuutit and their local partners in Ottawa. There will also be presentations and meetings in Iqaluit with appropriate stakeholders.

The meetings and presentations in Ottawa and Iqaluit will be co-presented by one of the Community Health Representatives in Kugluktuk, who has been involved in the project from the beginning and me. Having a community member facilitate the dissemination meetings with me facilitates community research capacity building and ensures the principles of CBPR are carried through to the final stages of this project. It is important to bring these results to the organizations and individuals in Iqaluit and Ottawa, as this is a link that is often disconnected. This plan for KTE will ensure the people who are making decisions hear these results first hand.

Summary

This research project took a 'determinants of health' approach to examining Inuit women's experiences and perceptions of STIs, HIV, and sexual and reproductive health promotion and education. There was a special examination of themes of strengths and resiliency. The qualitative research method of storytelling sessions was used to generate data that were then analyzed through participatory analysis. Although the health issues are numerous within Inuit communities, there is little literature exploring the context and determinants of these health issues (Healey & Meadows, 2007). Having Inuit women's narratives and ideas about how to best look after their communities, their families, and themselves is paramount in tackling these disparities. Understanding the complexities of the social determinants of Inuit women's sexual and reproductive health can improve the sexual health of Inuit women in Nunavut, and perhaps provide insight for improving the health of Aboriginal and non-Aboriginal women in Canada.

Chapter Four: Findings

This research project intended to bring forward the voices of Inuit women. The findings are comprised of participating women's stories, including their perspectives on STI, HIV and community sexual health; their ideas about the determinants of community sexual health; and what they believe their community could benefit from with regards to HIV and STI prevention and sexual health promotion.

All of the participating women were Inuit, ranging in age from 18-61. They were all living in Kugluktuk and had either lived there all of their lives or for several decades. Their educational backgrounds varied, from primary school education only, to university graduates. Their employment status ranged from unemployed and on social assistance, to employment with the Hamlet of Kugluktuk or with the Government of Nunavut. It is important to note the stories will not be used directly in this thesis. This is because it is the themes that have emerged as they relate to the research questions that are of interest here. The participants and I determined the themes and the excerpts included in the following section have been chosen because they illustrate these themes.

Organization of Findings

This chapter is organized around the five major themes that emerged through the data analysis process: *the way it used to be, change, family, intimate relationships, and holistic strategies*. The findings are presented here with a description of each theme as well as the sub-themes that constitute the major theme. I have included a variety of quotes to provide evidence for and illustrate the emergent themes. I have drawn from as many of the

women's stories as possible. Throughout this chapter, participants are referred to by pseudonyms to protect their identity.

The way it used to be

I have used the phrase "the way it used to be" as a major theme because it was a topic that resonated within the stories of the participating women. In almost all of the story groups this phrase was used as a reference point to speak of change. Despite this, "the way it used to be", is a distinctly different theme than that of "change". I begin with this theme, as it was where most of the women began their stories. Women talked about *the way it used to be* as if to honour and to recognize teachings and ways of the past. This was done without judgment when it came to some customs that are considered quite unorthodox in the modern Inuit world, such as having multiple spouses. They spoke of situations they witnessed firsthand, stories and teachings they received, and reminisced about the way it used to be. The theme *the way it used to be* is built upon the sub-themes of Elders' teachings, rules and order, arranged marriages, multiple spouses and swapping, and menstruation.

Elders' teachings. This sub-theme reveals a gap in knowledge, as Elders typically did not share information about sexuality. Many women referred to Elders' reluctance to openly discuss sexuality, suggesting it was taboo to do so.

The following excerpt from the conversation between Heather and Ella illustrates that older people, or the generation before them (which would be Elders, as these women are 53 and 56 years old) are reluctant to talk about anything sexual.

Heather (53): *One of the things I noticed too though, you know the older people are still reluctant to talk about sexual health, sexual anything with anybody, you know, and maybe...*

Ella (56): *Sort of like a taboo.*

Heather (53): *Yeah, maybe they do know about all this information out there but they're not willing to really open up and talk about it. I think the generation after them, probably our generation, were a little bit more open so, you know, we talk about it to other people like in the schools, right. They have those programs. But I think there's that generation that, you know, they probably know all this information about sexually transmitted diseases or infections but they're not... To me, I find they're not very willing to openly talk even amongst themselves, I think, about all of this.*

The following younger participants discussed the emphasis placed on respecting and listening to their Elders, but that they did receive any teachings whatsoever from their Elders about sexual health:

Shelby (26): *Because our whole life we've been taught respect your elders and listen to your elders, right.*

Jenny: *Right, but...*

Joanne (23): *Like we do what they tell us to do and sex wasn't really talked about.*

Tania (27): *And not just from the Elders too, like from our parents.*

The following quote indicates that historically, sexually transmitted infections such as HIV did not exist among Inuit, thus Elders have little knowledge on the subject.

But for things like that Inuit people or Elders don't talk about HIV because they didn't have that sickness until not too long ago. It might be long ago but some elders really didn't know anything what was HIV and the sickness. The only time they found out what was HIV and when the health centre spread the word. (Kara, 50)

A discussion between Joanne (23) and Tania (27) suggests that it is not appropriate to discuss sex around Elders, and Elders in turn would not approach the youth in reference to this topic. Their discussion refers to long ago- the way it used to be, the taboo of talking about sexuality, which has carried forward to present day with Elders not sharing information about sexual health.

Joanne (23): *It's not because, yeah, maybe because we didn't talk about it. Like long ago you weren't even supposed to mention sex and fooling around.*

Tania (27): *Really, hey? You wouldn't find your granny and grandpa telling you to slap a condom on or take birth control or don't sleep around when you're drunk.*

The younger participants suggested that Elders might have an important role to play in promoting sexual health among youth. The fact that Elders in the past may not have had information on STI and HIV because, these illnesses did not exist in the communities, combined with the idea that it was taboo to discuss sexuality openly mean that today, because of *the way it used to be* prevents Elders from teaching younger generations about sexual health.

This quote from Joanne summarizes the previous points of Elders' teachings, she emphasizes the custom of listening to, and respecting your Elders, and she suggests if disease prevention messages were shared by Elders, it could be an effective way to encourage condom use.

Or it's like we're so used to growing up, when we're growing up we're told to do stuff by our Elders and our Elders never talked about it, so like they told us, respect your elders. So that's what we do all the time and if they talked like here's a condom everyone probably would use a condom (Joanne, 23)

There is a strong traditional value of learning from Elders that remains evident, and the knowledge gap as it pertains to STIs and HIV has created a predicament of not sharing important health information across generations. It seems that the opportunity to learn about such things from Elders is important, but yet up to this point it has been a taboo subject area.

Rules and order. Another sub-theme within the major theme “The way it used to be” is rules and order. Many women referenced how, in the past, there were ways to ensure cohesion, both “in camp” and “on the land”. These were the ways in which communities self-organized, and these “rules” were vital in ensuring peace and harmony within their camps. One example of these rules, which can also be related to taboos, was that in order to keep families close, and to avoid temptation between brothers and sisters in-laws, there were rules about how to approach them. This is heard here in Violet and Ella’s discussion.

Violet (59): *Traditionally too, when there were sisters, when one is married or both, you were not allowed to talk to your brother-in-law directly. You directed your*

questions to your sister and your sister directed the questions; that way there was no sexual involvement between sister-in-law and brother-in-law.

Ella (56): *So no temptation.*

Violet (59): *Yeah, no temptations, but that doesn't happen. I just thought of that when you said when people don't look at each other, but there was a very strong taboo about talking to your brother-in-law or your sister and sisters-in-law, that that at one time it was not allowed, you had to go through a third person to talk to that person.*

Along the same lines of brothers and sisters-in-law not speaking to one another directly, Jeannie refers to order being kept by not discussing certain things, saying, *"I mean there was a period where I guess to keep order or to keep people from doing things that they shouldn't, it was better maybe not to talk about it, but that's not the case anymore"* (Jeannie, 54). Her point links to the idea that not talking about sex would prevent people from having sex.

Another example of ways that peace-keeping and ensuring "rules and order" were followed within small camps was through knowing what was going on with members of the camp. This knowledge was said to be key in keeping everyone informed, and in dealing with any negative behaviour. Elaine (48) highlights the way that the "rules and order" affected life in the camps and how this created a more open and trusting atmosphere, predicated on truth and "knowing" which in turn helped avoid gossip:

But knowledge is power, right, knowledge is power and there was no shame in having that kind of knowledge. In the past, our grandparents' era, knowledge was power,

knowledge was everything. Knowledge controlled the community lifestyle, knowledge controlled the population before there was RCMPs, and who was boss and who wasn't. And if a person doing wrong, the whole community, the whole village was notified and knowledge was power. And right now we're up against a term of confidentiality which there was never Inuit practice in ancestors' era. Knowledge and knowing everything about your people was key to harmony in their camp, their life, their village... ..Or there's a negative aspect to it because people just begin to assume and make presumptions and then become judgmental without knowing everything about you. And then they label people and whatnot. So that's a big difference, old health and new health. I think to educate people like how to help people become more aware of STI and HIVs, having people talk about it. (Elaine, 48)

Elaine raises several points. Her point about confidentiality not being something that Inuit communities dealt with in the past, and that this confidentiality now encourages gossip; because people make assumptions, is an interesting one. Confidentiality is something taken seriously in modern Inuit society, especially when it comes to health services and sexual health. She discusses new health, with the strong emphasis placed on confidentiality, which in her opinion, often discourages people from discussing health issues with one another, and provides opportunities for gossip. Elaine feels, however, that the way to become more aware of STI and HIV is to talk and to be open about it, identifying lack of awareness as a problem. As she emphasizes, "knowledge is power", an important idea to consider when reflecting on "the way it used to be".

The lifestyle of Inuit was very different before they moved into settlements; what information and how it was shared was key to maintaining balance and harmony within the camp. In present day, it seems that the more information is shared, the better it is for the community. There is no longer a need to withhold information from people in order to keep things in check.

Arranged marriages. Women in one storytelling session reflected upon stories they had heard from a woman Elder at a workshop they had attended. She had said that when private conversations took place, children were asked to play outside so they would not overhear what was being discussed. These conversations, she speculated, were related to arranged marriages:

Heather (53): *One woman, she said there was a situation where as soon as things that were very intimate were being talked about you were yelled at and you had to go out. And they made sure that you were out before they had their adult conversation, so maybe, I don't know, and she didn't go into detail but she said there were certain things that absolutely children were not allowed to be...*

Emilie (50): *To be exposed to.*

Heather (53): *Yeah, to listen in on. And she said she remembers being yelled at and she had to go out and they were, it was made very clear to them, that they're not going to be around that conversation. They had people there, so who knows what they talked about then? Maybe arranging marriages, maybe sexual, I don't know, and she's an old woman, like she's a great-granny. So she said this happened where she was forced out and she had to go play out until they were*

darn good and ready for her to come back, and they had their meeting or their conversations. She didn't say what the topic was [laughs].

These women reflected on the idea that things were kept private from children, and that sexual topics and arranged marriages were discussed without children present.

Elaine (48) also spoke about her family, and how her father did not want his daughters to marry into an arranged marriage:

I know my father absolutely would not put up with arranged marriages for any of his daughters. He said he was fortunate to find his, to find my mom, and when he was old enough and grown enough and was independent enough, his own father set him up with his own dog team. (Elaine, 48)

Elaine also referenced arranged marriages with regards to unhealthy relationships, suggesting that if there was violence or negative behaviour within a relationship, an arranged marriage could be used as an "excuse" for violent or poor behaviour towards a spouse:

I could hear people say that "well my parents were forced to be married anyway. My parents were in a forced relationship marriage so they didn't learn to love each other until later on". So they'll go back, they could easily use that as an excuse. (Elaine, 48)

Arranged marriages were also discussed in one of the participatory analysis groups. During a discussion around the issue of sexual relationships between blood relatives (incest), several of the women suggested that the Elders had a practical reason for creating arranged marriages: these were a way to keep track of who was related to whom. In

present day communities, not everyone talks about this, or knows who is related.

Participants said that arranged marriages helped prevent inadvertent cases of incest.

Multiple spouses and swapping. Women told stories of multiple spouses, as well as swapping spouses. This is something that was discussed with reference to the past, and is not something that happens regularly today. It was accepted as something that happened in the past, and was part of “the way it used to be”. One interesting point that was discussed was the perceived absence of jealousy in the past-with regards to swapping spouses or multiple spouses, *because people lived in different camps throughout the year...* (Emilie, 56), and *...some had long-term girlfriends or boyfriends and it was, it seemed to be accepted. I never heard of jealous fights over anybody*” (Violet, 59).

Suzanne speaks in agreement to Violet and Emilie, she said, *“I remember like way past down generations where a husband would have two wives. Nowadays, if they were to have two wives, hey, these two women, they would be punching each other out”* (Suzanne, 42).

The following discussion refers to having multiple spouses, as well as to swapping partners, and the acknowledgement that it was just “the way it was”, and that it seemed to be accepted.

Jeannie (54): *But for that generation before us, they openly had two partners.*

Jenny: *Two women or two men?*

Jeannie (54): *Could be either.*

Ella (56): *Either/or, yeah.*

Violet (59): *A very successful hunter or a very good hunter had more than one wife.*

Jeannie (54): *And it was still happening recently there. There was a lady with two husbands.*

Lindsay (61): *Not only their husband but boyfriend, girlfriend, extra...*

Ella (56): *Extra-marital affair.*

Violet (59): *And wife swapping.*

Jenny: *And were those things taboo and not talked about and like a negative thing, or was it just okay 'cause that's what it was like?*

Violet (59): *I think that at the time that it was happening it was to show friendship and to welcome your people from another camp.*

As women reflected on the spouse swapping and having multiple partners and spouses, they recognized this was something that was done in the past in some cases out of necessity and to show kinship. Women told stories that seemed to be gender neutral, it was not only men having multiple wives or swapping wives. Women recognized it was a different time and this was emphasized by their comments about their impression of the lack of jealousy that went along with these relationships.

Menstruation. Most women spoke of learning about menstruation as their main reference point for when they first learned about sexual health. These women also recognized that long ago, young women usually didn't learn about menstruation until after it happened. Many women remembered that they had thought were dying when they had their first menstrual period because no one had taught them about menstruation.

Well, for me, I guess, for my age group as growing up, anything to do with sex was taboo. Like, it wasn't discussed. The only thing that would come up was when women started their monthly and then that would be a little bit explained saying that you're going to have it every month. Basically that's it... ..And then they'd say, and if you stop, you're pregnant. That was it. I mean, you know, nothing to go with it or before. That's when you started, you were told you need to wear a pad, you're going to have it every month and if you don't have it, you're pregnant. And how do I get pregnant? I don't know. [laughter] That's a big surprise for me when I started my monthly. I wasn't told anything about it, wasn't talked about... ..I thought I was dying. (Candace, 56)

In reference to not learning about periods when she was growing up, Suzanne (42) had a similar comment to share: *Yes. Not even about when you're going to start your period at a certain age, nothing, no puberty information. You're only going to grow up.*

There has been a shift with regards to menstruation from “the way it used to be”. Women felt that they have played an integral role in this.

Yeah, I mean just in my short lifetime it was where I started my periods, I thought I was dying, and now we've come so far to where now we're actually sitting here and we're thinking, yeah, we need this information so that we're more open and we're passing it on to our younger people. (Jeannie, 54)

The older women recognized things are not the way they used to be, and as they reflected on it, they were happy that they were making the transition to “the new way” of sharing information with other women and girls. These women felt strongly about ensuring young

girls have adequate information before they start menstruating so that they are not shocked, and that the information is being passed on.

I'd say now the younger generation, they're not as embarrassed as, to talk about sex and what happens. Like, I know some mothers I've talked to say that because they weren't told about the menstrual cycle, they got to tell their girls about their menstrual cycle before they started and so they weren't as shocked as I was. (Candace, 56)

The way women related learning about menstruation in the past places it within this theme. According to the older women their first experience of learning about sexual health was their first menstrual cycle, which was a shocking experience that they were not prepared for. These women further reflected on how great it is that today they have the opportunity to speak openly about menstruation, and now, young girls are prepared for menstruation before it starts. They feel like this is an important change from the way it used to be.

The “way it used to be” is linked to the next major theme, “change”. Although “the way it used to be” refers to things from the past that have changed, these two themes differ in the way women talked about them. The “way it used to be” in some ways honoured and recognized the ways of the past, and was strongly linked to traditional lifestyles, whereas “change” speaks of new ideas and activities happening in a modern Inuit world.

Change

The major theme of “change” emerged from a variety of stories that can all be linked back to a change, be it personal, societal, or community change. Most of these were changes that

women had personally observed over their lifetime with regards to sexual health, STI and HIV. Several sub-themes are included under “change”: sexual health teachings, alcohol use, sex trade, gender and power, transience and travel, and taboo.

Sexual health teachings. Women in this study reflected on the changes that have taken place within their own families, and in some cases, within the wider community, with respect to sexual health teachings. This sub theme is built on women’s stories of changes they have seen in the sharing and teaching of sexual health information.

Jeannie (54), noted the big difference between the education she received regarding menstruation and that which her daughter is received,

*We've gone through such a huge change and I mean I'm so grateful that my little kid turns round and she's, 'oh yeah, mum, they [teachers and students at school] talked about periods' and this and that. And I said, 'you know, how fortunate you are?' she says, 'oh, it's about periods and about sex, I don't really want...' She's only a little kid. I said, 'look, when I was your age, a little bit older than you when I started my period, I thought, I literally thought I was dying'. So I told her, you are very fortunate; I said **knowledge is power**. She still goes, oh, [laughs] (Jeannie, 54).*

Jeannie's daughter described to her mother about the teachings she has received at school about menstruation. Although her daughter found it embarrassing, Jeannie was happy this subject is being taught in the school, and is eager to discuss it at home with her.

When discussing whether sexual health was talked about at home, the following conversation arose among some of the younger women:

Shelby (26): *Never really talked about. ... Sexual health...*

Tania (27): *I don't know.*

Joanne (23): *I think it was never talked about and now it's changing. You see more about it in the news.*

Shelby (26): *Yeah, than you did in the past, right. Our parents were... [overtalking].*

Tania (27): *And even if you look at old traditional knowledge that's out there, like that's been written down, there's nothing in there about sex.*

Joanne (23): *Yeah, there's nothing there.*

Shelby (26): *Nothing at all.*

Shelby (26): *So it is changing though.*

A change noted throughout various story sessions around sexual health education is that it is discussed more openly now, including in the media, and is known, and now expected, to be taught in the schools. Youth are now expected to have adequate access to information about STI and HIV at school. Women also expect that the wider community should have access to information through the health centre and other places in the community.

The schools, parents and the wider community are all mentioned here as this is to where Lindsay (61) feels programming needs to occur:

...and having, going into the schools too with the programming, like there's a program in grade five health, even if it started from grade four, about changes in your life for the girls and the boys and talking about how to prevent this type of disease. That helps and I think that needs to be more, also more has to be done at starting into the next school, the high school... And the parents have to sign a consent form for that subject to

be taught to their child and I think more has to be made, more of the community and the parents have to be given, have to be made more aware of what the program is instead of teaching about just sexual activities. But 'cause some of them, not knowing what is gonna be taught, don't want to sign the consent form, so therefore you see a child or two who are not included during that class. That happened every year in the elementary school. I think more has to be talked to the parents and the community (Lindsay, 61)

Lindsay raised several points here; she believes more can be done with the programming within the school. Also, she feels that more involvement by parents and by the community would help with sexual health education. Given the fact that parents must consent to allow their children to participate in human sexuality classes at school, the more information provided to parents, the greater chance the parents would allow their children to participate. Parents need information on what is going to be taught; they hear the words “sex”, “sexual health” or “sexuality”, and feel their child is not ready to receive that information, without knowing what will actually be covered.

Heather and Violet discussed the need to disseminate information about sexual health to those youth who may miss out on the programming at the school, because “...with so many non-attenders in a community, things like this have to be put out more to the youth centre as a program...”(Heather, 53). Violet emphasized that the programming needed to be tailored in such a way to make it accessible for youth, adding to Heather's comments: “...in a way that it doesn't scare the kids that involves kids in a good way, not to shame them out or discourage them from participating” (Violet, 59).

Lindsay (61) reflected on past health promotion activities that had taken place within the community, and suggested that sexual health education take place outside of the school within the community, *“Like the way when you did healthy eating and healthy snacks; that went well. Maybe something like that would work as well when going to the communities outside of the school.”*

Women’s stories of sexual health education revolved around improving curriculum within the schools and adding programming in the community. They reflected on the fact that this is a change that has taken place within their lifetime. They shared stories of what was happening, and what they hoped for future community sexual health education.

Alcohol use. The sub-theme of alcohol use was discussed in all of the nine story telling sessions. This arose in response to what women thought contributed to negative sexual health outcomes. Often, the first thing women thought of was alcohol and drugs. Alcohol as a sub-theme sits within the major theme of change, as the introduction of alcohol to Northern communities was a major change because it impacted the way people behaved and related to one another. Rachel (53) reflects on how alcohol impacted her community: *“I remember when I was a kid and all the alcohol and that came to the DEW lines⁴, that’s when... it’s like I got so lost. I was only four or five years old when I remember those days... The kids... and the DEW line came and then the alcohol came and then they had no time for kids.”*

⁴ DEW Line – Distant Early Warning line: In 1955 the USA and Canada agreed to build a system of 63 radar stations far North (42 along the Canadian Arctic Coast) to detect incoming soviet bombers during the Cold War. The DEW line created centres where Inuit could find employment, access medical services, and trade goods, thus encouraging Inuit to settle in sedentary communities (Bonesteel, 2006).

In response to how the spread of STIs could be stopped, Kara (50) described the difficulty of strategies working when drugs and alcohol are involved. She also reflected on her youth, and how, when she was involved with alcohol, she didn't care about such things.

...it's gonna be pretty hard again because there's so much drugs, and youth... and they might just do whatever they want... ...you know, when you're like drunk or anything use and they won't care because it's pretty hard like to do anything when you're drunk. I know that since [when] I was a teenager I used to drink lots. And then we don't seem to care what's happening in the world especially in that situation from drugs and booze and that's how it [the spread of STIs] keep going on and on (Kara, 50).

Here, Elaine shares her perspective of alcohol and drug use contributing to vulnerability, of vulnerability to sexual assault, and of negative sexual health outcomes from not practicing safer sex.

I know there's a lot of ignorance to it [with regards to STI] especially when substance abuse is taken into consideration. ...women are, they think about their safety sober, always, first and foremost. But under the influence of alcoholism which is too big of a habit in the community where women do get drunk that's where they just, they're vulnerable. (Elaine, 48)

Many women talked about how alcohol and sex are mixed, "*Because there's so much alcohol and sex mixed that once you get drunk you don't even know if you had sex or not. It's scary right there.*" (Rachel, 53)

In many women's stories, alcohol was in the front of their minds and was tied to sexual health. These young women discussed feeling as if they were the exception to the rule, knowing that for many people in the community, sex and alcohol go hand in hand:

Shelby (26): *But the other big factor to me is all the partying and sleeping around.*

Tania (27): *But again there's a few things inside of that partying that changed that. I mean I partied lots, I'm not sleeping around every time I get drunk.*

Joanne (23): *I party lots too, I don't sleep around.*

Shelby (26): *Yeah, it comes down to the individuals, yeah.*

Although the term "sleeping around" used by these young women sounds as though there may be some degree of stigma associated with this behaviour, from what I have seen and heard, this comes from a place of concern, rather than judgment. They acknowledged many people associate/ combine alcohol and sexual decision-making, and the reality is many people they see do this. They however, are aware this is an un-safe situation for their own sexual health, and note that they enjoy partying and drinking, but do not have the same association of "sleeping around" when they are partying.

Alcohol use came up a number of times in the storytelling sessions as a factor negatively affecting sexual health. Women also noted the importance of prevention programs including components to address alcohol and sexual decision-making. Within the participatory analysis groups, we discussed briefly why so many people used alcohol, and combined sex with alcohol. It seemed as though, this topic could lead to another entire study in itself, and decided that we would acknowledge addictions, drugs and alcohol, and focus on it as a factor contributing to negative sexual health outcomes.

Sex exchange. A sub-theme closely linked to alcohol, drugs and addiction, is sex-trade. This was discussed by women in several of the story groups. Women told stories they knew of women in the community trading sex for something in return. Struggling for money is one reason Suzanne (42) suggested women may find themselves in this situation: *Probably even other people who are struggling for money are going to see other people there too and have sex with them for money.* All of the other sex-trade related stories were linked to trading sex for money to pay for various addictions, specifically, for drugs or alcohol, or money to obtain drugs and alcohol, or for gambling.

During another storytelling session, a discussion between Tess and Rachel explained what they knew of sex being traded for drugs, or alcohol, or money. This conversation also illustrated their understanding of the connection between trading sex and the spread of STIs.

Tess (58): *Younger people who like drugs, they'll do anything to get something.*

Rachel (53): *Drugs even, they would have sex so they can get drug money or do whatever like that - drug money, booze money or whatever. I heard that in town.*

Interviewer: *Yes, and you think..*

Rachel (53): *Yes, in town; yes, just for drugs or play cards; money anyway; sex for money.*

Tess (53): *And that's where all these STDs are coming from because it's not just from one partner, it travels on.*

Several women shared these same views with Rachel and Tess, and additionally, they expressed great concern that they were not sure how to help women who were in such situations.

Here, Sam and Sylvia talked about women in these situations, and how they do not seem to care about the risk of STI.

Sam (26): *Well, they don't care. They don't care.*

Sylvia (18): *Some people don't care. All they care about is going to other men or other women.*

Sam (26): *Or they've got booze and drugs, they should go fooling around with them or something, you know.*

Jenny: *Oh, yeah, to get them.*

Sam (26): *When they're desperate they do that, like I know a young girl and a mother, they go to an old man just for the money. And I was at the neighbour's with them and they went there and then the daughter and mother start fighting over money from that guy.*

Rachel shares her concern of the dangers for women in these situations:

They don't realise it's dangerous; they just go and do it just for that \$10 or \$20, whatever. Never mind your body; it's just that money that's right there, you know? Sometimes they think like that and I don't like the sound of it, you know? (Rachel, 53)

The stories told about women trading sex were all second-hand, that is, the storytellers were talking about other women, and other community members' involvement with trading sex. The stories were told with a slight degree of stigma, in that the women reflected on these situations and felt that these were negative health behaviours, especially with respect to sexual health. The stigma was expressed in their disagreement with such behaviour, but it seemed to come from a place of wanting to help, and wanting to ensure these situations could be avoided.

Gender and power. Women spoke of the change in dynamics between males and females. Whereas in the past it was common for males to assert their dominance, in the present day women are visibly gaining more independence and freedom from their male partners. Some of their stories of gender dynamics were discussed broadly and were not directly related to sexuality or sexual health. Other stories of partners cheating and contracting and transmitting STIs were laden with gender and power dynamics.

Elaine (48) refers to the power men had, remembering *...women had such a little voice when men were such dominating, domineering individuals of a community. It is almost like taboo to say no, and so it was hard. I know I was scared.* In Elaine's reflection she could remember being scared to speak up to men, and speak against what they said or wanted. This was not necessarily directly related just to sex, but was more broadly discussed with all relations between men and women (which would involve sexual situations, too). She continued:

But for the most part I see so many equal relationships between the man and the woman [in Kugluktuk], whereas living in other parts of Nunavut, one community, the last community we lived in, it's a very, very male dominant society and I fear. I feared more for women there than anywhere else and for young girls, yeah.

Elaine is encouraged by the number of equal relationships she sees in Kugluktuk, but expresses her concern for other parts of Nunavut that appear to her to be very male dominated.

Louisa (59) recalled government work she participated in a few decades ago and how she had to fight to have her voice heard:

When I was sitting on boards way back, it was male-dominated. I was only the one woman sometimes. And they used to try and talk around me and talk down to me and I'd say, excuse me, I have experience and knowledge of this. I will speak on it. And if you do not let me speak, then I will complain to so-and-so. You know, like I knew the system.

Louisa raised an interesting point about gender and power within politics. She had experience in various governmental positions and on advisory boards, and yet she, being female, felt as though she had to fight to have her words considered. Although this is not representative of an intimate relationship, the power dynamics in the larger society (i.e. the political environment) can certainly influence gender and power within a household.

Jeannie (54) shares her thoughts of how the physical dominance men would exert over women has changed. She suggested that physical violence within relationships was much worse in the past. She is hopeful that since the evidence of physical violence is not as visible as it once was that hopefully, relationships are improving.

Like in my younger days it was not uncommon to see so many black eyes and that's not a common thing here anymore. It used to be just like so much of it. It's not

anymore and I think it's true that hopefully the same with the relationships and with sexual health. Jeannie (54)

Within many of the storytelling sessions, women spoke of contracting an STI, and many of them specifically talked about contracting STIs from their long-term partner (husband or common-law). Here, Myia (47) reflects on her experience with her former common-law partner, who would accuse her of cheating, and fight with her:

It happened to me for years. It's been going on all my life it's how come I left my ex-common-law. He was the one always fooling around; he'd accuse me and then take it out on me even though I didn't do anything. Myia (47)

Louisa (59) shares her perspective:

... our men were seen as, oh, you know, they, as a wife you stay quiet. ... I was told that. You stay quiet! Your husband is your husband. He rules the home. You do not question him. You do not argue with him. You listen to what he says and does. You don't question. If he fools around, you accept it. That was the norm. And that was how it was... Sure there was a lot of anger. There was a lot of fighting and whatnot and, but along with that also came STDs. I as a wife and many of us, suddenly we were called in the nursing station and that was the biggest, most painful, most embarrassing moment in my life was to be called in to take these pills because suddenly I was seen as having an STD. And I'm wondering where in the hell did I get it. What did I do? ...And I am, I was educated. I was educated in university but I had forgotten that it is passed on through sex. And that is from the spouse. You never want to think of it as he's not fooling around on me, he's not doing those things. So we

had to be treated and after that we protected ourselves more even as a wife. I did anyways. And so did other women. We talked about it amongst ourselves with my cousins and whatnot and other women.

Louisa (59) raises several points here. She tells a story of contracting an STI from her husband, and experiencing the pressure to just accept it, as he was “the boss”. In her story she uses the term ‘we’ instead of ‘I’ because she is referring to this being a common experience for her and her peers. It did appear that this was a common experience for women, and was discussed in several storytelling sessions.

Tess (58) also talked about contracting STIs from her husband prior to their divorce. *And it was my ex-husband that liked to fool around so I was getting STDs.*

Elaine (48), described the successes women have shared in overcoming male dominance, and her pride in being a part of a community with gender equality.

But for Kugluktuk women, I’m glad and I’m very proud to say I’m from here because women have come such a long way from overcoming the dominance of men now, and we’re all equal here. I see very, very few women that are still, in my view, you know, dominated by the male in the family.

The stories women shared regarding the theme of gender and power all spoke of change, that women have more say than they once did, and that things have been with regards to women having a say. Other stories were more individualized, and women spoke of the power struggles within their intimate relationships. Although the stories of husbands cheating and transmitting STIs to their wives were, in some cases, painful and embarrassing for these women to talk about, they had all overcome this, and had either

worked through the situations with their partners or had found the strength to get out of the situation altogether.

Judging from the stories women shared of experiencing the imbalance of power with men, and the re-balancing that has taken and continues to, take place it appears that the gender dynamics are changing. Although the political gender dynamics may not be directly related to sexual health outcomes, it does appear to influence intimate partner gender dynamics.

Transience and travel. Transient workers entering the community, as well as community members traveling for work were discussed as factors relates to the spread of STIs. Community members often travel in and out of mine camps for work, and construction crews enter the community to work for various periods of time. This transience creates conditions that are conducive to the spread of STIs.

Elaine (48) talked about *loneliness and travel*, stating that she would see people travelling for work, and that they would end up in sexual situations outside of their committed relationships. She also commented on the spread of STI with workers who travel in and out of their home community, stating, “*People coming in to work from out of town. Mine camps probably, when people go to—I heard people talk about that..*”. Elaine also mentioned the workers who arrived temporarily to work on construction, “*Where the STIs are happening that way. But it does open for a threat of it for sure. Construction companies that bring in seasonal workers.*”

Not only does this transience relate to the construction and mining industry, but it also affects Education and Health Care. Louisa (59) talks about the trust that is needed with

teachers and health care workers in order for effective prevention and education to take place.

I was able to tell our teacher, look, I want my daughter to know this and this [sexual health information] and this and you give it to her because she will listen to you as a teacher. She trusts you. Back then our teachers stayed long term and there was that trust and bonding and also our healthcare system. So they would come in and speak with a teacher. So was that building trust was shared. So, to me, I'd like to see that happen again, even if the people are not long-term healthcare workers and teachers. Somehow that building up of trust has to start again, has to be there so that the passing on of knowledge and preventativeness and prevention is still passed on.

(Louisa, 59)

Louisa's point about long-term teachers and health care workers and building trust is an important one. When new teachers and nurses arrive in Kugluktuk from “the south” it is difficult to build a trusting relationship because those workers are inherently transient, leaving the community when their contracts are completed. Louisa viewed the trusting relationship with teachers and healthcare workers as key in knowledge exchange and STI prevention.

Taboo. The word “taboo” was used frequently within women’s stories. This sub-theme illustrates attitudes regarding open discussions about sexuality and sexual health. It is also often mentioned within other sub-themes. Most women used “taboo” to describe the changes that they were seeing with attitudes towards sexual health. They felt a change is occurring towards people being comfortable discussing these topics.

Candace reflected on what it was like when HIV/AIDS was discovered and awareness was raised in her community,

...when the HIV/AIDS came out, that was a big scare in the community, a lot of it just coming out and when we had the guest speaker come that was positive and with AIDS, there was a lot of talk around it but nothing really taught to children even though parents had heard the story and things like that. It was still quite taboo to be talking to your kids in your own home setting. (Candace, 56)

Although the issue of HIV/AIDS was being discussed within the greater community, she felt there was little information brought home and shared with children, because it was taboo to discuss these topics with children.

Ella echoed Candace's sentiment and felt that for a group of people to discuss STIs openly was considered taboo:

But to actually sit down with maybe three or four people and get into discussions, I don't think that ever happened. Well, because it was sort of a taboo thing, you know. You know, just sit around a coffee table and start talking about sexually transmitted, sexual anything. (Ella, 56)

Heather and Violet suggest it is taboo for older people to talk about sexual health with anyone,

Heather (53): *One of the things I noticed too though, you know the older people are still reluctant to talk about sexual health, sexual anything with anybody, you know, and maybe...*

Violet (59): *Sort of like a taboo.*

These three examples illustrate how 'taboo' can be an impediment to open discussions regarding sexual health concerns. Respecting taboos was a large part of traditional Inuit culture, and to break a taboo was thought to bring negative events to the camp. This moves beyond the idea that talking about sexuality is taboo because to do so causes discomfort or embarrassment, and suggests a larger cultural consequence.

Although discussing sexuality openly is said to be taboo, these women were eager to break that taboo, reflected on observing the breaking of the taboo, and were encouraging this change by talking about sexual health with their families, friends, and within this research project. They spoke of celebrating the fact that we were able to openly talk about these issues.

All of the sub-themes within the context of the major theme "change" signify ways in which things have, or are beginning to, change in Inuit culture. The women's stories focused on these past concerns and they noted that there have been meaningful changes in all of these areas. Some of the changes here have led to negative sexual health outcomes, such as alcohol and substance use and abuse, trading sex for money or alcohol or drugs, and transience and travel which can encourage sexual practices that lead to the spread of STIs. However, there are positive changes such as discussion of sex and sexuality becoming less taboo, changes in gender and power dynamics, and increased sexual health teaching that are leading to more positive sexual health outcomes. The fact that women are identifying these changes as influencing community sexual health creates knowledge that can help better promote sexual health outcomes. The women who participated in the discussion felt that they had played a role in initiating these changes over time.

Family

The theme of “Family” emerged as most women's first reference point as to where they learned about sexual health. Many women reported learning about sexual health from their cousins or older siblings. Although most women did not learn from their parents, they stressed that children *should* learn about sexual health from their parents and that the family should be the first source of sexual health information. Women who were mothers and grandmothers discussed taking an active role in educating their children and grandchildren. Some younger women who were not yet mothers discussed taking a teaching role with their younger siblings.

I tell my children. The sub-theme, “I tell my children”, is based on a phrase many of the women used. Despite generations of Inuit women not learning about sexual health from their parents, these women are committed to educating their own children and grandchildren about sexual health. This was also noted by women who do not yet have children.

Joanne (23) emphasized the need to get the message to parents, saying, *We need that and somehow we need to go out and tell the community it's okay to communicate with your children about sexual health.* Candace (56) also illustrates the need for parental support to help parents discuss sexual health with their children by stating, *“ I've got no problems with teaching my kids, but with one, a good friend, she didn't know how to tell her daughter or how to talk to her daughter about sex and the menstruation cycle.”* Suzanne (42) mentioned not learning very much about sexual health and STI until she was older, and

said, *“Since I know some of this information I tell my children about it, let them know what to expect so they grow up.”*

Tania talked about how passing on information about sexual health is important. She noted that despite the awkwardness, she tries her best with her siblings, to ensure they are being safe:

But even for me to talk, like I try to talk to my brothers and sisters about it but it still feels awkward, like it's a hard discussion to have. But then again the other day I told my brother to put a... 'cover it up, boy!' that's exactly what I said to him. [Laughs] It was like, 'oh, cover it up, boy!' He was, he gave me the weirdest look. (Tania, 27)

Violet (59) shared a story of her experience with her teenage grandson, and her promotion of sexual health education:

One of the things that I noticed too is I have a teenage grandson that lives with me and when I do his laundry I'm always finding condoms in his pockets. So having that available is good and I think what they need to be educated on, or everybody needs to be educated on, is how they're used and how good they are and what they prevent you and your partner from getting, stuff like that.

Despite most of the women reporting they did not learn about sexual health from their parents, they are committed to educating their own children. Many women talked about teaching their children, grandchildren, and their younger siblings about sexual health. Although in previous generations it was not the norm to have open communication about sexual health, it is clear these women fully recognize the importance of children learning about STI, HIV and sexual health from parents.

This comment from one of the younger participants reinforces the effectiveness of youth receiving sexual health information from their parents,

If your parents, like they tell you that you have to go to school in the morning, that's a lesson that you learn from them. Or you've got to go and sweep grandpa's floor, you go and do that. But in our homes, well in my home, using a condom or having safe sex was not something that was said. I never heard my parents talk to me about sex before (Tania, 27)

Tania acknowledges the value placed on lessons learned from parents, and suggests a lesson that was missing in her home was one about safer sex practices.

Future generations. Women recognized that for them, their knowledge of sexual health was not comprehensive enough and that they had missed a lot of information because it was not discussed with them. These women are committed to ensuring that future generations have more information available to them. They realize the seriousness of the state of sexual health, and rates of STI in their communities, and worry about the future generations.

Suzanne (42): *I don't know, Jenny, I'm starting to think of our... like our future generations.*

What kind of information they would have. Think for our futures. They're only a baby now but they will grow up and go through all this too maybe.

Myia (47): *For sure, hey?*

Suzanne (42): *Basically, it's getting badder and badder; how bad will it be when these babies grow up? What kind of information will be out there on all this STI and HIV?*

Suzanne sat with her baby grandchild on her lap as she talked about future generations and reflected on her experiences witnessing STIs getting worse and worse within the community. She worried that it will continue to get worse, and wondered what it will be like for future generations.

Heather (53) emphasized that the next generation needs more education, and refers to this research project as the information that is needed to share with the wider community, stakeholders, and youth. She emphasized youth, again reinforcing the importance of focusing on future generations, and said, *"I think for the next generation there's a lot of education that needs to happen through like what you are researching. It needs to be shared with the stakeholders and put out to the community, especially to the young people."*

Louisa (59) imagined out loud the possibility of a future where one is required to pay for health care, and mentioned future generations who may need to deal with this. She said this as she emphasized the importance of prevention, *"Someday maybe my children will have to pay for health care. Maybe my grandchildren. So by then I hope to see more prevention of all these diseases that are still out there."* Louisa (59)

Rachel (53) shared an interesting perspective about the emphasis placed on Elders and Youth, which excluded her from learning many valuable lessons.

It started when I started working here or anywhere - they all say, 'Elders and youth, elders and youth'. What about the middle-aged people? That's what I always say. We could have been taught by the elders and youth, right in the middle and then it would carry on from there to there to there, and we just get forgotten; totally, completely, that's why we can't teach our kids, our younger kids anything because we were all left out for years, completely - only elders and youth, no middle-aged people. We're just totally left out for years...We could have been proper teachers; if we all get involved too then we could have been like the elders, teaching our kids by now but we were always left out, didn't know what's going on. That part hurts me the most because I can't even get to teach my children what our elders go through because I'm left out from here...

(Rachel, 53)

Rachel was emotional as she described her feelings about being left out. She felt as though she missed important learning opportunities that she now needs as a soon-to-be Elder. The government, schools, and community programs have for many years placed great emphasis on connecting "Elders and Youth", which is important and is a traditional Inuit value. However, that created a gap of Inuit who were middle aged when these programs began. As a result Rachel now feels as though she is unable to teach the next generation, since she was left out of such valuable lessons.

Although they worry what is to come, women realize it will take several generations for the change to take place.

Yeah, maybe they do know about all this information out there but they're not willing to really open up and talk about it. I think the generation after them, probably our

generation, were a little bit more open so, you know, we talk about it to other people like in the schools, right. They have those programs. But I think there's that generation that, you know, they probably know all this information about sexually transmitted diseases or infections but they're not... To me, I find they're not very willing to openly talk even amongst themselves, I think, about all of this. (Ella, 56)

Ella raised several points in her reflection of the change between generations. She could see that that her generation is more open than the previous one, and described the progression from generation to generation. This point came up with several women. They believed their generation was more open than the previous one, and spoke of future generations having more access to information and being more open to discussing sexual health than was their own.

Inuit traditional values place emphasis on passing knowledge and skills onto the future generation. Therefore, it is not surprising while discussing community health issues that the future generation was highlighted as an important component to focus efforts upon. Each of the quotes discussed here bring a slightly different point forward with regards to future generations. Above all, this is a strengths-based view that looks forward to ensure situations will be better in the future than they have been in the past.

Family homes. The sub-theme of "family homes" emerged as a component of the major theme Family. Women discussed the need for private time for adults to be alone together, and that there is an issue of over-crowded homes, which prevents this from happening. Some houses have over 13 children living there as well as the adults in the home. It is well known in Kugluktuk, as well as across Nunavut there is a serious lack of

housing. Over-crowded family homes had several negative sexual health outcomes that women discussed. To foster healthy intimate relationships couples need private/alone time, and this is especially hard to find *“when they have a lot of kids”* (Allison, 33).

In a discussion about what people need to be sexually healthy, Suzanne (42) said, *“I think maybe more time for adults to be alone together... children ahh go have your sex, you can make the loudest noise; we just need a quiet place to go to or kick all the kids out.”* This is an important issue which was further discussed within this storytelling session as Amanda (38) illustrated just how crowded homes were: *“one house could have 13 kids and the other house could have only one!”*

Serious situations can arise due to lack of housing, such as the following situation wherein victims of sexual assault are forced to live with the person who assaulted them. Rachel (53) says in Kugluktuk, *“We are so short of houses and there are other people staying in other houses and are being sexually assaulted by that person they’re living with, and they can’t even say anything because they need a roof over their heads.”* This also contributes to women not being able to report the assault for fear of losing their housing.

Another negative sexual health outcome that Amanda linked to overcrowded houses was family members having sexual relations with family members (incest). In reference to this she said: *“It’s [incest] still probably happening with so many people in one house”* (Amanda, 38). There are many houses with inadequate numbers of bedrooms and beds to sleep everyone, which results in family members sharing beds which as Amanda suggests, can in some cases lead to incest. The situation of overcrowded family homes is a serious one, not only affecting sexual health as outlined here.

Although this theme, Family, has only three sub-themes, many women discussed the role of family with regards to community-based sexual health promotion and disease prevention. Women spoke of family within many of their stores and this can be seen throughout other themes. It is clear that family is an important factor when it comes to Inuit sexual health.

Intimate Relationships

Naturally, as the storytelling sessions were focused on discussing community sexual health, HIV and STIs, "intimate relationships" was a prominent idea that was discussed. Intimate relationships emerged as a theme in various ways; women told stories about their observations of other people's relationships, as well as their personal experience within their own relationships. This major theme focuses on intimate relationships; however, it is interesting to note there are many examples within these women's stories about intimate relationships influencing other interpersonal relationships, and vice versa.

Communication. Within the major theme of "intimate relationships" emerged the sub-theme of "communication" which was discussed in the context of romantic relationships. A few of the younger women discussed the role of communication, or lack thereof, in deteriorating relationships. They also discussed the idea that having healthy and communicative relationships could help to reduce STI rates. The women highlighted that a common occurrence in a deteriorating relationship is one partner having sex with someone outside of the relationship, noting their inability to communicate about the relationship as a reason they may cheat.

This discussion between Joanne, Tania and Shelby, reflected on the need for healthy communication within sexual relationships. They spoke of lack of communication as contributing to unhealthy sexual decision-making, such as cheating as a way to break up with someone instead of communicating with their partner about ending the relationship.

Joanne (23): *Even another factor could be like if you're not happy with your current relationship, you go out and sleep with someone else.*

Tania (27): *Yeah, for sure. A lot of...*

Joanne (23): *You see a lot of that.*

Tania (27): *Yeah, a lot of people don't know how to communicate in that kind of situation, if they're in a bad place. They don't know how to break up or, you know, so they break up by fooling around and sleeping with somebody else.*

Shelby (26): *Just need better communication. Yeah, it's like there are these girls having a good healthy relationship, I think that would play a key role in... not prevention, but it's reducing the numbers [of STIs].*

Within the following excerpt from Candace (56) she refers to past difficulties within her relationship with her husband. She suggested that having a stable, intimate relationship can help ensure people are able to communicate about sexual health with their children. She feels that, as a parent, if your relationship is stable and healthy, it makes communicating about healthy relationships to your child easier:

... like, before when our relationship was not stable, the touch [from intimate partner], I used to just cringe. But now, it's just a little touch and then dragging the other half to the bedroom. ...but if people could find relationships like that, they'd have no problems

with communicating to their kids about healthy relationships, sexual health and the STIs and HIV/AIDS.

Candace explains in her story that, for her, having a positive intimate relationship makes it easier to communicate with, and educate her children about, healthy positive relationships and sexual health issues. She feels that if other people are in healthy relationships, it may be easier for them to teach their children.

Communication is vital in healthy relationships and is important for being able to share information with partners and family members regarding sexual health. The following quotation tells of unhealthy relationships, which can be linked to lack of communication, and contribute to negative sexual health outcomes like STIs:

Being in small communities there's so many unhealthy relationships where individuals find themselves bouncing back between same individuals. So they might have this boyfriend or this girlfriend, they break up and go back to this other woman and constantly, you know, back and forth like a bouncing ball effect that people do. They're just sharing the same diseases (Elaine, 48).

The theme of "communication" can be seen throughout other themes throughout these findings. It is an important component community sexual health and HIV and STI prevention. Communication within an intimate relationship is as important for sexual health as communication with health care providers and educators.

Self-esteem and self-image. The following discussion shows a link between interpersonal relationships (with family) and intimate relationships. Tania points out the idea that a lack of supporting family relationships can lead to unhealthy intimate

relationships. This also, as the other women point out, is strongly linked to one's self-esteem and self-image.

Tania (27): *Maybe just not having supporting relationships in their lives; maybe they don't have their mums or their dads or families, or even friends to rely on, so that's probably one of the things I think [contributing to unhealthy intimate relationships]. You know, you're looking for that connection to somebody and if that's the way you're connecting to people then that can end up being a factor. Self-esteem, big I think.*

Joanne (23): *I think that's a really big one, self-esteem.*

Tania (27): *Yeah. If you've been the victim of abuse it can affect it [intimate relationships].*

Tania and Shelby discuss self-esteem and self-image within sexual relationships, and how, if someone has a negative self-image, he or she are likely to connect with their partner in ways that may be unhealthy.

Tania (27): *Unmm I had a thought. ...kind of like the self-esteem thing, about how, like self-image, how you see yourself and how you see, how you fit into other people's lives. If you have that, I guess it kind of went along with the self-esteem thing. If you only can see yourself connecting with people that way [through sex] then you probably have a really low image of yourself, you don't think of yourself as like a valuable person or...*

Shelby (26): *Like if you're hanging out with that person, like that type of person, like for a person to be in a bad sexual relationship, a really bad relationship, it's because that person accepts them. You would think that way about the sex, right.*

The examples shared here by these young women show that low-self esteem, and negative self-image can contribute to people being in unhealthy intimate relationships. This is something they have witnessed within their community, and feel is linked to negative sexual health outcomes.

Role modeling. The significance of "role modeling" as it pertains to intimate relationships was discussed in several of the storytelling sessions. Self-esteem and self-image, and communication, the other sub-themes within the major theme "intimate relationships", are definitely related to "role modeling". Women felt, in particular, that for youth to be able to identify healthy intimate relationships, they need to see examples of these in their own lives. The women discussed broken families, children seeing their parents with many partners, and children seeing their parents within unhealthy situations in their intimate-partner relationships, all as having modeling influence over people, including children.

Candace (56) told a story of how she wanted to get away from home because she was exposed to abusive relationships within her family home, and then ended up in a similar situation herself.

I think, from my view, I wanted to get away from my home setting, were my parents, because it was abusive situation and so I went out and searched for mine, got it and it was an abusive situation as well.

This story illustrates the difficulty in forming and maintaining relationships without having positive relationship role models to learn from. The following story from Tess, discusses a parent's role in ensuring youth witness healthy intimate relationships, and gives examples of young girls seeing their mothers with many partners within unhealthy situations.

Tess (58): *Also too that those little girls in the house, but they're older - their mothers do what they're going to do when they get a little bit older.*

Interviewer: *What do you mean?*

Tess (58): *Like the mother, their mother is kind of... how do you put it? She likes going to bed with certain... with anybody, anyhow, and the little girls think it's going to be okay so when they get older they'll start doing the same.*

Within Tess' example of little girls seeing their mothers going to bed with "anybody", there is some judgement. This judgement could be interpreted as stigma towards her granddaughter's behaviour. Tess feels that in this example, mothers are not teaching their daughters health seeking behaviours, and that this is negative role modeling. The storytelling sessions within this research project focused on what is needed for community sexual health promotion and STI and HIV prevention. Tess's negative attitude toward this behaviour was in favour of health promotion and educating children by being a positive role model, and not necessarily stigmatizing her behaviour.

This following conversation between Shelby and Tania also articulated the importance of role modeling. These women illustrated that the more frequently young people see unhealthy relationships, the more likely they are to view this behaviour as normal and take it on as their behaviour:

Shelby (26): *Unless you get to the root of, you know, having a healthy family, a healthy lifestyle, you know.*

Tania (27): *And there's so much broken families too, like mums and dads cheating on each other and they got kids all over the place and then their kids learn that behaviour and it becomes a part of their own image and their own, you know [behaviour].*

Shelby (26): *I guess most people, a lot of people think it's normal and it's not very... They just have to see the image of, you know, that's not normal, don't do this, right, like. I mean it just depends on how you put across a message, you know*

Tess (58) emphasized the importance of exposing children to examples of healthy relationships, and always considering how actions will leave impressions on children:

So you know, it really comes down to the point that when you want to be a role model to your daughters and granddaughters you have to think twice before you do anything, especially when there's little kids in the house. Tess (58)

Women shared stories with several examples of how role modeling can influence intimate relationships. Some women spoke of their own experiences while others described situations they had observed around them. There was a particular emphasis on role modeling for children; however, women recognized the influence of being exposed to examples of positive intimate relationships.

Incest. The topic of incest was discussed in a few storytelling sessions. The topic was framed in two ways; in some instances, incest was discussed as sexual abuse or sexual assault, and in the other case it was referred to as instances where two people did not

know they were related. Within the participatory analysis groups, we discussed how incest should be framed. Women said it should be discussed within the context of relationships; more specifically, the idea that a major component of healthy relationships is that it is *appropriate* for the two partners to be together. Appropriate meaning they are not a blood relative. The examples below illustrate the two different ways that incest can be viewed:

Suzanne (42): *And of course, the family relationship...*

Jenny: *Yes.*

Suzanne (42): *I know children get all their... explaining to them, to them, he saw the family members - 'You can't stay with him, he's your family member'.*

Jenny: *Right, because people are related, right?*

Amanda (38): *Yes.*

Suzanne (42): *It's like my brother slept with my aunty.*

Myia (47): *Even kids going out with cousins; it happened a couple of times with my kids too, with their own blood cousins.*

Suzanne (42): *So I was saying to my children too, 'Hey, maybe I married my own uncle' because other family members don't even explain who our family members are.*

Here, Louisa explains her concerns around incest and child sexual abuse. Incest was mentioned a number of times, yet sexual abuse was rarely mentioned in storytelling groups. This is not to say it is not of concern to other women, nor to say it does not occur. Indeed, the strengths based framing of the research project, as an asset driven, solution

focused approach allowed women to express their solutions and visions for the future. I have also often heard women say, "don't worry back", meaning don't dwell on the past. This could be evidence for that belief, as participating women placed emphasis on solutions, and not the negative experiences of the past. There was a positive, forward-thinking attitude with many of the story sessions, which created space for acknowledging negative sexual experience, but for the purpose of searching for ideas for sexual health promotion and disease prevention, not to dwell or worry on what has happened in the past.

That also means addressing issues of a big, big taboo we see today is still incest. Incest is still very big, big problem in Nunavut. And to me, I would like to see that addressed. Because in incest are the children that suffer. And when I used to teach, I'd see a lot of sexual abused children, sexually abused and physical and mental, spiritual and that's why today we have so much damaged people again (Louisa, 59)

This conversation also discusses incest as somewhat common:

Suzanne (42): *That's what I think. How come they used to have... a man would have two wives long ago and nowadays they probably would be punching each other. It's probably more fun when I was growing up - I would see... which I wasn't probably supposed to see my family members sleeping with family members. I think that still goes on today a bit. I remember sleeping with family members.*

Amanda (38): *Yeah, I think so...*

Jenny: *Do you remember that from when you were a kid?*

Suzanne (42): *Yes.*

Jenny: *And you think it still happens?*

Suzanne (42): *Yes.*

Amanda (38): *It's still probably happening with so many people in one house.*

Jenny: *Yes.*

Amanda (38): *It just happens with everybody too. 'cause it went through my family, I had an aunty sleeping with her own brother, her uncles.*

Within this conversation Amanda makes the point of the overcrowded houses contributing to incest. This point, coupled with alcohol use, was also mentioned within one of the participatory analysis groups. These conversations implied that incest is common. Louisa mentions it as a major concern across Nunavut that she would like to see addressed, and the conversation between Amanda and Suzanne tell a story as if it is a common experience. The previously discussed sub-theme of arranged marriages was mentioned in participatory analysis groups as a means by which Elders were able to prevent incest, as they kept track of who was related and helped arrange marriages. It is evident the sub-theme incest has a variety of other themes that influence it. This was clear within the stories shared by women.

Holistic Strategies

The major-theme "holistic strategies" emerged from women's stories of what they thought the community needed in order to improve sexual health outcomes and prevent STI and HIV. Women explained a variety of strategies they thought were key in changing sexual health outcomes and reducing STI and HIV transmission. Not only did the women have a variety of specific approaches, but they recognized a variety of persons/ organizations

responsible for these approaches. Most women spoke of several different strategies, and discussed carefully constructing the programs/ approaches in order to include 'hard to reach' community members such as non-attenders/ school dropouts. The women were also concerned about including men and younger youth (elementary school age) as they are often left out of current programming. Their ideas show the need for multi-pronged approaches.

Awareness and information. Many women told stories of a real lack of awareness about STI, HIV and other sexual health issues, and had similar personal experiences of not really knowing about STIs until they contracted one. Women also spoke about there not really being any awareness programs or materials available to educate oneself about these topics.

Shelby explains that within Kugluktuk awareness of STI is low, and people don't talk about it openly except at the health centre:

STIs in Kug... not many people come out and talk about it right, and the only time you talk about is probably when you find out you have it at the health centre. There's no really awareness programs for that, that I know of anyway. (Shelby, 26)

Amanda shared similar sentiments. She also emphasizes the seriousness of STIs:

I think people in the community need to get more information on it [sexual health, STIs, and HIV]. I don't think there's enough information going around. Even when I was younger I didn't know anything about it and then ended up with an STI one time. People, they think it's a laughing matter, but when it happens to you, it's serious. I think maybe more information, you know, signs when you have it [STI] and stuff like

that, I think it's going to make it a little bit easier for teenagers, and tell them.

(Amanda, 38)

Amanda raises several points here regarding awareness, she speaks of her own experience where she contracted an STI and had little information about it, she also describes her desire for greater availability of information for other community members, especially teenagers.

Louisa had specific ideas about how sexual health information should be provided to communities, noting it should be in more than one language:

So I'd like to see anything that is of a preventative nature go out in Inuinnaqtun...

English and Inuinnaqtun in some of our communities. And also in written and also in oral. By the oral I mean for, like, what you're doing, having meeting gatherings, get-togethers, giving out information, doing questionnaires and telling the people that they own their information that they're giving out. ... Simple communication and that's how we create awareness. Back then [in the past] everything was by word of mouth and it was so accepted because it went fast, okay? (Louisa, 59)

Women saw the need for more information and awareness. This could be increased through the variety of ways information can be spread, including having materials available in Inuinnaqtun. When women reflected on the storytelling sessions themselves, the idea of having face to face meetings to discuss and learn together came up several times. Women felt this research process itself was a way to bring awareness to the community.

The discussion of women's awareness of HIV differed depending on the age of the women. This is because many of the older women in the storytelling sessions recalled when

HIV first hit the media and the information about HIV first came to their community in the 1980's and 1990's. They told stories of a travelling awareness program where an Inuit woman living with HIV travelled all around Nunavut (NWT at the time), sharing her story. There was a lot of information and prevention messages that came out then, but women reported not hearing much since then. They also said that this way of sharing information, with personal stories, was powerful. They felt this could be an effective way to spread the awareness message now.

Louisa (59) recalled the time when a woman travelled around the north sharing her story, and noted this was an ideal way to learn:

A young lady decided to travel all of the north, all the northern communities. ...she was from way in the Eastern Arctic and she travelled to our schools. And she talked about herself as being HIV infected, how long she had to live, what she was going through and that was powerful because we learn from seeing, we learn from doing and that is how we learnt. We are oral people, we were a doing people and that is how we still learn today, that is how we still comprehend, many of us.

Heather and Ella recall the same presentation from the educational campaign Louisa described that took place in Kugluktuk decades ago:

When HIV and AIDS first came out there was like a really noticeable campaign, how to protect yourself in that and just like it's not so much noticeable now... There should be still more awareness of it 'cause maybe they think AIDS won't happen to me; you know, it's still around, it could happen to anyone... And then it's some ways to keep themselves safe and healthy. (Heather, 53)

It's just like that HIV when they first started experiencing it up here, whoever, the people from the east came to Kugluktuk more than once to talk about it, to educate the people, and that was good. (Ella, 56)

The messages these women remember from when these presentations took place in Kugluktuk was echoed by several other women in their storytelling sessions. Many women within this age group remembered details of this presentation, which emphasized the power in this method of message delivery.

Women recognized that it was important to have multiple strategies, as there is no one strategy, which addressed all of the issues for all people related to community HIV and STI prevention, and sexual health promotion. In many storytelling sessions, women listed several approaches they thought could be used together. This illustrates the need for more than one strategy or approach.

Message delivery. Throughout the storytelling sessions, women came up with a variety of ways for sexual health promotion and disease prevention messages to be delivered. Women believed comic books and stories discussing sexual health issues, HIV and STI would be a valuable approach. They also acknowledged the things that youth are interested in and suggested that television, videos and YouTube may be an effective way to reach them. Women thought that the community could take on the project of creating some of these promotional materials, and discussed the idea of people getting together with youth to make informational videos.

Ella (56) suggested a variety of modes of message delivery, including the use of YouTube: *I think posters and television and radio ads will really help or even on the YouTube. Well, the kids listen to YouTube or watch videos. Like maybe catchy.*

Violet, Emilie and Heather, all listed multiple modes of message delivery:

Violet (59): *I think through TV ads you could reach more people somehow, 'cause everybody watches TV.*

Emilie (50): *And radio.*

Heather (53): *Social media.*

Elaine described the need for more public messaging and listed what is needed to deliver messages, and where messages should be available:

Definitely more publicity about it, like the health centre pamphlets, you know, what are some of the signs. Definitely making condoms and, you know, whatever, available at more public places. Everywhere, mine camps even. Having, I know at one time they started a health fair. Health fairs could be brought back to the communities or done more often and that could be one table on its own. I don't know if there's scientifically links to cancer but people are very aware of cancer and whether that's long term STIs lead to cancer. If that were, cancer was the key word in opening up the conversation, prevention.

It is interesting that Elaine made the connection between using another, well-known, illness like cancer to draw attention to sexual health and STIs. She said that many Inuit people understand cancer as a sickness, and that this knowledge is important to them. She is suggesting that linking the two may help to get the message across. She also brings up

several other points, about where messaging could be available, and what form messaging could take.

Rachel had ideas of what the health centre should provide for print information, and said, *I think the health centre should have some pamphlets too about HIV and STI, but then again, the young people nowadays don't read, don't want to read.* (Rachel 53)

Humour plays an important role for Inuit when addressing sensitive issues. This point is illustrated with this discussion between Tania and Shelby:

Tania (27): *Yeah. I find that it helps to have that little bit of humour when we talk about this kind of stuff, sensitive stuff.*

Jenny: *Yeah, definitely.*

Shelby: *But that's how Inuks are, eh? When they talk about sensitive stuff they always have to bring the humour.*

These women emphasized the need for the messages to be humorous, and that this is a way Inuit communicate about sensitive issues. This draws attention to the messages used and how they can be delivered creatively.

Women had several ideas about message delivery, and they suggested places to provide sexual health promotion messaging, as well as how it should be delivered. Often women gave a list of ideas, which emphasizes the point that there is no one way to share this health information.

Responsibility. The sub-theme "responsibility" emerged from stories of where the responsibility of community sexual health lies. Within the sub-theme of responsibility nests several themes of who is responsible. Women revealed that there are multiple parties

responsible for sexual health promotion and disease prevention education. Women told stories of parents and family members, schools, health system, and the community all having a hand in community sexual health education and disease prevention.

Parents. The idea of having more education and support for parents, as well as parent programs to help parents talk to their children about sexual health and relationships was discussed in many of the storytelling sessions. Despite perhaps not learning about STI, HIV and sexual health from their own parents, women emphasized that parents have a huge responsibility in community sexual health.

Shelby, Joanne and Tania discussed promoting parental involvement and parents talking with their children about sexual health, as well as the importance of parents talking to their children. They also had some creative ideas of how to promote this approach.

Joanne (23): *We need that and somehow we need to go out and tell the community it's okay to communicate with your children about sexual health.*

Tania (27): *Maybe through like a parenting class; that should be a lesson in the parenting classes. If there was a script - actually this was just on the news. On CBC like two days ago there was a guy on the Early Morning Show talking about a script that was created for talking to your children about safe sex...*

Shelby (26) *It would be interesting to do something like that up here; that's a good start to, you know, start off, to have families talk about sex. That would be good to start off with, especially as we don't know how to start anything in the first place.*

Tania (27): *That's the thing too like. I know for a woman to talk about, to their daughters about sexual health, it's just as important for men to talk to their children*

about sexual health, you know. It might be really awkward, but that's really important as well.

Rachel points out the need for youth to have as much information as possible about sexual health, and suggest parents help with providing this information: *“I think young people nowadays need a lot of information, any kind of information that's going to help them as they start getting older and the parents have got to help too”* (Rachel, 53).

Both Lindsay and Louisa had experience with obtaining consent from parents in order for their children to participate in sexual health lessons at school.

We had to have parents' consents if we were going to do that part of it [sexual health part of the curriculum]. Very limited. When we went to get some parents' consents and don't forget this is back in the '70s and '80s. Many parents did not even really understand what was, why are they talking about sexual health? Sex is sex. (Louisa, 59)

Both women elaborated on the need to provide parents with information, because if parents didn't understand what is being taught, they were unlikely to let their children participate. The importance of teaching the parents and community was highlighted in these stories.

... and the parents have to sign a consent form for that subject to be taught to their child and I think more has to be made, more of the community and the parents have to be given, have to be made more aware of what the program is instead of teaching about just sexual activities. But 'cause some of them, not knowing what is gonna be taught, don't want to sign the consent form, so therefore you see a child or two who

are not included during that class. That happened every year in the elementary school. I think more has to be talked to the parents and the community. (Lindsay, 61)

Since parental consent is needed to allow children to participate in sexual health lessons in school, it is important that schools work with parents and provide as much information as possible. This also, in turn, supports parents to discuss sexual health with their children. It is clear through their stories, women believe it is a team effort, with parents having strong involvement in teaching children about sexual health.

Schools. Naturally, schools, are a source of education, and women discussed the current programming that happens within the school but felt like more was needed:

...going into the schools too with the programming, like there's a program in grade five health, even it started from grade four, about changes in your life for the girls and the boys and talking about how to prevent this type of disease. That helps and I think that needs to be more, also more has to be done at starting into the next school, the high school. Lindsay (61)

Candace felt that because some parents are still not comfortable talking to their children about sexual health, it is important this subject was discussed in the classroom, so children had another opportunity to learn this information

I guess in a way it's still sort of...parents are embarrassed to talk to their kids yet about sex and what happens and whatnot, so getting into the classrooms and talking to the kids about healthy relationships and what could happen if they're having sex and they don't use condoms. Candace (56)

Sylvia and Sam also thought it sexual health education should be covered often within the school setting:

Sylvia (18): *They should do it at the school, like once a month.*

Sam (26): *Especially in the high school now that a lot of teenage girls are getting pregnant and going from guy to guy.*

Sam shared a specific example of why she feels there needs to be more sexual health education at schools due to teenage pregnancy and young girls having multiple partners. sexual health outcomes, and more education could help prevent these outcomes.

Hamlet. The Hamlet's role in promoting sexual health, and disease prevention could be by supporting and hosting sexual health promotional events, as well as providing access to condoms, and providing programming through their wellness program.

Health fairs and presentations at the community complex were suggested as venues to share information about sexual health: *Oh, like they should like have meetings [regarding community sexual health] at the complex first...* (Sylvia, 18)

Lindsay (61): *And I think too with the youth centre, like not, with so many non-attenders in a community things like this have to be put out more to the youth centre as a program, to the community as well.*

Heather (53): *In a way that it doesn't scare kids... that involves kids in a good way, not to shame them out or discourage them from participating.*

Lindsay (61): *Like the way when you did healthy eating and healthy snacks, that went well; maybe something like that would work as well when going to the communities outside of the school.*

Many women recognized the hamlet as having partial responsibility for community sexual health. A few of their suggestions of holding community meetings at the complex (community hall), and ensuring there is programming available to the community other than just at the schools are opportunities for the hamlet to share in the responsibility of sexual health promotion.

Health system. Women discussed the health system having a responsibility in contributing to community sexual health promotion and education. Specifically, it was suggested that the health centre, social workers, nurses, the community health representatives (CHR) and the Kugluktuk Pre-natal Nutrition Program should play an integral role in disseminating information and teaching about sexual health.

Suzanne talked about the shift in accessibility to sexual health teaching, and said that in the past, condoms and birth control would not often be discussed, but now the CHR goes into the community to teach about these sexual health topics.

Suzanne: *Not back in the past. I think they do that nowadays. I remember [the CHR's name] going around teaching all this information about how to use condoms and birth control.*

Amanda shared a similar reflection to Suzanne's in that she did not remember learning about sexual health in school; however, the CHRs went into schools to teach her children:

I remember going to school when I was young I don't think there was any of that discussed during school, but since my twins are going to school and they're teenagers - I know [the CHR's name], the CHR goes to the school and talks about stuff like this but there are some other teenagers that don't even go school. Where can they go to get all this information? (Amanda 38)

Amanda's final thought about many teenagers not attending school reinforces the idea the need for a community wide approach, as school cannot be the only place to try to reach youth.

Rachel (53) also recognized the CHR as a source of sexual health information for the community saying *[The CHR's name] should have some information too...*

Sylvia and Sam discussed the idea of having small groups to facilitate teaching about sexual health, and mentioned the pre-natal program.

Sylvia (18): *Or in like little groups, like at the...*

Sam (26): *Like this, they could have little groups.*

Sylvia (18): *Pre-natal, they have during the day, pre-natal and...*

Sam (26): *That's what they should be teaching up at the pre-natal.*

Incorporating health and social services into school programming provides a more comprehensive approach to school based sexual health programming, as suggested by Louisa (59), *So for me, creating awareness, whether it's in verbal, whether it's at schools, whether we have the healthcare representatives come into the schools like we used to working with the Social Service Department.*

Heather and Emilie both agree that having more community social workers could help individuals with sexual health concerns:

Heather (53): *I think we should have more social workers.*

Jenny: *Yeah?*

Emilie (50): *That would help with people not being good about things like this [sexual health issues]*

Stories shared by women in this study clearly describe a variety of parties who are responsible for community sexual health. These women suggest health and social services, parents, schools, as well as the hamlet all have a part to play in community sexual health promotion and STI and HIV prevention. In many cases individual women mentioned several groups who should provide sexual health teaching and support. This shows that sexual health is understood to be an issue that should be tackled community-wide and holistically, and there is no one approach.

Continuity of community health care. Within the subtheme "continuity of community health care" there are several ideas that have emerged from stories of experiences in dealing with the health and social services department within the community. Many women shared stories of past negative experiences with the health centre some regarding not receiving enough education from nurses, others, regarding issues with confidentiality.

Suzanne told a story of contracting an STI from her partner and explained her experience with the nurse. She felt the nurse asked who else she had sex with in a way that implied she must have more than one partner, when she actually had only been with her one and

only partner. This was an upsetting situation where she felt the nurse was assuming she was the unfaithful one:

Suzanne (42): *And they ask who you always are sleeping with - only this one man!*

Jenny: Yes.

Suzanne (42): *How many more men am I supposed to sleep with? But I think seeking help is good; there's a mental health worker that takes appointments.*

The last thing Suzanne mentions here is an important point. She talks about contracting an STI, but also suggests getting help from the mental health worker in town. Suzanne's experience of receiving her STI diagnosis was difficult for her, she recognized sexual health and dealing with issues such as STI within relationships require more than just medical attention at the health centre, but that mental health support is also important.

This dialogue between Amanda and Allison reflects on their experience of contracting an STI and not receiving an explanation from the nurse. They both felt they did not receive enough information about their infection when they received their treatment.

Amanda (38): *I think the nurses should give more explanation to us what you have, because when they told me I had STI they didn't even explain what it was.*

Allison (33): *Even me, when I had... when I first got it.*

Amanda (38): *They didn't even give me any information to read on or anything like that.*

Allison (33): *When I first got chlamydia I was like, 'How come I'm taking all these pills, they're so gross'.*

Amanda (38): *You have to take so many different ones.*

Allison (33): *And she was... I was trying to ask her, 'Why am I taking all these pills'? She wouldn't even explain.*

Joanne, Tania and Shelby discussed why they think people may avoid seeking help with sexual health issues at the health centre, as well as the assumptions people make about young woman in the waiting room of the health centre.

Joanne (23): *That's what I think, maybe they're scared, maybe their family member works there [at the health centre] or maybe they don't want to see people at the health centre, what if they ask what are you doing here. I know it's confidential, but some people do ask.*

Tania (27): *They do. I've gone in there and I've had somebody ask if I was pregnant, like I've got a fucking cold, I'm not coming for a pregnancy test or have an ultrasound or anything like that.*

Shelby (26): *I know, the mentality is so like, you know, a young female woman...*

Joanne's first point about being scared to go to the health centre or afraid of running into a family member is a reality for such a small community. These young women also described a common experience for young women in Kugluktuk. Each of them had on several occasions experienced the situation of waiting in the health centre waiting room, and other patients assuming they are there because they are pregnant.

The following excerpt from Louisa discussed confidentiality and fear of healthcare workers disclosing information, as well as the staffing turnover affecting the trust of healthcare workers. She listed several health care practitioners who play an important role in

community sexual health, and she voiced her desire to have trust in health services in order to help community members who have STIs.

The other big fear is confidentiality, with their great fear of disclosing names, information because the nurses are not like long ago. They don't stay here anymore. They're gone. They're just, revolving door. So alongs with that comes distrust. It's not only the nurses, it's the whole healthcare people. Social Service workers, managers, the, anyone. So you have to build up that trust right away when you work in the health...in the nursing stations, you have to build that trust up right away with the community. And in doing that, you will be able to gain, get more knowledge of how you're going to learn and pass on for, in prevention and in helping the person affected with these illnesses [STIs]. (Louisa, 59)

In the following conversation, many of the women contribute different ideas about issues related to health care. They discuss what is needed, and also provide situations that arise and what is needed to help community members access sexual health services. Also, Heather makes a joke in reference to providing a urine sample, which reinforces the previously mentioned pregnancy assumption.

Ella (56): *Just trained people [health practitioners] that would be able to help other people.*

Heather (53): *To give you direction if you needed it.*

Violet (59): *And then sometimes when they're going for help down in the health centre there's already a roomful of people in the waiting room. And then they might just walk out without even seeing anyone.*

Ella (56): *And sometimes when you call there and you make an appointment, they say what for. And you don't want to tell them. It's between you and your doctor or nurse.*

Heather (53): *I know. When I go to do my pee I tell everybody they're checking to see if I'm pregnant [laughter].*

Violet (59): *And when somebody's upset too, most people's reaction is to, oh, what's wrong, you know, like wanting to help. But maybe they don't want anyone to really know yet.*

Several of these comments refer to the privacy of the waiting room at the health centre. There are issues of confidentiality but also, there is often no possibility for anonymity within the health centre. With a small community where everyone knows everyone, and there is only one health centre, it is difficult if not impossible to provide anonymous services. Each of these women had valid points regarding privacy within the health centre, and the desire to have well trained health centre staff to help the community.

Another story from Heather reinforces the point about privacy when seeking health services within the community, specifically mental health services, and fear of breaches of confidentiality:

Just around this sexual health, one of the areas that I have a concern with is on confidentiality because it's a very small community and you think, oh, I have an infection, I should go to the health centre. And then you hear, oh, there was a party and there was talk about some files or whatever or so-and-so has got a disease from somebody else, or things like that. And that gets... I mean as much as we like to say,

okay, we're gonna keep things confidential, things eventually leak out. And like for me to say, okay, I wanna go for therapy, it's a very small community, people say, hey, how come Heather is going for therapy, why is she seeing that mental health person.

Heather (53)

Heather raises several points here, including her concern about confidentiality at the health centre, as well as the issue of privacy within a small town. These ideas were mentioned in several other storytelling sessions as well. Whether these situations happen directly to an individual, or they happen to someone they know, they can seriously affect community members seeking help at the health centre.

Another example of a negative health centre experience that has caused Violet concern is the language nurses use to discuss health issues within the health centre. Here, Violet explains an experience with a nurse, who was not using plain language, and caused offence to her granddaughter regarding treatment.

Violet (59): *And the words that they use too... My granddaughter had a real bad toothache when she went down and she wanted something stronger than a - because there was no dentist - something stronger than Tylenol. And the nurse tell her, we can't give you narcotics, and she goes she's calling me an addict, you know.*

So I didn't get that part so I had to go down and say, what are you doing, calling my granddaughter an addict, why are you calling her an addict. But she didn't call her an addict, it's just that we can't give you narcotics, you know.

She goes, narcotics, does she think I'm an addict. Use more simple words than... words that they can understand instead of things like that.

Violet suggestion for nurses to use more simple words that everyone can understand is an important idea to consider. In this case, Violet was able to help her granddaughter sort out the communication, however other cases like this may occur, and that can have a really negative impact on seeking services at the community health centre.

Heather (53) shares a story of breach of confidentiality within the health centre. She tells of her own experience of the health centre staff revealing at the grocery store that she was having a baby, before she had the opportunity to tell her own family:

I've just thought of this now, the health system; you hear, eventually you hear about leaks and it's happened many times to me, ... where I had very confidential information, [I] never told anyone maybe except like one or two people and they never told anybody else. [I] go to the store and then they turn around, oh, you're having a baby. And it's like, huh, nobody else knows [laughs] and things like that. I mean at the time it's confidential... My kids didn't know and the health staff are turning around and saying, oh, you're having a baby and then my kids are going what, what. I said I don't know what she's talking about, because I'm not showing yet and we don't know like what's going on and anything.

After Heather's story about the breach of confidentiality and her children finding out about a baby on the way at the grocery store, she gave an example of STI contact tracing, where the message delivery was by a driver instead of by phone. Many of the women nodded and spoke in agreement of experiencing similar things. (Often when houses do not have phones

in Kugluktuk, messages are sent from the health centre, by a driver who works at the health centre.)

Heather (53): *And if I had an infection and then somebody else said I had an infection when I was one of their partners, and they sent a driver to tell you, oh, you have an appointment, you have to go, instead of being called [?], you know, that's another thing.*

Jeannie (54): *Oh, yeah.*

Violet (59): *Wow.*

Heather (53): *So already like this amount of people know, you know, even before you get to your treatment.*

Ella (56): *So that's happened, yeah, it's happened.*

Confidentiality within the health centre is an important issue that was raised by several women throughout the storytelling sessions. This is highlighted by Heather, “*So I mean confidentiality has to be something that's, I mean at least in the health centres where you want to feel safe to tell your worst fears that it's safe to tell them*” (Heather, 53).

Through their stories, it was clear that the women recognized health care services as having a strong influence over their sexual health. They shared stories of their own experiences with health care within Kugluktuk, as well as stories they have known to have happened to others. Their experiences shaped how they access health services, and they showed concern for how youth may feel in accessing services, or how others may deal with their own sexual health care needs. This is an important theme when examining structural

influences, as these services are provided by the government, and are meant to be accessible to all.

Testing was a commonly discussed method of prevention of STIs, and women had many ideas around emphasized encouraging people to get tested regularly.

One woman told a story of how she had recently got back together with her partner after being separated for a period of time. She talked about getting tested shortly after they reunited and was currently waiting for her results from the health centre:

Well, I just went back with my common law and we ended up having sex, so I went to the health clinic and I wanted to get checked. And I saw them so I'm gonna be hearing [my results from the health centre]. But I never heard from them [the health centre] yet (Sam, 26).

Shelby (26) emphasized teaching about regular testing if people are sexually active as an important method of prevention:

But not only that, you know, part of that [sexual health] teaching is, you know, if you are sexually active go and get your regular checkups, right. It might be painful but go and get your regular checkups. That might be embarrassing but that's the only important thing too is regular checkups if you're sexually active, right.

Elaine told a story of when her husband went away for college. She said when he came back to town she made him get tested before she would have sex with him again. Elaine suggested teaching other women to do the same within their relationships in order to help prevent the spread of STIs, “...teach women how to say you've been away at college I'm not

touching you till you get tested” [laughs] (Elaine, 48). Elaine’s story also speaks to the change in gender relations discussed under the theme "gender and power" discussed earlier in this chapter. Her request to her husband to get tested illustrates balance and open communication within their relationship.

Shelby also brings forward the idea of the importance of promoting testing, and ensuring people hear that message: *“But we need to put big messages out there, it's okay to go get checked up, right.”* (Shelby, 26)

Within one of the participatory analysis groups we discussed the sub-theme of promoting testing as a strategy, and several women discussed a “testing blitz” idea. The community recently had a “diabetes testing blitz”, which was a week-long "blitz' where diabetes testing events were held throughout the community. There was also a promotional campaign for everyone to get their flu shot, and the health centre and CHRs often had a prize or some other incentive for people to inquire about testing. Women discussed that this could be an effective approach to promote community-wide STI testing.

More Support. Throughout many of the other themes, there is a sense of a real lack of support for sexual health promotion and HIV and STI prevention (both personal as well as program support). It was clear there is a drive from these women to support parents to teach their children about sexual health. This subtheme emerged from women speaking of their experiences dealing with sexual health issues and wanting more support for various aspects of their health.

Allison and Amanda discussed their experience of contracting a STI from their committed partner. Amanda felt as though she had no support, and was all alone when she dealt with this, whereas Allison had a supportive friend to help her through this experience:

Amanda (38): *Me, I couldn't go anywhere in the past; I was too embarrassed to let other people know.*

Allison (33): *Me, I used to always go...*

Amanda (38): *So I didn't know where to go; I didn't want anybody to know so I just stayed at home.*

Allison (33): *I used to always go to one of my best friend and talk about it just so I won't keep it in and have so much anger. I used to always go to my best friend and tell her about it so everything is out so I won't be so mad when I go home, but I'd just talk to him. I used to always do that.*

Suzanne told of an experience similar to Amanda's:

But once you don't even know your other half is fooling around and then all of a sudden your health centre is calling telling you to go down and take some pills - I don't know what they are. You get frustrated and mad and where do you turn to from there? (Suzanne, 42).

Many women shared this experience of contracting a STI from their husband or common-law partner whom they had been with long-term. This was a painful, embarrassing, and lonely experience for many women. If they did not explicitly speak of the desire for more

support with this difficult issue, it was clear from their stories that had they had more support, it would definitely have been helpful to them at the time.

Louisa (59) described how she felt when she contracted an STI from her husband of this she said,

Sure there was a lot of anger. There was a lot of fighting and whatnot and, but along with that also came STDs. I as a wife- and many of us, suddenly we were called in the nursing station and that was the biggest, most painful, most embarrassing moment in my life was to be called in to take these pills because suddenly I was seen as having an STD. And I'm wondering where in the hell did I get it. What did I do?

Tess (58) also shared her experience and said it happened to her for years when she was married: *And it was my ex-husband that liked to fool around so I was getting STDs.*

This experience is also mentioned in relation to gender and power dynamics within relationships. However, it was coupled with a real feeling of lack of support, so it is also nested within the subtheme of more support. At the time women often felt alone, embarrassed, and as if they had no place to turn. This need for support was heard loud and clear through these women's stories of contracting STIs.

Allison had several ideas about support. She acknowledged that the health centre is often too busy to provide the appropriate support, and shared her experience of working at the Women's Shelter, *"I think maybe more support places to go when women find out they have these infections. Instead of letting it all build up in there maybe more support places to go to. Health centres are always so busy."* She further added:

... I know some ladies phone there [the Women's Shelter] for support when they need it or when they've got nobody to turn to because I know of them. I used to work there and some ladies would phone there and say they've got nobody to talk to (Allison, 33).

The theme of needing more support was heard throughout a variety of other themes. Women need more support for a variety of things including sexual health issues. Amanda (38) felt as though participating in the storytelling sessions for this project served as a form of support and said, *"It's good to talk about it; you should have more sessions like this with other people too."* Several other participating women agreed with her. This research project, and its participatory process, has provided many of the women with support. Women identified the health centre as a source of support; however, their impression was that they were often "too busy" to teach women about sexual health issues. The mental health worker can help with difficulties related to sexual health, as Suzanne (42) suggests, *"there's a mental health worker that takes appointments."* However, as women have explained, there is a lack of privacy at the health centre, and often, community members would question why a person is visiting the mental health worker, as Heather (53) suggested. Support is needed in a variety of ways, support to school programming and parenting, as well as personal support while facing difficult sexual health experiences.

Reaching the hard to reach. In conversations about strategies to help reduce the risk of STIs and HIV within the community, women spoke about the importance of reaching the "harder to reach" community members like non-attenders at school, school drop-outs, and men. There are few resources available to men specifically, and they are often left out of any sexual health programming that does go on in the community. The Canadian

Prenatal Nutrition Program (CPNP) includes sexual health education within its programming, which is offered to pre-natal women.

Drop-outs/ non-attenders. The following three citations illustrate the emphasis women put on reaching youth who do not attend school, or who have dropped out. Amanda (38) said, “...my son junior didn’t even know what was STI when he was reading the paper too; he didn’t even know what it was because he doesn’t go to school; he doesn’t even know what it is.” Lindsay (61) was in agreement with Amanda, and suggested the youth centre as an option to reach non-attenders: “And I think too with the youth centre, ... with so many non-attenders in a community things like this have to be put out more to the youth centre as a program, to the community as well.” Candace mentioned young people who have dropped out of school before receiving sexual health education, and that they may not protect themselves and may contribute to the spread of STIs:

But still, you get, a lot of STIs. They’re [youth] not protecting themselves, and those are the ones that are probably dropouts from school and aren’t getting the information that they need. And they come here, they’re treated, they go back out and they still go [have unprotected sex]... (Candace, 56)

Men were also discussed, in that they don't receive any programming around sexual health issues. Several participants asked if there would be a similar project with men in the future. Jeannie discussed attending meetings in other communities where they have healing sessions available to men and women in the community, and she thought something similar would benefit the community:

Maybe some young men feel like, hey, there's something missing, I don't know. I mean there's very little offered for men or even for women. I have gone to another meeting and I thought they are so fortunate because they go to communities and they have these healing sessions or whatever, and they have them in their languages and people really take part in it (Jeannie, 57)

Men are also left out of the birth process, as they typically do not go south with their partner for her delivery. This is because women are flown out of their home communities at approximately 36 weeks for confinement and delivery. Amanda referred to this fact in one of her stories, and wished her partner had been there for the birth of their children. She fantasized about what if men were the ones who had babies, saying, *"They would feel the pain we go through; it would make a woman's life a whole lot easier"*. Allison (33) agreed with Amanda and said, *"They are so lucky they don't feel pain and what we go through..."* She further explains her experience giving birth, *"When I was in labour with Patrick I was telling the nurses and doctors, 'Oh, I wish my honey was here, I would hold his balls really hard. Make him say, 'I'm sorry! [laughter]'"*. Although this was said as a joke with laughter, the fact that men are completely left out of the birth process, and are miles away in their home community when their partner goes into labour reinforces leaving men out of the entire process. They are not involved with the birth of their children and therefore do not receive the valuable knowledge that can be gained from this experience.

Substance use and sexual decision-making. Alcohol use was a recurring issue that arose throughout the storytelling sessions. It was identified time and time again as a factor contributing to negative sexual health outcomes. Due to the perceived role of alcohol use in sexual decision-making, the idea of programming, which includes the effects of

alcohol use and sexual health, is an important one. Targeted programming that addresses this issue is important as Elaine (48) notes here:

So if being under the influence of alcohol is still one of the biggest reasons why STIs happen that has to be a part of how, learning how to drink socially, responsibly. And one day when the communities talk about why people should not be drunks that should be one of the things right up there alongside, you know, the fact that children are left alone when parents are drunk. Women and men, men even. It's a two-way thing, it has to be addressed at both. (Elaine, 48)

This was also discussed within one of the participatory analysis groups. When we re-visited the theme of strategies, several of the women agreed that alcohol use should be included in sexual health programming.

Condoms. It may seem like an obvious part of STI and HIV prevention. The main issue that arose with respect to condoms in Kugluktuk was that they are only available at the health centre, which is only open Monday through Friday between 8:30-5:00. As Emilie suggested,

I know they have condoms available at the health centre, but it's only open until five. There should be another place in town with condoms 'cause kids, anybody's gonna have sex, whether they're in love or not. They need to be safe, yeah. (Emilie, 50)

Amanda (38) suggested the need for an alternate place to make condoms available, besides the public waiting room in the health centre. She noted that it can be uncomfortable to take condoms when there is a waiting room full of people:

...or even at the schools, dishing them out at the health centre...My son was going to grab condoms the other day and he got scared because there were so many people watching. They should have condoms in other places besides the health centre.

Elaine (48) suggested condoms being available in more places: *“Definitely making condoms and, you know, whatever available at more public places. Everywhere, mine camps even.”*

Allison (33) spoke in agreement with this sentiment: *“Should just bring a box of condoms to every house.”*

In the past, it has been difficult to make condoms available in more public places, because they have been stolen or have ended up as litter all around town. Suzanne (42) noted the trouble with having them available everywhere is that too many kids take them and play with them, so they end up as litter, but that parents can also get them for their children:

Too much kids taking them, but yes, the parents, I’m sure a parent would go and get some because that’s what I’ve been doing for years, getting condoms for my children saying, ‘They’re here and you need them, if you need more let me know’. Picking some up for them might be a good idea just for them to have safe sex because they’re learning and they’re experiencing all this new stuff for them. It’s their turn; we’re trying to keep their health healthy.

Women noted the importance of condoms coming with education. They identified that simply having the condoms available is not enough and that community members also require information in order for them to be a useful tool. The need for information and condoms is illustrated in the following two quotations from Amanda, and Violet:

Yes, because if I knew all this information back then I would have been using condoms and being prepared, but I'm 38 now and I'm just starting to realise what it is too.

(Amanda, 38)

... having that [condoms] available is good and I think what they need to be educated on, or everybody needs to be educated on, is how they're used and how good they are and what they prevent you and your partner from getting, stuff like that.

(Violet, 59)

Women felt that if there were condoms available in a variety of places around the community, people would be more likely to use them. They also had creative ideas of providing condoms to every household, and in public places, and they were sensitive to the fact that not everyone is comfortable picking condoms up in public places where everyone can see. Also, when discussing condoms, women's ideas were in-line with other themes in this chapter, in that they were more than willing to make condoms available within their own homes to their children and grandchildren.

This chapter has revealed the five major themes, which are built upon several sub-themes that emerged through the analysis of the data from the storytelling sessions. Throughout the presentation of each sub-theme, I have attempted to illustrate and provide evidence for the construction of each major-theme. I have been mindful to capture the diversity of women's lived experience, and their perceptions of community sexual health. The excerpts from stories and conversations among women reflect their perspectives as Inuit women living in Kugluktuk.

Throughout this chapter, it has been my intent to examine the collective experience of these women's stories. In the next chapter, I will expand the discussion beyond these women's lives and their experiences to look at how these findings compare and contrast to the findings of other research. I will examine their experience in comparison to currently available literature and see how my findings contradict or support literature is available with regards to community sexual health and HIV among Inuit communities. I will also reflect back on my original research questions and examine the findings to answer these questions and provide some insight toward moving forward. Finally, I put forward implications based on the findings of this project as well as current literature as to how this research may contribute to future programming and policy for Inuit specific HIV and STI prevention and sexual health promotion.

Chapter Five: Discussion

The purpose of this research project was to examine Inuit women's perceptions related to the social determinants of sexual health. This was achieved by creating space for a dialogue to inform future development of HIV and STI prevention programming. To facilitate this exploration, the following research questions were proposed:

1. What are the perceptions of Inuit women in Kugluktuk about sexual health, sexually transmitted infections and HIV in their community?
2. What do Inuit women in Kugluktuk think would benefit the community in regard to sexual health?
3. What do Inuit women of Kugluktuk perceive to be the determinants that most influence the sexual health of women and communities?
4. What role does Inuit women's strength and resilience play when it comes to informing them how to take care of their sexual health and that of their families?

Answers to these questions were sought by meeting with community members to gather and analyze data collected through storytelling sessions with 21 Inuit women from Kugluktuk. Inductive thematic analysis, conducted by 13 participating women and me in three analysis groups, revealed five major themes, each containing numerous sub-themes. These themes provide insights that can inform the development of community sexual health promotion, as well as specific HIV and STI prevention, programming and health policy.

It is my hope that through presentation of the research findings in the previous chapter, the reader now has an understanding of the depth of the participating women's knowledge and their perceptions of community sexual health. In this discussion chapter, I will move beyond the themes emanating from the lives of the women who participated in the storytelling sessions and participatory analysis groups. I will examine their collective stories and reflect on how they compare to relevant literature, as well as use the information gained from their stories and analysis to answer the initial research questions. The findings of this project suggest that women have a multitude of insights about what is needed to improve the sexual health of their community. The five major themes that emerged from the data illustrate the interweaving of IQ, showing Inuit ways of past, present and future. This presence of IQ principles within the findings will also be highlighted within the discussion.

This discussion chapter is divided into four sections. First, I will return to the research questions and draw on the findings to answer these questions. Next, I will revisit the literature, in order to situate the findings within the greater body of existing literature. This will help facilitate understanding of these findings. The third section is introspective and reflects on the experiences of the participating women, as well as my experience as a researcher. I will use one of the research questions to guide a researcher reflection. Finally, in the closing section of this thesis, I will examine the implications of this study and what these implications mean for this community, and for future research and praxis.

Returning to the research questions

The research questions were designed to provide an opportunity to better understand community sexual health and HIV and STI prevention. These questions formed the basis for the storytelling session topic guides. This section will re-visit the initial research questions in this study.

What are the perceptions of Inuit women in Kugluktuk about sexual health, sexually transmitted infections and HIV in their community?

It is clear from the findings of this research project that community sexual health is a priority for Inuit women in Kugluktuk. They shared stories about their personal experiences, events they have witnessed, as well as their observations made within the community, all of which articulated that community sexual health is a priority health issue within Kugluktuk. Women recognized that sexual health, sexually transmitted infections and HIV are complex issues with many contributing factors. Their perception of these complexities is reflected in the IQ principle of "**Qanuqtuurniq**, the concept of being resourceful to solve problems and seeking solutions" (Government of Nunavut, 2006). The participants have a variety of creative and innovative ideas about how to address sexual health at the community level. They have also taken initiative within their own families to ensure their children and/or the next generation are knowledgeable in how to take care of their sexual health.

Through participating women's personal stories, it becomes clear that they have real, lived experiences to share, and that these personal experiences have influenced their perceptions of community sexual health. One of the most prominent ways their lived

experiences have shaped their approaches to community sexual health is their attitude about educating their children and the next generation. These participating women do not want the next generation to learn by "trial and error" as many of them have. Women told stories of their efforts in ensuring that their children have condoms available to them at home, as well as discussions they have with their children and grandchildren about safer sex practices. Women also noted that not all families feel comfortable talking about sexual health, so more support needs to be available for families in Kugluktuk.

Many of the women's stories revolved around youth, the younger or next generation, and things being better in the future than it was for them. With the lowest proportion of Inuit persons over age 65 and 31.7% under the age of 15, Nunavut has the youngest population in Canada (Statistics Canada, 2012). The strong emphasis women placed on children and youth when they discussed community based HIV and STI prevention and sexual health promotion, combined with the age distribution in the territory, is evidence that focusing programming on youth is important.

Although youth and the next generation were the focus of many of the women's stories, it was also clear that sexual health is an issue for the entire community to be concerned with. Their stories included community members of all ages, reflecting a life course attitude and approach (Loppie Reading & Wein, 2009) to community sexual health, as everyone has a role to play. Despite the high rates of STIs and other negative sexual health outcomes in Kugluktuk, these women are optimistic. Women saw this project as a step forward, and they voiced their excitement about having the opportunity to be involved in this research, as it reflects progress toward lowering STI rates and ensuring they live in a healthy community. Women have a profound understanding of the societal clash that has

happened in their community and they are innovative in recognizing the strengths of traditions while also incorporating modern day knowledge. They perceive sexual health promotion and HIV and STI prevention as a community wide, family focused effort with a particular focus on youth (the next generation).

What do Inuit women in Kugluktuk think would benefit the community in regard to sexual health?

The participating women had a wealth of suggestions for improving the sexual health of their community. The overarching theme of their suggestions is that the approaches taken to address sexual health disparities need to be holistic, community and family driven, and youth focused. Women identified what the community currently offered for sexual health education and disease prevention, and where improvements could be made.

The community needs more information presented in relevant ways. Relevant means combining Inuit ways of teaching and learning with current technologies. This was evidenced in women's explanation that it is appropriate for youth to learn by seeing, which is a traditional learning practice within Inuit culture, but they also suggested there should be YouTube/ social media incorporated into the messaging. This combines the traditional learning style with current available technology with which many youth can relate.

Message delivery needs to be done in a variety of ways; participating women recognized not all Inuit want to receive information in the same way. Pamphlets and fact sheets are good for some people, but perhaps comic and story books work better for others. There is no one-size-fits-all when it comes to message delivery. Sexual health

messaging must also consider language, and needs to be available in Inuinnaqtun as well as English.

Health care in Kugluktuk is centralized within the health centre. This causes some concern, especially for those who have had negative health centre experiences (such as a breach of confidentiality, which is especially sensitive with sexual health information). There is also a high turnover of health care workers. This influences the continuity of care between visits to the health centre, when patients see a different health care worker each time they have an appointment. The disconnect between who does STI testing, to who does follow-up, and seeing a different practitioner for a yearly pap test makes women less comfortable in seeking further sexual health information.

Participating women were also concerned that health practitioners do not always understand Inuit culture, and may use language or make assumptions that are unsuitable. Some women felt that health practitioners were judging them and assumptions were made about their sexual history if they had contracted an STI. This resulted in a negative experience leaving women feeling as though they did not want to seek sexual health services from the health centre. Women suggested that if health centre staff were provided with more of a community and cultural orientation that included community members concerns about healthcare, this may be helpful in improving care.

It is clear that women fully recognize sexual health education and disease prevention as a shared responsibility among the entire community. Parents, schools, health and social services, and all three levels of government (hamlet, territorial, and federal) among others, all have a role to play in community sexual health. This is in line with the Canadian Guidelines for Sexual Health Education, which emphasizes the

comprehensiveness of sexual health education and the shared responsibility that is needed to support a comprehensive approach (PHAC, 2003).

Ultimately, women are calling for more support. Support for parents to teach their children about sexual health. Support for women and men to heal from negative relationships and negative sexual health experiences. Support for healthcare workers to deliver health education and the best care possible and support for a shared community approach.

What do Inuit women of Kugluktuk perceive to be the determinants that most influence the sexual health of women and communities?

The determinants of sexual health can be found within women's stories of change, intimate relationships, and their lived experience of sexual health challenges. Women identified a variety of determinants they felt influence sexual health status of themselves and their community. Much like the framework of the three categories of determinants explored within the literature review of this thesis, the determinants women spoke of influence one another.

One of the most prominent themes influencing sexual health was alcohol use. This was discussed in every storytelling session. Alcohol use was linked to negative sexual health outcomes including STIs, sexual assault, and closely linked to alcohol and substance use was trading sex to obtain alcohol or drugs. Alcohol use is linked to many negative health outcomes, and for these women it is clearly linked to negative sexual health outcomes.

Education and awareness were also linked to sexual health outcomes. Women had a variety of experiences with sexual health education, and they strongly felt education was

linked to sexual health. Many women recalled learning very little formally and needing to seek out information from cousins or sisters about menstruation. This was often due to the fact that it was considered taboo to discuss sexual things openly. This however, is changing. Women indicated these topics were becoming less taboo, and they were committed to teaching their children about sexual health.

Systems such as the education system and health system were identified as sexual health determinants. Specifically the continuity of community health care was linked directly to sexual health for many women. Their past experiences in dealing with the health system in their community showed insights into what is needed to help services be more equitable for Inuit women and communities.

Overcrowded housing, transience and travel, low self-esteem and poor self-image are all issues that were articulated by women as issues influencing sexual health. These are issues that influence other aspects of health, and therefore cannot only be approached with a narrow approach of only addressing sexual health. These determinants and more and their complexities are discussed in the next section.

Returning to the literature

In re-visiting the literature, I aim to focus on social determinants of Inuit sexual health. To that end, I will return to the proximal, intermediate and distal approach to organizing determinants (Loppie Reading & Wein, 2009), which emerged as a theme within this research project. It is important to note, the organization of these three levels, does not mean they exist only in that level. That is, although as they are presented here it appears as though they fit within one of three distinct levels or categories (proximal,

intermediate, and distal) any one determinant may be present or play a role in determinants at other levels.

Distal determinants of Aboriginal health refer to historical political, social and economic contexts which influence the system/infrastructure level (intermediate) determinants of health, which in turn shape proximal determinants, which tend to be most visible in the lives of individuals (e.g., socio-economic status, physical environment, resources) (Loppie Reading & Wein, 2009). Pauktuutit (2010) insist that "Inuit sexual and reproductive health must consider the non-medical determinants of health-- social, economic, political, and environmental conditions that affect the physical, mental and spiritual lives of Inuit" (p. 5). This supports the relevance of examining all levels of the determinants of health, and the importance of including determinants that go beyond biological and lifestyle determinants.

Proximal

The proximal determinants of health are the most obvious to individuals, as they are the determinants that directly affect one's every-day life. These were the most readily discussed by the women of Kugluktuk, as they were identifiable to participants.

Health behaviours

Throughout the storytelling sessions, women reported a variety of health-seeking behaviours. Women told stories of accessing health services, seeking support, the desire for and acquisition of health information as well as their aspirations to teach their children. Dion Stout, Kipling and Stout (2001) stress the importance of focusing on Aboriginal women's health-seeking behaviours, as there has been a long history of research and policy

which tends to "portray Aboriginal women as victims and to pathologize their lives" (p .24). This message has only recently garnered the attention of researchers and policy makers, and is it therefore, important to document Inuit women's health-seeking behaviours.

The health-seeking behaviours discussed by women in this study illustrate their agency to address personal sexual health issues, and contribute to the "emerging body of research that recognizes the centrality of women's agency in addressing Aboriginal people's health concerns" (Dion Stout, Kipling & Stout, 2001, p. 26). In order to balance the perception of Aboriginal women's relative agency, their stories of seeking information to share with friends and family, taking the initiative to go for regular screening, and their drive to change the way sexual health information is delivered to the community must be highlighted.

One specific health seeking behaviour women reported was STI **testing**. Women discussed going to the health centre to get tested, as well as encouraging their partners to get tested. They also made suggestions about promoting community wide testing, for example with a testing blitz, so that others would be encouraged to seek testing. Testing and treatment are key components in preventing the spread of STIs and HIV within Inuit communities. Pauktuutit recommend that both Inuit males and females seek regular testing; however, they note, overcoming the fear of testing is critical to ensuring sexually healthy lives among Inuit. Yet, the women in this study discussed testing without any reference to fear. Many women in Kugluktuk go for *well woman check-ups* once a year, which includes a pap test as well as STI screening. The routine nature of the well woman checkups may help mitigate the fear referred to in the literature. Women not only discussed getting tested but they also talked about encouraging their partners to seek

testing. This displayed their agency in communicating with their partners about preventing STIs. It can also be seen as a hint at the balance of power within some relationships. This balance was not the same for all women.

In all of the storytelling sessions, women pointed out **alcohol use** as a major health behaviour contributing to negative sexual health outcomes. Many women referred to alcohol/ substance use as addictions, and expressed concern for community members who mix alcohol and sexual decision-making. Likewise, in the literature there is a well-established and consistent linkage between alcohol use and STI acquisition (Devires et al., 2009; Fortenberry, 1998). Substance use within Inuit communities is said to be a major health challenge, with a variety of related implications including, violence and unwanted (non-consensual) sexual contact, such as sexual assault (ITK, 2009).

Healey and Meadows (2007) discuss the introduction of alcohol, as well as infectious diseases as examples of negative consequences of interactions between Inuit and European visitors. High rates of risky alcohol use/sexual activity, unintended pregnancy and STIs are said to represent particularly obvious health disparities among Aboriginal youth (Banister and Begoray, 2006). Devires et al. (2009) support this in a report of their study exploring factors associated with sexual behaviour among Aboriginal youth, suggesting that one of the strongest factors associated with sexual behaviour was substance use.

Much of the overall burden of diseases can be linked to common behaviours such as unprotected sex and alcohol use (WHO, 2005). Discussing the co-occurrence of unprotected sex and alcohol use and misuse is when examining risk of HIV infection. Unlike injection drug use and HIV infection, very little literature exists with regards to alcohol and unsafe

sex (WHO, 2005). Unsafe alcohol use can overlap with other risky behaviours and synergistically increase the chance of HIV transmission (International Centre for Alcohol Policies [ICAP], 2014). This is clearly an issue within Kugluktuk as the women had several ideas about how to decrease these negative outcomes. Women suggested that, when creating interventions to prevent STI and HIV, a specific component covering **substance use and sexual decision-making** should be included. Recommendations from ICAP (2014) support this, and offer that developing “interventions that target these overlapping behaviors [substance use and sexual activity] can provide a unique opportunity to strengthen HIV/AIDS prevention activities” (para. 23). The WHO (2005) further suggest that alcohol use and sexual behaviour are laden with cultural values, therefore it is important to ensure that programming and research addressing this issue are developed in a culturally safe manner.

Gesink Law et al. (2008) hypothesize that high rates of STI in the Arctic are merely an indicator of the much greater public health concern of substance abuse, mental health concerns, and historic trauma. This is echoed by ITK (2009) who suggest that alcohol use in Inuit communities can be seen as a symptom of a much larger social and economic issue. To this point, the linkage of poor sexual health outcomes and alcohol use do not exist in isolation, as there is a myriad of factors contributing to this combination. This complicated interaction of factors needs to be considered while creating educational programming and interventions to address alcohol use and sexual decision-making. Furthering this complication, Devries, Free and Saewyc (2012) caution that, "interventions designed to reduce Aboriginal young people's substance use and sexual risk behaviors will have limited

effect in a context where substance use has affected community structures and family relationships" (p. 50).

Family relationships and community structures are definitely influenced by alcohol use in Kugluktuk. This is evidenced in women's stories about alcohol as a major determinant of sexual health. Collaborating with other health promoting efforts, and including alcohol use in sexual health teachings can be a step in the right direction of addressing part of the issue. Kugluktuk is no exception to the point made by Bjerregaard, Young, Dewailly, and Ebbesson (2004), who state that, "misuse of alcohol is a major determinant of ill health and social problems in Inuit communities" (p. 32). It is important for sexual health programming to include discussions about alcohol use; however, it is also important to recognize the bigger social implications involved in Inuit communities with regards to alcohol use.

Among Inuit alcohol impairment is reported in most incidents of violence and sexual assault (ITK, 2009). It is well known that alcohol has negative influences on individuals' health; however, alcohol use is a symptom of a larger social and economic problem facing Nunavummut (people from Nunavut). Although the issue of alcohol use and addictions is a complicated problem within Inuit communities, it is helpful to consider including a discussion about alcohol and sexual decision making in sexual health promotion programming. Integrating discussions of alcohol use into the dialogue of sexual health and ensuring the two are discussed together (sexual behaviour and substance use), can increase awareness and begin to address this issue that was so prominent within this study.

The sub-theme of **sex-exchange** is considered health behaviour because of the context within which it was discussed among women in this study. Participating women spoke about women in Kugluktuk exchanging sex to support addictions such as gambling, drugs or alcohol. There is very little literature exploring Inuit women's involvement in the sex trade or participating in sex exchanges; what information is available only considers Inuit women living in urban centres (Ship & Norton, 2001). Looking more broadly at Aboriginal women's involvement does not capture what these Inuit women have discussed either, as most available literature speaks to southern/ urban Aboriginal women's experience. However, literature examining Aboriginal women's involvement in the sex trade does suggest that they are overrepresented (Ship & Norton, 2001), which is linked to social and cultural isolation, poverty, abusive relationships and pressure to provide for their children, all of which stem from colonization (Bourassa, McKay-McNabb, & Hampton, 2004).

The ICAP (2014) proposes that this connection between alcohol misuse and HIV risk behaviours is particularly evident within communities that are lacking social and structural support, who experience inequality, discrimination and poverty. Limited opportunities and the above mentioned factors increase an individual's susceptibility to co-occurring risks including the incidence of transactional sex for drugs, money or shelter (ICAP, 2014). This scenario is mirrored in stories women in Kugluktuk shared about women in their community participating in **sex exchange**. The connections between risk factors are present in Kugluktuk. Women experience inequality, and high rates of poverty, and there is evidence of transactional sex for money and drugs. All of these factors are compounding and increase the risk for negative sexual health outcomes including HIV.

Ikpigusuttiarniq is the IQ principle of caring for others; taking their situations and who they are into account (Government of Nunavut, 2006). When women told stories of other women in situations where they were exchanging sex for their addictions, they talked about this sex exchange in a caring way and acknowledged their struggle with addictions as being part of their situation. The way the storytelling women discussed sex exchange in their community was with a sense of Ikpigusuttiarniq, as they considered the struggles women were experiencing, and their individual situations, and they reported often feeling they did not know how to help.

Condom use plays an essential role in sexual health and women readily identified condoms as an important method to prevent STI and HIV. However, they reported that the accessibility of condoms in Kugluktuk is limited. A need specific to Kugluktuk is having condoms available in more places within the community. A study examining determinants of STI among Inuit youth indicated that elevated STI rates are caused by infrequent condom usage by Inuit adolescents (Cole, 2003; Steenbeek et al., 2006). The Pauktuutit report also advocates for the distribution of free condoms, which does take place in Kugluktuk; however, they are mainly available at the health centre. Women who participated in this study suggested that accessing them could cause embarrassment. This perceived barrier is congruent with Steenbeek's (2004) findings as she reports several reported barriers to condom use among Inuit, including embarrassment in purchasing, discussing condoms and the fear of a bad impression.

The Nunavik Inuit Health Survey reported 34.4% of Inuit used a condom the last time they had sexual intercourse; this report noted rates of condom use were higher among younger participants (Dodin & Blanchet, 2007). In another study with Youth in Iqaluit, Cole

(2013) found that 67% of male participants and 58% of female participants reported they “Always” use condoms. Other research examining condom use among Aboriginal youth illustrate a complicated relationship between condom use, social supports, personal skills including assertive communication skills, and having correct information about STIs and HIV (Shercliffe, et al., 2007).

Devries, Free, and Jategaonkar (2007) state that, although condom promotion is the "cornerstone of sexual risk reduction programs" (p. 48), they caution that the well-known models of health behaviour applied in condom promotion programming do not "adequately address the specific needs of different Aboriginal peoples" (p.48). Therefore programs for Inuit communities must be developed to attend to local realities, and thus will target unique needs within communities (Pauktuutit, 2010; PHAC, 2003; Shercliffe et al., 2007).

Physical Environments

The participating women identified over-crowded **family homes** as a determinant of sexual health. Lack of space to relax and spend time alone with one’s partner was identified as a concern related to healthy sexual relationships. Loppie Reading and Wein (2009) note that Inuit are ten times more likely to live in over-crowded housing conditions. A variety of other sources have articulated that over-crowded housing conditions are very common for Inuit families and communities (Bonesteel, 2006; Cameron, 2011; ITK, 2009; NTI, 2008). Over-crowded living conditions leads to increased family tensions, stress, violence, as well as increased vulnerability to communicable disease and respiratory infections (Cameron, 2011; NCCAH, 2010f; NTI, 2008).

It is clear from the women's stories as well as the statistics revealed within the literature, that housing is an urgent public health concern with implications for many social issues within Inuit communities. Part of the challenge of housing is due to Nunavut's remote arctic environment. However, due to federal funding cuts to Inuit social housing in 1993, all Inuit regions in Canada have experienced an ever-growing housing crisis, particularly in Nunavut and Nunavik (ITK, 2009). Nunavut has a growing population, however major barriers for housing the population due to the federal government's exclusion of Inuit from Aboriginal housing programs (ITK, 2009). Over-crowding is an urgent public health priority across all Inuit regions in Canada and affects every community in Nunavut (Government of Canada, 2013; ITK, 2009). Housing disparities reflect a variety of other disadvantageous social determinants including lack of education, low socio-economic status, unemployment, and social exclusion (NCCAH, 2010f).

Overcrowded living conditions were also implicated in women's discussions of **incest**. Mancini Billson and Mancini (2007), propose that defining incest in Inuit culture is complicated by the practice of customary adoption. This idea was also put forward by the participating women, who explained that no one really talks about who is related to whom anymore, and with custom adoptions, it makes it difficult to know who is related, since elders do not share this information as they once did.

Education

The relationship between higher levels of education and positive health outcomes is well documented (ITK, 2009; Raphael, 2009; Reading-Loppie & Wein, 2009). Within this research project, the importance of education emerged in a variety of ways. Specifically,

women told stories of a community wide, holistic approach to sex education. To them, sexual health education is the responsibility of parents and family, the health centre, the schools, the hamlet, as well as the federal government. Women thought it should be a shared responsibility. A sexual health survey administered in Nunavut in 2002 revealed that 67% of Inuit youth reported not receiving enough teaching about STI and contraception (Cole, 2003). The women in this study clearly indicated a need for more sexual health education at all levels within their community.

Much of women's focus of sexual health education was for the youth. With the lowest percentage of persons over age 65 and 31.7% under the age of 15, Nunavut has the youngest population in Canada (Statistics Canada, 2012). Given these age demographics, combined with strong values that families are the heart of Inuit culture, youth is a logical focus. The strong emphasis women placed on children and youth when they discussed community education will have the greatest impact.

Women's education surrounding **menstruation** was commonly discussed as a marker for their own sexual health education. There was variation depending on the age of participants, with younger participants learning about menstruation in school and older women revealing that they did not learn in school, nor was it openly discussed prior to their first menstrual cycle at home. The discussions surrounding menstruation is a key indicator of women's' commitment to educating the next generation about sexual health. This commitment is matched by the Government of Nunavut's (2012) sexual health framework, which is working towards developing "a sexual health education program that incorporates core themes of sexual health for youth, adults/parents, and elders" (p.10).

This, along with establishing a support system for schools, will increase the number of Inuit receiving sexual health education, at home and at school.

More generally, the ITK (2009) illustrates the interconnectedness of Inuit wellbeing with education. They suggest that education means learning throughout the lifespan, which is a concept that emerged through the stories women told about when they first learned about the various aspects of sexual health. They advocated for youth learning (including their own children) about prevention of STIs and maximizing sexual health at earlier ages.

With only 25% of Inuit youth graduating from high school (ITK, 2009), ensuring that sexual health is introduced at every grade level is key, as is having alternate spaces for sexual health education to occur. Women expressed great concern for youth who drop out of school as well as non-attenders, who miss this critical information. Consequently, sex education needs to occur within community settings as well. Inuit children traditionally learned by observing their Elders, and following the examples they set for them (Pauktuutit 2006). The younger women who participated in this research suggested that many of their Elders considered the subject of sexuality taboo, thus creating an environment of silence and thus a gap in sexual health education at the community and family level.

While discussing sexual health information, many women in this study used the phrase **I tell my children**. This indicates they are actively participating in educating their children about sexual health. Research indicates that parent-child communication about sexual health has positive influences on sexual behaviour later in life (Short & Rosenthal, 2003). The younger participants revealed that although they learned about sexual health in school, it was not discussed at home. Ironically, many youth have reported preferring the

source of sexual health information to be their parents (DiCenso et al., 2001). The role of parents in sexual health education was also a focus in women's stories, and many of these women, despite not discussing sexual health with their parents, were very committed to this changing for the next generation.

The idea of **role modeling** healthy relationships was discussed in several of the storytelling sessions, which aligns with Inuit ways of educating youth. The Inuit social value of "**Pilimmaksarniq**: The passing on of knowledge and skills through observation, doing and practice" (Government of Nunavut, 2006), draws attention to the cultural significance of role modeling. Observing and following examples set by Elders is how Inuit children traditionally learned (Pauktuutit, 2006). Mancini, Billison and Mancini (2007) refer to this as a natural learning process that Inuit have embraced for thousands of years. Elders and parents practiced this by encouraging the learners (youth) to watch, listen, and pay attention. Healthy relationships were emphasized not only within the context of modeling for youth, but also as an indicator of positive sexual health outcomes. Ensuring youth have positive relationship role models to look up to is an important strategy to consider for sexual health promotion. Incorporating role-modeling activities into sexual health education programming can also be a strategy that corresponds with Inuit ways of learning.

Employment and income

Employment and income did not emerge directly from the data. A possible explanation why this issue might not have emerged within this study is that access to health services does not necessarily differ within Inuit communities as it relates to relative

employment and income among community members; access is the same for everyone. Employment did not appear to overtly influence women's experiences with STIs, as there was no drastic difference between the sexual health experiences of women who were employed, unemployed, wage earners, or on social assistance. Employment and income is however linked to housing, which was expressed by participating women as a determinant of community sexual health. The differences in housing situations for women who are on social assistance compared to that of women who are employed would be drastic. Women living on social assistance would likely live in more crowded houses than women who own their own homes. Overall women in this study had similar sexual health experiences regardless of employment and income.

One finding that is related to employment and income is the subtheme of **transience and travel**. This theme appeared in women's stories of men and women travelling for work, either duty-travel (work related travel is commonly called duty-travel) or into mine camps. This theme also revealed transient workers like construction crews that come into town for periods of time. Often, people in government positions must travel to regional or territorial headquarters for meetings. Women shared examples of partners having sexual relations outside of their relationship back at home, and indicated this was a cause for negative sexual health outcomes.

The WHO (2005) have reported on the difficulty migration (specifically a migrating labour force) causes for sexual and reproductive health, noting it is difficult to design sexual health programs for transient populations due to social and cultural barriers which limit the use of health services. The development of sexual health promotion and disease

prevention programs and policies need to recognize the travel that takes place between communities. The increase in travel throughout the North, and between the North and South does increase the vulnerability of Inuit to STIs including HIV (Cameron, 2011). This is a factor that needs to be included in future interventions.

Social supports

The findings of this research project highlight the need for **more support** (social support) to improve individual and community sexual health. As Inuit women told stories about their experiences of being diagnosed with STIs, and having difficulty within their relationships with their sexual partners, they expressed a great need for support. Some sought this from friends, and others felt they had nowhere to turn; lonely, ashamed and embarrassed. This could also be heard in women's reflections about participating in the storytelling sessions. For some women, this was the first time they discussed such topics, and they reported feeling as though the process was healing, and it felt good to get their stories out. They said the group story session should be recreated as a source of support for women.

Social support is said to be a significant health determinant in general and within Inuit communities (Raphael, 2009; Richmond, Ross & Egeland, 2007). The opportunity to share problems, feelings and gain strength, support, and encouragement are all reported benefits of social support when dealing with health issues (Richmond, Ross & Egeland, 2007). Women reflected on the process of sharing their stories for this research project, and felt it was beneficial to them to have the opportunity to share their stories within a

group. They suggested more groups "like this" take place as a source of support for women within the community.

ITK (2009) reports that social safety nets, a term that refers to the "availability and quality of family, community and societal supports" (p. 12), is a determinant of Inuit health. Devries et al. 2009 argue that feeling connected to family and school helps manage stressful life situations and encourages one to pursue further education, all of which are linked to lower STI risk. This sense of connection is important for overall health, as well as sexual health as can be seen in the study by Devries et al. (2009). Women in this study discussed low **self-esteem** and negative **self-image** as determinants of poor sexual health outcomes. Specifically, they linked this to unhealthy sexual relationships that may be abusive or violent. Through these women's stories they illustrated the connection between lack of social support similar to the connections put forward by Devries et al. (2009).

Many women shared stories of contracting STIs from their committed partner (husband or common law). This was an embarrassing and lonely experience for many women as they said they had nowhere to turn. A few women mentioned talking with a friend or family member, but most women felt as though they had no support. Sexual health topics are considered taboo to many people in Kugluktuk, thus leaving women with few supports. Also, women felt as though they had little support from the health centre, and reported little privacy if seeking appointments through social services to see, for example, a mental health worker. They also wanted to help support parents to be able to discuss sexual health with their children, which would create greater social supports throughout the community to promote sexual health.

For Inuit, one of the most significant psychological effects of colonialism has been on family relationships (Kral, Idlout, Minore, Dyck, & Kirmayer, 2011). Prior to colonization, kinship was central to Inuit societies, dramatic changes to family and communication have occurred which has upset traditional structures. It is said that "[v]alues and practices related to kinship, mutual interdependence, and cross-generational teaching and support guided the Inuit for many centuries before foreigners came to their lands" (Kral et al., 2011, p. 427). Evidence of these values were present in women's stories, and their stories pointed out the change in teaching that has occurred, and emphasized their part in ensuring the teaching of sexual health information to their children. They call for more social support to help parents educate their children, as well as for individuals who are dealing with negative sexual health issues and need support to get through the difficulty. Although this upset in the role of kinship, communicating and sharing has occurred, women seem determined to regain these traditional forms of support.

Gender relations

The theme of **gender and power** emerged through the data analysis process, within the context of generalized changes in gender relations. Women told stories of the change from male dominated households of the past, to present day, where women are more independent and able to speak up and participate in decision-making. It is interesting to note that the origins of male dominated society within Inuit communities are the processes of colonization. Traditional Inuit society held men and women with equal roles, it has been reported that Inuit lived with "relatively balanced, if not egalitarian, power relations during the period before European contact" (Mancini Billson & Mancini, 2007, p. 54).

Much of the changes in gender dynamics reflected a specific time in women's lives (and in history). The age of the participants who spoke of noticing the decrease in male dominated society, and less intimate partner violence, are women who can imagine the camp-life they experienced at a very young age or hear of their parents speaking of, where the gender roles were well defined and equal. These same women have then experienced or heard of the huge shift in this organization of roles. This shift caused males to assert dominance over females within relationships. Whereas the political gender inequity that was discussed would have been reflective of the political landscape for broader Canadian society 30 years ago.

The changes in gender relations for Inuit have been complex. When Inuit were forced into permanent settlements, it was much easier for Inuit women to retain their gender roles of taking care of the home/ camp, and children. Hunting and trapping, predominantly male roles were more difficult to sustain in settlements, thus, male role of provider diminished. Women moved into the role of primary provider, as they were able to transition into wage-labor jobs more easily than men, and this led to imbalances, which influenced their relations (Mancini Billson & Mancini, 2007; Morgan, 2008). The shift in gender roles has led to "increased violence toward women decreased female well-being, and volitions of women's human rights" (Mancini Billson, 2006, p. 70).

Women in this study perceived the rates of intimate partner violence and attitudes of male dominance to be lessening from that of the past. They reflected on the past, where women had no say, and they would see many women with black eyes, and said that today it is much better than it used to be. In a study by Healey and Meadows (2008) Inuit women

reported progress and positive change for gender roles in families. This may be evidence that things may be (re)structuring towards a more equal gender balance.

Closely linked to the theme of gender and power is **intimate relationships**. The significant changes that have taken place within Inuit communities have influenced relationships. Traditional approaches to intimate relationships were **arranged marriages** (Christopher, McDermott, & Flaherty, 2011) now; a more contemporary form based on individualism and choice is prevalent (Kral et al., 2011). Thus, things have gone from a situation where youth had guidance from parents in relationships, to where they now have little guidance.

Given that parents and Elders are virtually left out of young Inuit's intimate relationships, the value of communication and well-being in relationships has been lost. **Communication** was discussed as a contributor to healthy intimate relationships. Women emphasized the importance of communicating with intimate partners to ensure a stable healthy relationship. The loss of traditional relational teachings was depicted in many women's stories. Kral et al. (2011), in their study examining community change in Nunavut, report one of the most prominent themes was talking and communication. They suggest communication needs to increase in Inuit communities, as it has declined. This is echoed by Mancini Billson and Mancini (2007), who claim that "lack of communication surfaces time and time again in our conversations" (p. 165).

Self-esteem and self-image have been discussed in reference to social supports; however, this theme is also linked to intimate relationships and should be discussed with relation to risky sexual behaviours. Self-esteem has often been examined in relationship to risky sexual behaviour, particularly among adolescent females. It is shown that girls with

poor self-image will be more likely to have risky sexual relationships (Ethier et al., 2006). This includes initiating sexual activity earlier, not using protection, and having risky partners. The study by Ethier et al. reported similar findings. They referred to young women in unhealthy sexual relationships, and staying in unhealthy relationships because they have low self-esteem and negative self-image. Mancini Billson and Mancini (2007) suggest Inuit women with low self-esteem and negative self-image women forget to take care of themselves, and include specifically, not using condoms.

Discussing self-esteem and self-image as determinants of sexual health emphasizes the holistic view of sexual health. These factors contribute to overall health including mental and emotional health and therefore considering their effects can improve sexual health outcomes. Programming addressing sexual health promotion should include an examination of self-esteem and self-worth.

Intermediate

Determinants of health operating at an intermediate level represent systemic resource allocation that heavily influences proximal determinants.

Education systems

Within their stories, women expressed the change that has occurred with regards to **sexual health teachings** within the schools. Although women were pleased sexual health lessons were taught in schools to their children as many women did not learn about sexual health in school, they were concerned that the school system was not delivering enough sexual health education to youth in the community. They felt curriculum should be developed in order to reach youth earlier, and that sexual health material should be

delivered monthly. Women who had knowledge of the education system spoke about what they thought could be done to increase **awareness** of STIs and HIV. One woman talked about the consent forms parents have to fill out in order for their children to participate in the sexuality section of health class. She suggested that more work needs to be done to inform **parents** about the details of what is covered, to increase the number of students participating. She said every year several students do not participate because their parents did not consent. This is an important point that should be explored within the education system. If parents do not fully understand what was being taught, they are hesitant to allow their children to participate. This supports the parent and school partnership for child sexual health education. Providing more support to parents would help school based sexual health education.

Listed in the Nunavut's sexual health framework is the priority action to work with the department of education to develop and implement "an improved sexual health component into the school health curriculum", and to "establish a reliable health and social services support system for schools and teachers for the implementation of sexual health component of the health curriculum" (Government of Nunavut, 2012, p. 10). This was heard within women's stories, their aim to improve on what is already done in school. Women recognized the CHRs as being sources of sexual health education within the school system, and this partnership was an important one that if supported, can improve sexual health outcomes.

Beyond the scholastic education system is community education. The theme of **reaching the hard to reach** resonated for many women in this study. This theme is linked to the IQ principle of **Tunnganarniq**: fostering good spirit by being open, accepting and

inclusive. Women were considerate of youth who were not in school: drop-outs and non-attenders. They were concerned about ensuring there was programming that would be inclusive of youth who are not in school, and ensuring educational programming would include them. Also, when many instances in the past exclude men, including men was the forefront of women's ideas of how to improve sexual health outcomes, including men.

Women clearly expressed a need for greater **awareness and information** within the community. Pauktuutit (2010) also highlighted the need for greater awareness in their call for greater awareness as it is fundamental in the prevention of STI and Sexually Transmitted Blood Borne Infections (STBBI) within Inuit communities. Women told stories that emphasized the importance of a variety of groups and individuals who need to be involved. Community sexual health is not the sole **responsibility** of parents or the health centre staff; it is a community-wide issue that requires a community-wide response. A 2010 report by Pauktuutit urges that to be effective, awareness programs need to involve a "range of players to reach the entire Inuit audience" (p. 6).

Health care systems

The federal government is the main source of funding for almost all health service and program delivery in Nunavut (NTI, 2008). Due to factors such as geography, program design, funding, and human resources, Inuit have limited access to specialized health care services (NTI, 2008). Almost all communities in Nunavut obtain only primary services; therefore, Inuit must travel to regional centres or to southern Canada for comprehensive services (e.g., surgery, child birth, medical specialists) (NTI, 2008). Jenkins et al., (2003) report that the delivery of culturally appropriate health services is complicated by the need

for medical transfers, which refers to Inuit patients who must travel outside their territory, often to southern Canada, for advanced health care. Moreover, lack of linguistic and cultural competencies as well as rapid turnover of health staff contribute to challenges in the **continuity of community health care** within many Inuit communities (ITK, 2009).

A theme in the findings of this study that was linked to continuity of community health care that was particularly a concern for women was the high degree of staff turnover at the health centre. It was noted that this was especially an issue when dealing with health issues as personal as their sexual health. They felt it was difficult to build trust with the health staff when they might be seeing a different person at each appointment. Several women also talked about receiving a STI diagnosis and prescription for medication but no further information. In one storytelling group women talked about how nurses can make them feel like they have done something to bring the infection on themselves, when they abruptly ask how many partners the women have been with, when their only partner is their husband.

This finding would have particular significance for the organizers of community health care for northern communities. It highlights issues that women experience that limits their access to seeking healthcare. Health Centre staff health education training, and cultural safety training, as well as the importance of health staff retention are all topics that are of concern here. These barriers that are created for women seeking health services are preventable, if government and policy makers take situations like these into consideration when preparing healthcare workers to go north, and when supporting Inuit to attend post-secondary training in order to work in these positions.

There are similarities between women's experiences in this study and that of Helle Møller's (2010) research findings examining how Inuit from Nunavut experience and make meaning of tuberculosis. Her study revealed similar situations to those experienced by the women in this research project. She framed these experiences as current-day colonial experiences by patients seeking treatment and care. Møller reported: "When discussing the treatment of Inuit by healthcare professionals, more than half of the Inuit participants and many in casual conversations said they felt patronized, not respected, controlled, not informed, and not listened to or taken seriously" (p. 42). Møller's (2010) example of continuing colonialism within the healthcare system in Nunavut is consistent with the stories shared by women in this study.

The findings in this study that can be linked to current day colonial experiences verify the need for more decolonizing approaches within the healthcare system in Nunavut. Most of Nunavut's health care practitioners are non-Inuit, and thus this finding has implications for developing a more comprehensive community specific health centre orientation for workers coming to the north. Although Nunavut adopted IQ to guide the territorial government's work, healthcare operates within a Euro Canadian institution, and thus Inuit values and norms are disregarded within healthcare settings (Møller, 2010). This finding demonstrates the importance of incorporating Inuit ways of knowing and doing and IQ into healthcare to achieve better sexual health outcomes for Inuit.

The language that practitioners use to communicate with Inuit patients was discussed as an issue in receiving services from the Health Centre. In one story the use of the word narcotics was offensive to a woman, who described how that language implied her granddaughter was a drug addict. Adelson (2005) addresses the issue of language

suggesting, "if health-care workers are non-Aboriginal, they are at particular disadvantage in that they are often only able to communicate through the language and culture of biomedicine" (p. 46). Biomedical health care is rooted in a very different position compared to that of Inuit ways of understanding health and "has been shaped by a century of internal colonial politics that have effectively marginalized Aboriginal people from the dominant system of care" (Adelson, 2005, p. 46). Ensuring that communities themselves are able to contribute to the way healthcare is delivered within their communities, given that "conventional clinical approaches may not fit well with traditional [I]ndigenous values or realities of contemporary settlement[s] (Adelson, 2005, p.47) is an important approach for Inuit community health.

Women's stories in this study also spoke about issues related to **continuity of community health care**, including concerns of confidentiality such as test results being leaked into the wider community, pregnancy announcements made at the grocery store, before women had a chance to tell their family, and medication conversations happening in the waiting room. Gesink Law et al. (2008) cite issues of confidentiality as a barrier to care within small isolated communities, and advise there is a widespread opinion that confidentiality can be easily breached. Many women told stories of this being their own experience, or it happening to a family member. In either case, they felt a lack of trust with health centre staff members; causing them to, at times, avoid accessing services.

In light of the literature it appears that the findings of this study, the experiences these women had with accessing health care in their community are not limited to them. That is, Inuit across other jurisdictions have had very similar issues with confidentiality and continuity of care. Ensuring that health care professionals who work within

communities in Nunavut receive cultural training and education could enhance the delivery of health care services in the North. A decolonizing (Inuit directed) approach toward the health care system would ensure that public health education is delivered in a culturally appropriate way, including delivery by Inuit. The provision of culturally appropriate health care services might result in greater use of health services by the Inuit of Nunavut and thus, improve treatment outcomes (NCCAH, 2010d).

Cultural continuity

Cultural continuity has been described as "the degree of social and cultural cohesion within a community" (Loppie Reading & Wein, 2009, p. 18). According to Chandler and Lalonde (1998), a high degree of cultural continuity exists in communities that have: successful land claims, cultural facilities and self-governance as well as control over education, police, fire, and health services.

Health promotion needs to be culturally informed and relevant in order for it to be effective. When examining the health of Aboriginal Peoples in Canada, it is important to note that there are vast cultural and linguistic differences; however, commonalities exist in the social, economic, and political disparities brought about by colonization and colonialism (NCCAH, 2010d). Enhancing cultural continuity through revitalization of culture and/or language can improve health outcomes (NCCAH, 2010d). Women in this study spoke of their desire for community health promotion materials to be available in Inuinnaqtun, as well as the oral delivery of prevention messaging, as this is the traditional mode of knowledge sharing.

With the immense changes Inuit have gone through within the past seven decades, using Inuit societal values to plan current day programming is key in making programs relevant. The findings from this research illustrate that determinants of sexual health such as changes in teaching and learning can also influence cultural continuity, which is a major determinant of health. The women in this study seem determined to avoid the loss of cultural continuity in their community. This is most apparent in their attempts and commitment to ensure that they teach their children and grandchildren. Developing sexual health promotion as well as HIV and STI prevention programming and policy with a foundation grounded in IQ can strengthen cultural continuity. The IQ principles are a valuable guide for program development within Inuit communities, as they represent well-established and culturally rich values that can breathe Inuit culture into current day programming and policy.

One finding of this research project revealed that many women felt that discussing sexual health openly was considered **taboo**. It is important to note the significance of taboos within Inuit culture. Traditional Inuit beliefs focused on taboos, and it was believed that spirits would show their displeasure towards people who may have broken a taboo. Breaking a taboo was believed to have potentially catastrophic consequences, such as missing caribou migration, which would result in starvation within a camp. As Sperry (2005) writes, "Traditionally in their culture, any kind of sickness or accident demanded a reason. Invariably, the root cause would be deemed to be the malicious attack of a malignant spirit or due to the breaking of a taboo" (p. 127).

In this study many women claimed that discussing sexual health openly with an Elder was considered taboo. They also suggested that years ago discussing it openly with one another would have been considered taboo, however this has changed. Considering this deeper meaning of taboos within Inuit culture is important, as the meaning is not simply related to being polite, or uncomfortable, as many outsiders may understand it to be. It was believed that if one is careful to follow taboos, they would be protected from danger (Sperry, 2005). The contemporary beliefs around taboos have changed; however, the fact that they seem to be inextricably embedded in Inuit culture requires further exploration in order to maximize effectiveness of sexual health programming. With such high value placed on youth learning from Elders, combined with the feeling that it is taboo to discuss sexuality with Elders there remains a gap that needs to be explored.

Distal Determinants

The distal determinants of health are the most abstract and overarching, representing the historical, social, economic and political contexts within which all other determinants are constructed and exist (Loppie Reading & Wien, 2009). Notwithstanding this important influence, distal determinants are by definition quite removed from an individual, and thus, their influence on health can be difficult to articulate.

Colonialism

The colonization of what is today known as Nunavut has indeed had grave impacts on the health, culture, and society of Inuit (Møller, 2010). Although none of the participating women articulated the process of colonization/colonialism as directly affecting their lives, it was subtly present throughout their stories. The health of Aboriginal

Peoples is influenced by distal determinants of health such as colonialism "through the construction of unfavorable intermediate and proximal determinants" (Loppie Reading & Wein, 2009, p. 21). Through their stories about the effects of moving in from the land into settlements, about schooling, seeking care within a western health care system, and the DEW line camps, it is clear that distal determinants have profoundly shaped the sexual health of these Inuit women.

The resettlement process resulted in the disconnection of closely-knit families and kinship groups. The trauma of this type of separation was exacerbated when Inuit children were sent away to residential schools and tuberculosis patients were kept in facilities in Southern Canada for treatment. Resettlement was part of the Government's larger plan for sovereignty over the North during the Cold War and this began acculturation and assimilation of Inuit (Bonesteel, 2006). Within different contexts, acculturation may have different meanings. Within a Nunavut context, it means replacing the traits of one culture (Inuit) with those of another (Southern Canadian) (Healey & Meadows, 2008).

A major theme emerging from this research is **the way it used to be**, which speaks to the colonization of Inuit communities and drastic changes in traditional Inuit ways of learning, maintaining social order, gender relations, marriage, and sexual practices. The subthemes reflect how Inuit society organized itself, when people lived a semi-nomadic life including: **multiple spouses and spouse swapping**, how **rules and order** were kept in camp related to sexual relationships, **Elders' teachings**, and **arranged marriages**. These practices have changed as a result of the resettling and restructuring of communities, through the transition to hamlets from small camps. All of these changes were initiated or enforced by the federal government. Of the Inuit, Mancini Billison and Mancini (2007)

assert that "[i]n one brief generation, they were resettled from a hunting and gathering economy based on sharing, reciprocity and cooperation to a post-industrial society based on wages, accumulation of resources, welfare and competitive norms (Mancini Billson & Mancini, 2007, p. 5). These changes have had a substantial impact on the lives of Inuit people, including their sexual health.

Within the literature, colonization and westernization have been identified as responsible for high rates of STIs and HIV within the Arctic (Gesink Law et al, 2008; Steenbeek et al., 2006). In fact, it has been suggested that communicable diseases were practically unknown among the Inuit until contact with traders, missionaries, RCMP, whalers, and anthropologists (Mancini Billson & Mancini, 2007). Travelling from Southern Canada, the US and Europe, these settlers brought with them "waves of tuberculosis, influenza, measles, venereal disease, and other debilitating or fatal sicknesses against which the Inuit had no natural immunity" (Mancini Billson & Mancini, 2007, p. 13). Steenbeek et al. (2006) likewise put forward an analysis of STIs among Inuit youth as an example of how historical and cultural conditions linked to colonialism shapes health.

Oppressive colonial processes have resulted in a health profile among Inuit people that is comparable to that of those living in the developing world (Adelson, 2005; Waldram Herring & Young, 2007). Across Canada and the world, Indigenous and Aboriginal Peoples have experienced colonization, which has contributed to, and continues to cause, numerous health inequalities compared to that of non-Indigenous populations within the same jurisdictions. Although resettlement controlled widespread starvation and tuberculosis (Mancini Billson & Mancini, 2007) the socio-cultural changes Inuit experienced within such

a short period of time, has resulted in substantially negative mental, physical, emotional and spiritual health outcomes (ITK, 2009). Colonization affects all aspects of Inuit health, including sexual health. For example, disproportionately high rates of HIV/AIDS among Aboriginal women in Canada can be understood as one of the most devastating consequences of colonization (McCall et al., 2009). These high rates can be linked to residential school system, devaluing of Aboriginal women's status, and increased violence due to drastic change in gender relations (Hawkins, Reading, & Barlow, 2009). It is important when examining the literature that highlights Aboriginal women's high rates or vulnerabilities to disease (i.e. STI and HIV) among other health issues, that we consider the influence of colonization and postcolonial process that create barriers to access health care (Bourassa, McKay-McNabb, and Hampton, 2004).

Waldram, Herring and Young (2007) emphasize the need to understand colonialism, but warn that we cannot be restricted by it. This may come across as a provocative statement, and is not intended to mean get over it, and get on with it. I believe this resonates within the findings as women discussed the effects of colonization in a distant way, but focused on what they can do today with modern technologies to influence the most pressing sexual health issues. Waldram, et al. further explain that health researchers need to consider the modern day context within which Aboriginal people live; while imminent problems such as housing and employment are linked to colonialism, they require contemporary solutions.

The women participating in this study provided contemporary solutions that also reflect Inuit ways of knowing and doing. From within their lived experience emerges immense knowledge and direction. Their stories acknowledged colonialism, as they linked

family difficulties to alcohol arriving and increased exposure to workers from the south. They talked about residential schools as a period of time where children were disconnected from their families, and they spoke fondly of a time before settlement.

Racism and social exclusion

Social exclusion results in poor health outcomes and is created by the structural processes that prevent people and groups from accessing and participating in economic, social, cultural and political activities other people in society are able to take part in (Kiepal, Carrington, & Dawson, 2012). Aboriginal people in Canada experience social exclusion in many aspects of their lives, including labour market exclusion leading to poverty, spatial segregation on remote reserves, settlements and hamlets, and isolation from family and communities due to family dissolution (Amnesty International 2004; Kiepal, Carrington, & Dawson, 2012).

Wynne and Currie (2011) reveal that both individual and social exclusion contributes to higher STI rates among Aboriginal men and women. They contend that residential segregation is a clear example a form of institutional social exclusion that influences Inuit sexual health. Aboriginal communities that are in rural and northern regions have less access to health services, which is a determinant of STIs. It is clear from women's stories that the limited access to health services is a determinant that influences the sexual health of women in Kugluktuk, their stories told of lack of privacy in seeking health services, as well as a lack of support for sexual health. This results excluding women and community members from accessing sexual health services, which is directly linked to negative sexual health outcomes.

Women told stories that illustrated they were cognizant of the social exclusion of others in their community. These stories drew a link between the social exclusion of non-attenders and drop-outs from school and men to the limited access to sexual health education and HIV and STI prevention information. Women in this study expressed the importance of reaching the hard to reach community members, those who are in their mind, socially excluded.

Inuit youth experience individual social exclusion by being involved partly in traditional life and partly in modern life, yet struggling to find meaningful ways to fully engage in both (ITK, 2009). Feelings of hopelessness, helplessness, and mistrust can all be linked to experiencing social exclusion and can result in increased chance of risky (including sexual) behaviour among vulnerable populations (PHAC, 2011). Women's stories about youth mixing alcohol and sexual decision-making, (risky sexual behaviour) could be linked to their experience of social exclusion.

There was no mention of overt racism in women's stories; however, there was evidence of structural racism which "is perpetrated when policy makers and power brokers [re]produce or fail to redress structural inequities between racialized groups" (Reading, 2013, p.4). Ship and Norton (2001) state that HIV risk is often strongly correlated with social and environmental factors like stigma, discrimination, sexism and racism, rather than individual behaviours. Women's stories of negative experiences within the health centre illustrate the historical colonialism has established present day structures that create vulnerabilities leading to poor sexual health outcomes among Inuit. The health system at times is unapproachable, women felt as though health practitioners were too

busy to take the time to teach them. In some cases women felt judged by the practitioners and made to feel they were doing something to bring STIs on themselves.

Self-determination

The health disparities within Aboriginal communities are not only linked to the associated economic, political and social disparities, but also to the "limited autonomy Aboriginal peoples have in determining and addressing their health needs (Adleson, 2005, p.55). A growing number of reports and studies cite self-determination as the most important determinant of health as we move toward healthier Aboriginal communities (Cameron, 2011; Loppie Reading & Wein, 2009; ITK, 2009). There is a widespread consensus that the more Inuit governments, communities, and organizations regain control over Inuit specific social supports, education systems, health services as well as programming and infrastructure, the better their health will become. Community members can influence their officials, and bring their needs forward, thus enhancing self-determination. Autonomy to identify issues that resonate with localized, culturally defined, age-appropriate and gendered experiences of Aboriginal women is an important to reach positive health outcomes (Peltier et al., 2013). Sexual health programming and HIV prevention for Inuit must be based upon self-determination.

Inuit women know how to take care of themselves and their families. Their ideas and strategies in the findings from this study show evidence of this. A major theme was the importance of approaching community-based sexual health promotion and HIV and STI prevention through **holistic strategies** with shared **responsibility**. The multiple strategies and shared responsibility women suggested is in line with the work of Peltier et al. (2013)

who insist that, in order for an intervention aimed at HIV risk for Aboriginal women to be effective, it must take a community wide approach, where "men, women, children, families, and community members are all working towards the common goal of HIV prevention via greater health and well-being" (p90).

The holistic strategies suggested by women were an example of the IQ principle of **Qanuqtuurniq**: The concept of being resourceful to solve problems and seeking solutions. Their ideas were creative and took advantage of resources available within their community as well as being in line with Nunavut's sexual health framework (Government of Nunavut, 2012). Released late in 2012, this is another example of self-determination for community sexual health outlines the Nunavut government's plan to improve sexual health in the territory. This framework incorporates IQ principles within its priority actions, and is the government's first coordinated commitment to address sexual health in Nunavut.

In their paper exploring racism, sexism and colonialism and its influences on Aboriginal women's health, Bourassa, McKay-McNabb and Hampton (2004), underscore the importance of self-determination when they assert that "...in order for culturally appropriate services to become available, they must be developed with women who are from within that culture..."(p. 27). That is, if women are left out of defining the issues within their own culture, and are "excluded from the decision-making structures that will determine how Aboriginal health resources are to be designed and distributed"(p. 27), these resources will be useless.

The purpose of this research project was to bring women's voices forward, so that they can be involved in the discourse around community sexual health promotion and

disease prevention. The essence of this quote by Bourassa, et al. was the impetus for this dialogue. Inuit women must be involved in the discussion about what can be done to improve their sexual health and that of their families. This is echoed by ITK (2009) in their discussion of self-determination, as they describe self-determination as Inuit fully participating in planning and implementing programs that affect them.

Participants' reflections

At the end of each session, I checked in with women to see how they felt after telling their stories. All of the feedback was positive. One woman claimed, "*It's good to talk about it; you should have more sessions like this with other people too*" (Amanda). Another woman said it felt "*Good... It feels like no more... just like no more anger inside... get it all out!*" (Allison). It was also reported to be a healing experience, to have the opportunity to share stories they have not shared before. Elaine reflected on the experience of participating in the research process, "*It's healing to let your story out... And if other women can do it, that's why I'm so happy you're getting participation*".

Louisa talked about how powerful she thought the research project would be once it is finished:

So today, for us who are participating, it would be very powerful to see it in writing once you are done. It would be very powerful because it is something that we gave to and are, we're a part of and that we were sharing and that we were willing to take ownership and say, okay. I let you have it. And you can do with it what you will as long as it does good. Because everybody, every human being, no matter where you live, you want to see good come out of something, okay. Because we all still live and work

collectively... I'd just like to see the end results and be shown and be very powerful.

It's a very powerful tool.

Rachel reflected on her feelings about sharing stories for the first time: *"It's the first time I said something about it because you're not scary"*.

Researcher Reflection

The fourth and final research question for this research project seeks to reflect on the strength and resilience of the participants, and examine what link (if any) exists to their role in community sexual health. This is a personal reflection, and given the fact that resilience is a context specific, culturally constructed (Ungar, 2003), and I have a vast knowledge of the context and culture surrounding this research project, this is an appropriate approach for answering this final question.

What role does Inuit women's strength and resilience play when it comes to informing them how to take care of their sexual health and that of their families?

Strengths

In April 2011, when I first discussed the possibility of this research project with women in Kugluktuk, I knew it would draw on women's strengths and resiliency. Over the past several decades, a growing body of resiliency research has emerged. I would not frame this project as "resiliency research" but rather, a project that drew on the strength of Inuit women. Highlighting the strengths and resiliency of the participating women, what they have brought to this research project, and thus to the research dialogue on sexual health of Inuit communities is providing another version of the discourse about the population with the highest rates of STI in the country. The positive attitudes and forward

thinking solution-based approaches are what is needed to improve the sexual health of these communities.

The women in the study revealed resiliency through their stories of experiencing negative sexual health episodes, healing and moving forward from these issues. They also demonstrated strength in their dedication to teaching their children and grandchildren, despite receiving little or no formal sexual health education themselves. They shared with great eagerness innovative ideas about how to address community sexual health, and drew from their personal experiences to inform these ideas. Inuit women are the experts of their own lives, and it is their ideas that should drive programming, policy and research about community sexual health. Improving the health of Aboriginal women is critical not only for the individual women, but also for the revitalization of families and communities. Women's roles as mothers and caregivers extend their influence to the next generation (Halseth, 2013).

Change, and *The Way it Used to Be* are two major themes emerging from this research project, and it is no wonder, given the fact that there are few cultural groups which have gone through societal change as quickly as the Inuit. Those who are now grandparents were born on the land, grew up in ice houses, and traveled with small extended family groups with the seasons. Children now live in hamlets with houses filled with satellite television, computers, cell phones, iPods, and top-40 music. Inuit must straddle two cultures but perhaps never fully belong to either (Mancini Billson & Mancini, 2007). The disconnectedness between generations is heard within women's stories, as is their aspiration to reconnect.

This project has been, much like my relationship with Kugluktuk, filled with rewarding, uplifting moments, as well as difficult, heart wrenching moments. The time I spent with the participating women, listening to their stories, drinking tea, sewing, laughing, crying was the easy part. The task of 'taking their stories', organizing descriptions and concepts, presenting them back to the women, using available literature to compare findings, and then with their permission and guidance, beginning to write about their lives for others to read was emotionally, spiritually, psychologically demanding. Committing their words to print, fragmenting their lives, and deciding, which fragments fit together in segments was daunting. Often when I felt overwhelmed by these decisions, I called on these women for support, and they encouraged me, claiming that they knew I would make the right decisions, "We're so proud of you, you'll do it right, you know us". They had faith when I was unsure.

With their stories in hand, I delved back into the literature to examine what has already been written and compared it to what women told me. In each piece of literature, I hear their voices and could see their faces. Every case or example has a story personally attached to it. Thus, I would often feel as though the connection I have to the community was at times both a blessing and a curse. A blessing because I feel as though I can do this work justice, given my history with these women- I understand them; I know them. Yet, in reviewing the literature about the North, I could hear the voices of people I love whom are living in such inequitable situations; I often found that I had no words to articulate what needed to be said.

One day in particular stands out; I had just finished reading and re-reading literature on health behaviours. Heavy at times, the research reports discuss alcohol use, changes in physical activity, risky sexual behaviours, Aboriginal women's involvement in the sex trade, coping and suicide, all stemming from community trauma. Images of faces and families, and stories all swirl around in my head as I work through the literature, and at times I felt that it is so complex and overwhelming, I would ask what is all this for, how can this little project make change with any of this? I finished writing my discussion at the end of my 11-hour work day. As I was packing up my office for the night, my phone rang. It was my mom calling from Kugluktuk. The first words out of her mouth were, "So, we had another suicide last night... a little girl...13 years old...". I had no words.

My Lessons

There were many lessons I have learned and things that have been solidified in my mind as a result of this research project. The following is a selection of my lessons. My facilitating of this study also facilitated my transition from community based sexual health practitioner to community-based researcher. I quickly learned that many of the skills and abilities I had gained from my community health career were transferrable to CBR. Things like conducting my work tasks with guidance from community members and operating on the ground within the community was second nature to me. Some of the more challenging situations were navigating the University system, including the institutional bureaucracies and timelines. As articulated to me by Albert Marshall, I have an ability to *weave back and forth between two worldviews*, and I now believe that I should continue to work in

partnership with community and in service to community for as long as the community wants me to.

Shawn Wilson (2008) asserts that, "Indigenous research *is* a life changing ceremony" (p.61). I believe this to be true. This modest scale graduate research project, that has in partnership with Inuit women, utilized Inuit research methodologies, was, for participants as well as for me, life changing. In this study women revealed that the research process, for them, was healing, and participating women said they had never talked about these things before, yet felt comfortable to speak up in the storytelling sessions. This occurring due to this project so profound, I find it hard to articulate. Healing can happen through research, change can come from research, and thus health can improve as a result of research.

Through my learning, through witnessing how profound the process of research can be, I have become very protective over Kugluktuk when it comes to research. Since this project began, I have been recommended to several university student researchers (Masters and PhD), as well as practitioners as a point of contact prior to their visit to the community. Community members in Kugluktuk passed my contact information onto these students as they were preparing for their trips north. I was surprised as I felt critical and some scepticism and caution when these students contacted me. I felt protective over the community, and as if I was in that moment a gatekeeper of what can continue to rebuild the narrative of Inuit health research (good or bad). Once convinced they were ready, and I believed they could proceed and work with the community in a good way, I felt as though I needed to also check that researchers were prepared for what they were about to

undertake for themselves - I can even recall the words, "this will change your life" come out of my mouth, which perhaps seem somewhat dramatic, but in this case, I was assured, could not have be more true. I am committed to reshaping the narrative of Inuit health research.

This experience has solidified my commitment to improving Inuit HIV and STI prevention and sexual health promotion, with approaches that are on Inuit terms. I am committed to creating space for Inuit women and their entire communities to have their stories heard, so that their needs and realities are reflected in programming, policy, and research that affect their lives. I am dedicated to help facilitate with this Kugluktuk and, across all of Inuit Nunangat (all four Inuit Regions in Canada).

Hivulik paak - Implications

I hesitate to include a section entitled 'Conclusions' as the word infers an end, a closing or the finale. In contrast, I believe this is hivulik paak (the beginning). This section of this thesis will examine the implications that arise from this research project. It is divided into three sections: implications for the participating women and their community; implications for future Inuit health research; and implications for practice, programming, and policy.

CBPR seeks to find a balance between research and action to the benefit of all involved (Israel et al., 2013). The intent of this project was to initiate action to address inequitable access to community HIV and STI prevention and sexual health promotion in the north. This research project also contributes to information on community HIV and STI prevention and sexual health promotion within Inuit communities. The process and results

are both helpful in guiding future research and programming. The incorporation of IQ into the research framework has shown to be a promising approach for Inuit CBPR. The importance of taking time to meet, and spend time with participants, and having a relationship with the community cannot be emphasized enough. Because there has been very little HIV prevention research conducted in Inuit communities, this project has gleaned important information to add to a small body of existing literature. This project has also led to potential future research, and has implications for policy and programming, and this, reinforces the idea that there is no conclusion here, only directions for how to continue to move forward.

For Inuit women and their communities

This study would not have been possible without the women of Kugluktuk who participated in every phase of the project. It is these women who shared ideas and support for the project in its initial phases. They wrote letters of support to obtain funding, they met and collaboratively decided how the research should be conducted, and they shared their individual stories, to create the 'data'. They met again and collaboratively worked through the data to make meaning of it. Now, they will share the findings through continued KTE. As a result of this project, these women who participated are better equipped to participate in CBR as they have a greater understanding of how research projects work, and they have formed their own ideas of how such projects should ensue. CBPR focuses on building capacity for all partners involved. The participating women want more projects like this one; they are eager to participate in future research projects, and

have gained skills and knowledge that will enable them to drive the research agenda within their community.

Another important point to consider is that, for these women, this research was not just a project in which they participated. For many of them, it was an opportunity to learn, to share, and to heal. Denzin and Lincoln (2008) emphasize that Indigenous research methodologies and methods of inquiry must meet multiple criteria. They must not only be ethical, decolonizing and performative, but should also be transformative and healing, symbolizing commitment to community, cultural autonomy, and self-determination. This project was successful in meeting these criteria. For many of the women, this was the first opportunity they have had to share their experiences in a safe space. As Elaine reflected on the experience, "*It's healing to let your story out*". The power of this cannot be over-stated.

One of the nine principles of CBPR is that it works to build on strengths and resources already available within the community (Israel et al., 2013). Through this thesis, it has become clear that a major strength of this community lies in its people, particularly with the women. They are committed to ensuring their children are well educated about many things, including regarding sexual health, and this project has built their skills and capacity in community-based research. They were ready and willing to contribute to this project and are now are eager to collaborate in future projects.

Inuit health research

There is a history of research within Inuit communities where Inuit have been passive participants, and at times, exposed to unethical research situations. Oftentimes, researchers come and take the information, leaving Inuit wondering what happened to the

project, to their information, and to the researcher. This type of research and participation, which has little or no benefit to the community, is harmful. The women-centered participatory design of this research project ensured women had decision-making power throughout the research project. The research process ensured that women were kept up to date with the timelines and other details about project, and decisions were made together. This project makes an important contribution to reshaping the narrative of Inuit health research, as it provides another example of Inuit health research done *in a good way*.

Cochran et al. (2008) put forward that “the way researchers acquire knowledge in [I]ndigenous communities may be as critical for eliminating health disparities as the actual health knowledge that is gained about a particular health problem” (p. 22). This underscores the importance of the process researchers use, paramount in this process is ongoing Knowledge Translation KT. CIHR (2014) defines knowledge translation (KT) “as a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application of knowledge” (para 1). The ultimate goal of KT is improving health. IQ shares similar key characteristics as it relies on a “dynamic process of knowing, applying, experiencing, evaluating and creating new knowledge grounded in a continuum of knowing and continually improving” (Tagalik, 2012, p.2). The core goal of sharing ever-changing knowledge to continually improve wellness and life is at the root of these two concepts. Thus, ongoing KT is an integral part of Inuit health research that benefits Inuit health, by not only focusing on improving health outcomes, but it is also culturally congruent with Inuit societal values (IQ).

The utilization of Indigenous research methodologies within this research project ensured Inuit ways of knowing were central. Moreover, incorporating IQ into the theoretical framework grounded the study in Inuit traditional values. Finally, having women be equitably involved in each stage of this research project demonstrates steps towards self-determination in research.

Although I attempted to tailor this project specifically to be Inuit specific, due to available resources, much of the background research and literature used for this project took a pan-Aboriginal approach, considering broadly Aboriginal People within Canada. Therefore, although I emphasize Inuit community protocols, the project is rooted in a more broad approach that might have utility within other communities and contexts. Direction for future research and health programming can also be found in other Inuit sexual health research, taking place in Canada (CAAN, 2009, Healey & Meadows, 2007; Pauktuutit; 2010). However, due to the continuous development and ever-growing research interest in the Canadian North, further examples and tools that will enable communities to drive their own research and work with research teams in a meaningful way are needed.

The importance of a researcher building meaningful relationships within the community cannot be emphasized enough. This takes time. I do not believe this project would have been as successful, without my 10 years of relationship building as the starting place. An article written by Castleden, Sloan Morgan, and Lamb (2012) entitled *"I spent the first year drinking tea": Exploring Canadian university researchers' perspectives on community-based participatory research involving Indigenous peoples*, examines the tensions of CBPR theory versus practice for Canadian university researchers. This study

reports that difficulties often arise when putting the theoretical tenets of CPPR into action. A difficulty potentially faced by researchers is community time lines do not always line up with funding deadlines and releases, and that drinking tea does not necessarily fit within the academic time table, however it is just as important as other aspects of research. Inuit community-based research requires academic researchers to allow for time and activities to build relationships.

I must emphasize, I consider the cups of tea I drank, and the fishing and sewing, as important as the data collected. Certainly speaking with women about their lived experiences and perspectives of community sexual health would not have been possible without the relationships I have, and the insider status I hold within this community.

Practice, policy, and programming

The findings of this research project come directly from women who live in the region with the highest STI rates in the country. Indeed, numerous reports within the epidemiological literature tell us about the poor sexual health of Nunavummut. However, there is little available literature that examines women's perspectives of this situation, what they think would benefit communities, and what they think contributes to these statistics. The narratives emerging from this study create linkages between what is happening in the daily lives of women and families and the overwhelming epidemiological statistics.

The findings of this research project are consistent with research related to the social determinants of First Nations, Inuit and Métis health. Given the dearth of Inuit specific sexual health, HIV and STI prevention research, this project adds to that literature.

Specifically, the findings of what would be effective prevention methods within Inuit communities are instrumental. This information is of particular importance to practitioners, policy makers, and program developers. The following is an explanation of key points from the findings about what Inuit women feel is needed to improve sexual health within their community:

- Inuit community sexual health needs to be approached holistically. This aligns with Inuit values and principles. This not only means viewing sexual health as part of a whole person's health, but it also means considering physical environments (such as housing) and other social factors as they influence individual sexual health. A wide range of sexual health services relevant and affective for Inuit that consider generations past, present, are needed.
- All ages and stages need to be included in order to address sexual health. Specifically focusing efforts on families and youth is important, but also ensuring the entire community is included in sexual health efforts.
- Including the entire community also means the responsibility for community sexual health is a shared one. With emphasis on reaching the hard to reach community members and not only relying on the health centre.
- Health care and service delivery at the health centre is a key component of community sexual health. Improvements need to be made to ensure practitioners are able to provide culturally safe services to community members. The health centre also has a role to play in sharing information with the rest of the community and ensuring the sexual health workload is shared with schools, family homes, among families, and with the Hamlet. Sexual health relies on the clinical care and

services at the health centre, but the responsibility of community sexual health does not fall solely to the health centre.

- There needs to be increased availability / ease of access of condoms. This is particularly in line with the previous point about sexual health not being solely housed at the health centre. Condoms should be available at other places within in the community, not only the health centre.
- An Increase in awareness and availability of information about sexual health, STI, and HIV through a variety of creative message delivery techniques is needed. This information needs to be relevant and reflect IQ principles and needs to specifically include: encouraging regular testing, role modeling of healthy relationships, and messages about combining sexual decision making with substance use.

A main driving force of this research project is to bring the voices of Inuit women forward to be heard by policy makers, planners, and researchers, so the programs and policies being formed that most affect them, will have their insights and input included. KTE activities are planned in Ottawa and Iqaluit. Invitations will be sent to territorial and national Inuit organizations and partners such as Pauktuutit Inuit Women of Canada, Inuit Tapiriit Kanatami, The Canadian Aboriginal AIDS Network, Native Women's Association of Canada, The Society of Obstetricians and Gynecologists of Canada, Ministers of Health, Chief Medical Officers, and community members. These meetings will be co-facilitated by a community member who has been involved with the project from the beginning and me (the principal researcher). Having a community member co-facilitate the dissemination meetings with me encourages community research capacity building and also ensures the principles of CBPR are carried through to the final stages of this project. This plan for KTE

will ensure the people who are making decisions hear these results first hand. Once this thesis is finished and defended, with input from participating women; I will design an executive summary style document that summarizes this thesis. Copies will be provided to all participants and to the Hamlet.

Taima! - Finished

The significance of this project is that it provided an opportunity for Inuit women to share their own ideas, opinions, and views about community sexual health. It is my hope that the findings may be used to inform programs, policy, and practice related to community sexual health promotion and HIV and STI prevention. This research project is also useful in providing guidance for future HIV research within Inuit communities. These implications highlight the importance of taking a community-based approach to HIV and STI prevention, and sexual health promotion within Inuit communities. The findings of this study, generated from storytelling sessions with Inuit women and participatory analysis, emphasize holistic, community-based, family and youth-centred approaches. The women, through their stories, have provided a narrative to add to the epidemiological data currently available that shows the urgent need for prevention programming. The need for further research is evident and the desire and readiness for community prevention programming and education is clearly present in Kugluktuk. In order to provide prevention programming and policies that are relevant and culturally safe for Inuit communities, more research projects need to take place. The CAAN and Pauktuutit, are dedicated to Inuit HIV, STI and blood borne pathogens and sexual health, however, they have a national mandate with a variety of other foci. Community based studies like this one, and the remarkable work of CAAN and Pauktuutit provide the information for advancement in HIV and STI

prevention and sexual health promotion in Inuit communities. It is my hope that this project can contribute to the improvement of sexual health in Inuit communities, and to the equitable access to HIV and STI prevention programming and sexual health promotion.

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Appendix A - Letter to the Mayor of Kugluktuk



**University
of Victoria**

Jenny Rand
PO Box 1700 STN CSC
Victoria, British Columbia
CANADA V8W 2Y2

tel: (250) 857-2388
Email: jrand@uvic.ca

Faculty of Graduate Studies

Social Dimensions of Health
Program

May 17, 2012

RE: Research Project: *"Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women's Strengths and Resiliencies"*

ATTN: Mayor of Kugluktuk Ernie Bernhardt,

Thank you for making time to meet with me today. I appreciate your support of my research project, and am looking forward to October when the project will get rolling. All the preliminary meetings I have had have been positive, and I have heard nothing but support for the project.

I am writing to provide you with some details regarding my proposed research project as you requested so that you may bring it to the Hamlet Council.

This project is part of my Master's research project at the University of Victoria. Through combining the art and science of Inuit knowledge with community based, participatory research this project aims provide better access to HIV/STI prevention and sexual health promotion programs for Inuit women and their families. In addition to addressing an issue clearly articulated by Inuit women, the utilization of an Indigenous model of community-based research will ensure respectful and active collaboration with the community. Rooted in my long-term relationship with, and humble respect for, the women of Kugluktuk, this research will be conducted with a strong emphasis on reciprocity in the sense that I will learn more about Inuit-specific research protocols and will, ideally, be able to bring some of my experience in sexual health promotion and disease prevention to the community. Inuit women know best how to take care of themselves, their families and their communities. It is their wisdom and knowledge that will inform the products and processes of this research.

The planned methods are storytelling circles, as well as interviews, to be conducted from mid-October through mid-December 2012. Given the participatory nature of this research project, women who participate will be co-collaborators throughout the research process; they will be involved from the beginning through to the end in whatever capacity they choose. I hope this research project may generate a dialogue, placing women's voices forward to help inform future sexual health promotion and HIV/STI prevention programs.

Thank you again for your support, and if you have any questions, please do not hesitate to contact me.

Sincerely,

Jenny Rand
Graduate Student
University of Victoria
P: (250)857-2388

Cc: Don Leblanc, SAO Hamlet of Kugluktuk

Tuharnaarutikhaq, Niriqatigiiktilugit

Ublua: *Nuvipiri 22, 2012*

Humungaqqat: *6 mungaqqat*

Humi: Uallaryuk Katimaviani

Kangiqhidjut:

Tunngahuktitauyutit Jenny Rand-mit niriqatigiiktitaulutik, tuharnaaqtitiniaqturlu qauyahaqtaminik ilihaghuni,

“Qauyimattiarnirmik Nunallaani HIV, STI-niglu hamani

Nunami: Tunggaviqaqtunik Inuinnat Arnait

Hapingnitainnit”.

Hamna pidjutauyuq tunngaviqarniaqtuq uqaqatigiingnikkut inmingnut ihumagiyainnut, ihumaaluutigiyayunullu aanniaqtailimanirmut nuliarnikkut, qanuqtullu ilitpalliaqublugit Inuit aanniarutauqattaqtunut.

Tuharnaariyumagungni, ilauyumaguvillu uqaqatigiingnikkut haffumuuna HIV, STI-kutigut, qanuqtullu nauvalliaquvlugu ilihimaniq aanniarutiit mikhaanut, qanuqtullu aanniarutiit ikiglivalliatquvlugu nunagiyarni, ilaudajavutit niriqatigiingniaqtuni.

Jenny Rand hivayaqtaaqtat: 867.982.5997 qaritauyakkulluuniit jrand@uvic.ca

Feast & Information Session

Date: *November 22, 2012*

Time: *6:00 PM*

Location: Complex

Details:

All are welcome.

You are invited by Jenny Rand to a feast and information session about an upcoming research project called ***“Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women’s Strengths and Resiliencies”***.

This project involves talking with women about their ideas around **community sexual health programming**.

If you would like more information, are **interested in participating** in this exciting opportunity, and you are interested in talking about HIV and STI prevention and sexual health promotion for your community, please **come to the feast to find out more**.

You can contact **Jenny Rand** for further details at: **867.982.5997** or by email at **jrand@uvic.ca**

Hulidjutauyumut Kangiqhidjut

**“Qauyimattiarnirmik Nunallaani HIV, STI-niglu hamani Nunami:
Tunggaviqaqtunik Inuinnat Arnait Hapingnitainnit”.**

Naunaiyaiyuq

Atira **Jenny Rand**. Ilihaqqatauyunga Master’s – kutigut, Inungnut Tungaviqaqtunut Nuatqatigiingnikkut Aaniaqtailimanirmut Ilihaqtuni taunani Hilattuqharvigyuami Victoriami. Hamna **naunaiyaqtara** atayuq Ilihaqtamnut.

Hunauva?

Hamna naunaiyaiyaut **kangiqhidjutautquvlugu** qanuqtut Inuinnait Arnait Kugluktukmi ihumaqaqpakpat kangiqhinahuaangata **aaniaqtailimavlutik nuliarnikkut arnaunirmullu**, qanurlu ihumagivakpagik qitunngariyait aanniaqtailipkarahuaqhugit nuliarnikkut. Qanuqtullu tuhaqtitivanngiaqqat, ilihautidjutikhanik ilamingnut nulliarniq atuqpaquvlugu aanniahimaittumik tuniqqtauqattarmata aanniarutit inungnut nuliarnikkut taapkuat STI-nik uqariliqpagainni, Tahamnalu HIV qanuqtut uqariyautquninganut Inuit qauyimavaktakhainnik aaniaqtailimanirmut nunallaani.

Naunaiyautip Apiqquitiit:

- Arnait Inuinnait Kugluktukmi **ihumavakpat** nuliarnikkut aaniaqtailimanirmut, Nuliarnikkullu Tuniqqtauqattaqtut Aanniarutiit, tahamnalu HIV aanniarut nunamingni?
- Qanuqtut Arnait Inuinnait Kugluktukmi qauyimanahugivakpat kangiqhinirmik tahaffuminga nuliarnikkut aaniaqtailinahuaqhutik arnaublutik, nunamingnilu?
- Qanuqtut Arnait Inuinnait Kugluktukmi ihumaliuqpakpat nakuruqtitiniarutikhanik nunagiyamingnik nuliarnikkut, nutaraliurnikullu aaniaqtailinirmut?
- Qanuqtut Arnait Inuinnait piliuqpakpat hapiliqtailinirmjut qauyimapkainahuaqhutik ingmingnut, ilamingniglu aanaiqtailimarmut nuliarnikkut ?

Naunaiyaiyaut hamna ikayuutautqublugu Arnaiq nipingnit tuhaqtitautqublugit, qauyimayailu kangiqhidjutautqublugit ilihautikhanik Inuinnait Arnait ikayuqtautqublugit hilatunirmullu naamakpaqublugit aanniaqtailitqublugit nuliarnikkut inmingnut nuatqaimingnullu.

Qanuqtut?

Hamna atuqtauyuuq naunaiyaiyaut ilauyumayunut pidjutauyuuq, ilauyumayut inmingnik angiqhimavangniaqtut uqariyumayamingnik inmikkut. Ilauyut ilauvangniaqtut apiqhuqtauyumagumik, uqaqatigiigumalutik tuharnaqaqtitilutik, imaalu kangiqhipkainahuarlutik uqariyayunik aahiittauq ilaulutik tuhaqtitihimaarnikkut. Ilaunikut hamna pidjutaungmat ilaani apiqquitiit aallanguqpaqngiaqtut mikiyumik aullarutahimaliqtiluglu.

Huuq?

Piitpiavyangmat ilihautinik aanniaqtailimanirmut nunallaani HIV, tahamnalu STI-nguyunik nakuunirmullu aaniaqtailimanirmut nuliarnikkut kangiqhimadjutikhanik Inuinnait

nunalaanginni. Hamna pidjutauyuq Arnait Inuinnait ikayuqtigilugit nakuunikkut naipkaidjutikhanik aanniaqtailimanirmut kinguvaakhapta atuqpagakhainnik aaniaqtailitquvlugit.

Ayurnautauqattarmat, naupkaiyut atuqtauyukhanik, itdjuhiliurutauyullu titiqqatigut ihariahuqqattarmata kiinauyanik naunaiyaiyaamingnik amihuni nunallaani aullaarutikhanik amihunut nunagiyayunut Ukiuqtaqtumi, ayuqhautauqattaqtuq nipigiyayut tuhaqtauyungnaiqpangmata naunaiyaigaangata idjuhikhanut titiqqatigut malitauvaktunik. Tahamna ilitarivlugu naunaiyaiyaut hamna ikayuutaunianahugiyayuyq qakugu Nunallaami, Avikturviuyumi, Ukiuqtaqtumilu, Kanadamilu ilaugumik ukiuqtaqtumiut.

Hamna naunaiyaiyaut katitirivangniaqtuq qauyimayayunik Arnait ihumagiyamingnik, qanuqtullu ikayuutauniarninganut nunagiyamingni. Imaalu, ilauniarmata Arnait hivuanit, ikayuutauniaqtuq qauyimanikkut nunagiyamingni ilituriniarmatalu qanuqtut ilihautiliurnikkut aaniaqtailimanirmut.

Kina?

Ilauyumaguvit:

- Angiqhimalutit uqaqatigiingnikkut tahaffumuuna nuliarnikkut aaniatailimanirmut, HIV-miglu, STI-niglu qanuqtullu aaniaruitaaqtailinirmut.
- 18-nik ukiuqarlutik
- Arnaulutit
- Kugluktukmi nunaqarlutit

Arnait unipkaarutikhalgit qauyimayamingnik ikayuutautquvlugit aanniaqtailimanirmut nuliarnikkut, imaalu ihumagiyamingnik qanuqtut ikayuutikhanik uqariyumayamingnik ilauttaaqtut. 20-30 nik ilaupkainiaqtut haffumuuna ilauyukhanik.

Qanuqtut Ilauniaqqat?

Ikayuqtiulutit uumunga akiittumik imaatut apiriyauniaqtutit:

- unipkaarilugu qauyimayatit nuliarnikkut aaniarutinik arnanut aallanut amihuungittunut atautiuyunut
- naalaklutit aallat Arnait unipkaangit
- apiqhuqtaulutit unipkaaruirangata

Ilauyumaguvit hivuani haffumuuna ilanganut qakugu, uqautigilugu naunaiyaqtiuyumut.

Ilauniarutit

Ilauniarutit ikaarniit 2-4 nik ilauvangniaqtutit. Huliyakhaqaruvit, ilvit naunaiqhimaniaqqatit unipkaariniaqtatit hivituningit, nutaraqaruvillu nutaqqiqiyiqarniaqtuq Arnait katimatillugit.

Ilauyumaguvit naunaiyaiyaunmut uumunga Jenny Rand hivayarlugu 867.982.5997 qaritauyakkuluunniit jrand@uvic.ca, Hamaltkunnut pulaarluhuluuniit.

Project Information Handout

Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women's Strengths and Resiliencies

Researcher

My name is **Jenny Rand**. I am a Master's student in the Social Dimensions of Health Program at the University of Victoria, and I am doing this **research project** as part of my studies.

What?

The purpose of this study is to **better understand** what Inuit women in Kugluktuk believe to **most influence their sexual health**, and the sexual health of their families. It is also to find out what would work best for sexual health promotion, and Sexually Transmitted Infection (STIs) and HIV prevention programming and policies for their community.

Research Questions:

- What are the **perceptions** of Inuit women in Kugluktuk about sexual health, Sexually Transmitted Infections and HIV in their community?
- What do Inuit women of Kugluktuk perceive to be the **determinants** that most influence the sexual health of women and communities?
- What do Inuit women in Kugluktuk think would **benefit** the community in regard to Sexual and Reproductive Health?
- What role does Inuit women's **strength and resilience** play when it comes to informing how to take care of their sexual health and that of their family?

The goal of the research project is to give women an opportunity to have their **voices heard** and to **contribute to the wider knowledge** of helping Inuit women and their families live with improved sexual health outcomes.

How?

This project is a community based participatory project, which means all participants are invited to make decisions about the project itself. Participants will have the opportunity to participate beyond the interviews and storytelling groups, and will be invited to help with meaning making (analysis) and sharing the information (dissemination). Because of the participatory nature of the project, the above research questions may change slightly once the research process begins.

Why?

There is little information available to guide the making of community-based HIV and Sexually Transmitted Infection (STI) prevention and sexual health promotion programs within Inuit communities. This project works with Inuit women, to seek their knowledge and stories to help inform future policy and programming.

Unfortunately, program developers, and policy makers often have limited resources (money and time) to thoroughly consult communities in Nunavut. Because of distance between communities and the cost of travel in the North, getting community input for policy and

programming is difficult. This research project will increase the available information to help inform future programs at a local, territorial, and potentially national level.

This project will gather information from women on what they think would work best within their communities. Also, since women will be involved with the research project from the beginning stages it will build community understanding about health research.

Who?

In order to participate you must be:

- Interested in talking about sexual health promotion, and HIV& STI prevention
- Over 18 years old
- Female
- Living in Kugluktuk

Women who have stories they would like to share about what they believe determines sexual health and what can be done to help improve community sexual health are invited to participate. The project will include between 20 and 30 participants.

What is involved?

If you **volunteer** to participate, you will be asked to:

- share stories in small groups about sexual health with other women
- listen to other women's stories
- take part in an interview after the storytelling groups

If you are also interested in being involved in future parts of the research project, please discuss your involvement with the researcher.

Inconvenience

This project will take 2-4 hours of your time. To ensure minimal inconvenience, you will determine the time of the storytelling group, and the study will also offer childcare if you need it.

If you are interested in participating in this research project please contact Jenny Rand at 867.982.5997 or by email at jrand@uvic.ca, or in person at the hamlet office.

*This research project is provided with financial support from: Canadian Centre for Health Research (CIHR), the University of Victoria, and The CIHR Social Research Centre in HIV Prevention (SRC), and Universities Without Walls.

Storytelling Topic Guide

Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women's Strengths and Resiliencies

Review the consent forms.

Start the group by stating the following:

I would like to begin by thanking you all for agreeing to participate in these storytelling groups. I want to remind you, this is completely voluntary, and you may withdraw and we can stop at any point if you wish. Also, we will debrief after the session, and I want you to know there is counselling available through the wellness centre, as well as social services, and the RCMP are aware of the details of this study, and all these services know that participants may be coming for help.

You will receive an honorarium for participating in the storytelling group. If you withdraw, you will still keep the honorarium.

Before we begin, I would like to have a discussion about confidentiality. For these groups, confidentiality will be limited by the willingness of the participants to keep the discussions confidential. I hope we can all agree to not share private information shared here with others once you leave here. Also keep this limitation in mind with regards to how much information you do choose to share. I would also like for you to consider the confidentiality of those who are not present, but who may be in our stories. I want to urge you to not use names in your stories to help protect the identity of those persons who are not here.

Storytelling Group Discussion Points:

Tell us a story you think relates to...

- **What do Inuit women in Kugluktuk think about Sexually Transmitted Infections (STI) and HIV in their community?**
- **What do Inuit women of Kugluktuk think about the things that most influence the sexual health of women and communities?**
- **What do Inuit women in Kugluktuk think would benefit the community in regard to Sexual and STI and HIV prevention?**



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Munaqtuiyut Katimayit:
Dr. Charlotte Reading, PhD
Dr. Catherine Worthington, PhD

Ilihariqtut Iiharviat

Inungnut Aaniaqtailimanirmut
Iihautiit

Ilauniaqtup Angirutaat

Tunnahuktitauyutit Jenny Rand-mit niriqatigiiktitaulutik, tuharnaqtitiniaqturlu qauyihagtaminik iliaqhuni, **“Qauyimattiarnirmik Nunallaani HIV, STI-niglu hamani Nunami: Tunggaviqaqtunik Inuinnat Arnait Hapingnitainnit”**.

Jenny Rand. Ilihaqqatauyunga Master’s – kutigut, Inungnut Tunggaviqaqtunut Nuatqatigiingnikkut Aaniaqtailimanirmut Ilihaqtuni taunani Hilattuqharvigyuami Victoriامي. Hivayaqtaaqat apiqquqiaruvit uvunga (250) 857.2388 qaritauyakkulluunnit jrand@uvic.ca. Ilihariqhimagut, naunaiyahimaaqtuq tikinniarutaanut Masters-nut iliahtuni. Ilihaqtainnut munaqtiit Dr. Charlotte Reading (250)853.3109 taamnalu Dr. Catherine Worthington (250)472.4709.

Hamna naunaiyaut kiinauyaaqqtitauyuq ukuninga Canadian Centre for Health Research (CIHR), the University of Victoria, and The CIHR Social Research Centre in HIV Prevention (SRC), and Universities Without Walls.

Naunaiyautip Pidjuraa, Hulidjutikhailu

Hamna naunaiyaiyaut **kangiqhidjutautquvlugu** qanuqtut Inuinnait Arnait Kugluktukmi ihumaqaqpakpat kangiqhinahuaangata **aaniaqtailimavlutik nuliarnikkut arnaunirmullu**, qanurlu ihumagivakpagik qitunngariyait aanniaqtailipkarahuaqhugit nuliarnikkut. Qanuqtullu tuhaqtitivangniaqqat, ilihautidjutikhanik ilamingnut nulliarniq atuqpaquvlugu aanniahimaittumik tuniqqutauqattarmata aanniarutit inungnut nuliarnikkut taapkuat STI-nik uqariliqpagainni, Tahamnalu HIV qanuqtut uqariyautquninganut Inuit qauyimavaktakhainnik aaniaqtailimanirmut nunallaani.

Naunaiyautip Apiqutiit:

- Arnait Inuinnait Kugluktukmi **ihumavakpat** nuliarnikkut aaniaqtailimanirmut, Nuliarnikkullu Tuniqqutauqattaqtut Aaniarutiit, tahamnalu HIV aaniarut nunamingni?
- Qanuqtut Arnait Inuinnait Kugluktukmi qauyimanahugivakpat kangiqhinirmik tahaffuminga nuliarnikkut aaniaqtailinahuaqhutik arnaublutik, nunamingnilu?
- Qanuqtut Arnait Inuinnait Kugluktukmi ihumaliuqpakpat nakuruqtitiniarutikhanik nunagiyamingnik nuliarnikkut, nutaraliurnikullu aaniaqtailinirmut?
- Qanuqtut Arnait Inuinnait piliuqpakpat hapiliqtailinirmjut qauyimapkainahuaqhutik ingmingnut, ilamingniglu aaniaqtailimarmut nuliarnikkut ?

Naunaiyaiyaut hamna ikayuutautqublugu Arnait nipingnit tuhaqtitautqublugit, qauyimayailu kangiqhidjutautqublugit ilihautikhanik Inuinnait Arnait ikayuqtautqublugit hilatunirmullu naamakpaqublugit aanniaqtailitqublugit nuliarnikkut inmingnut nuatqatimingu.

Naunaiyautip Ihumaliurutingata Qulvahingninga

Amigaitkaluaqhutik naunaiyaqhimayut titiraqhimayullu nuliarnikkut mikhaanut (katitiqhimayut titiraqtauhimayunit) Inuinnarni, ikitpiaqtut naunaiyarutauyut qanuqtut ikigililaaqniarutikhaanut aanniarutauqattaqtunut nuliarnikkut kangiqhipkaidjutikhaniklu nunallaani aanniarutauqattaqtut mikhaanut. Naunaiyautip Ihumaliurutinga angmaqtiridjutauniarmat Arnanik uqauhiriyumayainnik ihumagiyainnik tuhaqtautqublugit. Ilaani idjuhikhat titiraqtauliqpaktut, maligaralaallu iniqtauliqpaktut ihumaliurutauhimaittumik aktuqtauniaqtut Inuit. Hamna ikayuutauniaqtuq **aanniaqtailimanirmut, kangiqhidjutikhanullu aanniarutinut nuliarnikkut**, qanuqtullu ilihautigiyakhanik nunallaani **ikiglivaliatquvlugu HIV / STI –lu**.

Ilauyukhat Kitkuuniaqpat

Angiqhimalutit uqaqatigiingnikkut tahaffumuuna nuliarnikkut aaniatailimanirmut, HIV-miglu, STI-niglu qanuqtullu aanniaruitaaqtailinirmut. 18-nik ukiuqarlutik, Arnautit, Kugluktukmi nunaqarlutit

Arnait unipkaarutikhalgit qauyimayamingnik ikayuutautquvlugit aanniaqtailimanirmut nuliarnikkut, imaalu ihumagiyamingnik qanuqtut ikayuutikhanik uqariyumayamingnik ilauttaaqtut. 20-30 nik ilaupkainiaqtut haffumuuna ilauyukhanik.

Qanuqtut ilauniaqpit?

Angiqhimaguvit naunaiyautuniaqtumut uumunga, ilaudjutitit imaatut atuqtauniaqtut. Unipkaaqtalutit qauyimayarnik Arnanut. Apiqhuqtauniaqtutit unipkaarurumik arnait katimayut ukununga mikhaanut: nuliarnikkut aanniaqtailimanirmut, qanuqtut ihumavit ikayuutauniarnahugiyarnik aanniaqtailimanirmut nuliarnikkut, imaaluunniit ihumaliurutauqatangininganut nuliarniq aaniqliqpaktut Inuit, qanurlu ikayuutauniaraluaqpat ihumaliurutikhat ikigilivaalliqublugu aanniarutit nuliarnikut inungni, nunallaanilu. Naalaqataulutillu allanut unipkaaqtunut unipkaaqtillugit.

Naunaiyaiyuq apirivangniaqtuq nipiliurumaluni unipkaaqtunik nipiliourutauyumut, piksaliurutauyumullu. Angiqatigiikhimagumik ilauyut nipiliurutiit atuqtauniaqtut, qingnihimagumik, nipiliulimaittuq, kihimi titiraluni naalaktaminik titiraqpangniaqtuq.

Unipkaarurumik, apiriyauttaaqtutit apiqhutauyumayaaqharniq. Apiqhuyi kangiqhittiarumagumi tuhaqtaminik unipkaaqtillugit.

Hamna naunaiyaiyaut tunngaviqarmat ilauyumayunut, kangiqhidjutauniaquq ilvit ilauguvit tuniqqutiginiaqtatit ikayuutauttaaqtut idjuhikhaanut, kangiqhinnarutinganut, unipkariyatillu ikayuutauttaarmata aallanut kangiqhipkainiarutaanut. Ikayuqtiuhimaarumaguvit Naunaiyaiyi uqaqatigilugu.

Ilauniarutiit

Ilauniarutit ikaarniit 2-4 nik ilauvangniaqtutit. Huliyaqhaqaruvit, ilvit naunaiqhimaniaqpatit unipkaariniaqtatit hivituningit malrungnik, aahiittauq ikaarninik ilaliutittaaqtuq apiqhuqtauniaruvit

unipkaarurumik. Nutaqqiqiyiqarniaqquq ikayuqtauyumaguvit nutaraqaruvit ilauyumaguvillu. Ilauttaqtutit hivuani qakuguttauq haffumunga hadja pilimaitkuvit. Ilvit naunaiqhimaniaqtatit qanuraaluktut ilauyumadjutigiyarnik.

Qayangnarninga

Hamna naunaiyaiyaut ikpingninga hapiliqtaidjutingalu mihigiyauniaqtuq. Ihumaliurutauhimaguvit naunaiyainiaqhimayumut ihumaliurutihimayait tahapkuat quvianaittuugalu atuatuhimaguvit aniguutitquvlugit ihumaalutauvaktut atuatuhimaguvit inmingnik inuuhirmingni quvianaittut nuliarnikkut aanniarutauhimaguvit, qanuqtullu aallanut atuuqungittugu tahapkuat quvianaittut, kihimi ilihimavakkumik nakuuyumik kangiqhihimavalirumik qakugu.

Ayuqharnaittumik ilauniarumik imaatut idjuhiqarniatut. Ukuat ilaliutauhimaniaqtut: Uqaudjiuyut, Paliihimallu hannaiqhimatquyauniaqtut uniudjauniaqtut haffumuuna mikhaanut, kinaliqaak anittiyumarumik ikayuqtauniarmat uqumailiurutigivaktaanik ikayuqtauyumagumi unipkaarutigiyumagumiuk ikayuqtiuniaqtut hannaiqhimatquvlugit ikayuqtiuvaktut nunagiyayumi. Inirniit ikayuqtukhat uqaudjiuyukhat hailiyainiaqtut, Naunayaiyuyurlu qauyimaniaqtuq haimanaqtumik taimaaqtilirumik atuuqtiluni ihumalungnaittumik taimaaqtilirumik. Qauyimaniaqtut nuliarnikkut unipkaat ilangnit quvianainniarmata, aahiittauq ilihautigiyayukhaungmata STI, HIV lu. Imaatulluunniit, nuliarnikkut naglikhaaqtitauhimaguvit atuatuhimaguvit uqumailiurutauniarmata unipkaqtuni, kihimttauq ikayuutauniarmata haimmaqhaanirmut ikayuqtuinirmullu, Nunagiyarni ikayuqtiit hailihimaniaqtut kinaliqaak ikayuqtauyualirumi.

Ikayurniarninga

Ilauyut tunihiniarmata kauyimayarningnik, atuatuyuminaqtullu **ikayuutaulutik ilihautikhanut qakugu hivuniptingni nuliarnikkut**. Ilauyut inmikkut mihiginaqtut ikayuutauyumik, ilitpaallirniaqtullu avaliingittut atuatuhimaguvit. Arnanut aallanut ikayurninga mihigiyauniaqtuq, aahiittauq naunaiqhimalirniaqtut qanuqtut nakuuyumik ihumalungnaittumik quvianaqtumik nuliarnirmik mihigivangniaqtut. Hamna ikayuutauniaqturlu hilatuyumik Nunavunmi, Kanadamilu. Ikayuutaugumi ilaa atuatavangniaqtuq aallani nunallaani.

Qanuqtut Quyagiyauniaqpit

Ilauguvit tuniyauniaqtutit quyalidjutauniarmat \$50 dalla. Kihimi angiqhimaguvit maniinarmut ihumagingnillugu ilaudjutiginaqtat, kihimi ikayuutigitquvlugit qauyimayait. Manigukaffuktut ikayurningnit mihigiyauihimangitkumik ikayuutauihimainmata maniinarmut piyumaguvit. Ikayurniaqhimaguvit kihimi ilauvagluhi.

Ilingnik Ihumaliuqtutit Ilauyumayaaqharnik

Ilaudjutigiyait haffumuunga ilingnik angiqhimablutit ilauniaqtutit, ilauyungitutit aallamit. Angiqhimaguvit ilauyumayarnut, taimaaqtaqtutit ihumangnik aturlutit. Unipkaqtatillu unguvaqtatugungni naunaiyaqhimayunit uqarlutit ihumaliutqikkuvit ilingnik. Arnait katimatillugit unipkaqtuni ilaliutauhimaguvit unguvainnalimaittut kihimi atautimiulirumik qaffiutillugit. Akiliuhiarutihimayait pihimaniaqtat.

Naunaiyaqtuup qauyimaninga Ilauyunut

Naunaiyaiyuq qauyimanakhariyait ilauyut ilannarigumigilluunniit, kinauyaakhaita luunniit qauyimakafukkumiuk, havaqatigihimavakkumiugluunniit, ilihaqtitihimagumiuglu. Naamaktuq ilaugumik ihumagigiqangitait ilaugiaqaqtumik ilannarigumikkut, Ilauyumayut inmingnik ihumiqtittayut. Havaariyallu nunagiyarni aktuumangittuq naunaiyaudjunmut. Ilvit ihumangnik ilauniaqtuhi ilauyumaguffi.

Hivituyumik Angiqhimaniq

Angiqhimainnaruvit ilaudjutigiyumayarnut hamna angiqhimadjutauyuq uqautiginiaqtara ilingnut pigiaqtinnata, pigiarupta, iniruptalu unipkaaqtunut, apiqhuqtauyunullu. Qaffiiqturniaqtutit ihumagiyat ilauniarutigiyat uumunga, taimaarumaguvilluuniit.

Hiamitirnaittuq

Itquumaqpiagtumik nalunarmat hiamitirnirmut tuhaqtauyunik, unipkaariyauyuniglu angiqhimalutik ilauyut tuhaqtamingnik uqaqtukhaungittut aallanut Inungnut ilaungittunut Iliffi ilauyuhi ihummiqtitauniaqtuhi qanuqtut uqarumaguffi naalaktauniaqtunik. Atiillu Inuit aallangurlugit unipkaarinaruviglit ilaani naunarmat Inuit hiamittinayukkamik tuhaqtamingnik. Itquumanahuarluhi kihimi ilautquyauniaqtuhi hiamitiqhimaittumik tuhaqtaffingnik. Ilvillu munarilutit ihumaliutqiglugit uqariyumayatit. Unipkaariyatit tutquumaniaqtut kiluutaqhimalugit tutquumavingmut hamani Kugluktukmiitullugit.

Kugluktukmit aullarumi Naunaiyaiyi, kiluuttaqhimalugit tutquumaniaqtut atuqtaungitillugit. Nipiliuqtauhimayut titiraqtauniaqtut. Titiraqtauhimalirumik nipirliuqtauhimayut, piksaluqtauhimayullu ahiruqtiqtauniaqtut. Titiraqti, Jenny Rand lu taapkuatuanguniaqtuk nipiliuqhimayunut titiraqhimayunullu takuniaqtait. Titiraqtauhimalirumi naunaiyaiyaut, Inuit atilluangit allanguqtiqtauniaqtut, ilitarnairlugit kitkuuyaakhaita.

Ilauyumayut ilauniahimangmata inmikkut, ilauhimaqtaaqut katitiritillu , Tunihinalirumillu Inungnut naunaiqhimalirumiuk iniqhimayuq. Unipkaariyatit kiudjutigiyatillu ilitarnainniaqtut ilingnuut atihii piiqtauniaqtut kannguhungnaittumik. Taiguqtiyumagumilu kinaliqqaak titiraqtauhimaliqtumut taamna taiguqtiuvangniaqtuq angiqhimaluni hiamitirilimauttuq quayimayaminik allanut Inungnut. Aallamik atiliuriaqqaqtuq angiqhimaluni itquumaniaqtumik angiqhimadjutimik.

Titiraqhimayut naunaiyaihimayut tutqutiqtavangniaqtut qaritauyam kiluutainnut tutuquqtirviuvaktunik. Taapkuannualu ilaani titiqiqvikkut tuyuqtauvangniaqtut.

Uqariyauyut hiamitaulimaittillugit Naunaiyaiyum itquumaluni tuhaqtitinaqtuq Paliihimanik nutaraq aktuqtauhimagumik, unipkaariyaugumik nutaqqat. Tahamna hugiinalamainnamiuk nutaqqat munariyaugiaqarmata. Nutaraq ihumaaluutaulirumi ihivriuqtaugiaqarumi Naunaiyaiyuq tuhaqtitiyukhauyuq Paliihimanik.

Tunihiniq Naunaiyaunmik

Ihumagiyauyuq, naruhugiyauyurlu naunaiyaqtayut tuhaqtitauniaqtut iniqhimalirumi aallanut imaatut: Nunallaanut katitirviuyumi Niriqatigiiktutilutik, Taigualiuqhimayuni, Ilihaqtuplu toitiraqtainni, tuharnaarutigiyauluni katimaryuaqtitiyuni aallatqiini gavamani, iliharvigiyauyuni, ilihaqtullu tuharnaarutigivagainni

Ahiruqtiriniq Nipiliuqhimayunik

Nipiliuqhimayut qunngialiuqhimayullu ahiruqtiqtauniaqtut, titirakaffukhimayullu igitauniaqtut ukioquq atauhiq aniguqpat nipiliurviyumit ulburiyaanik. **Qauyimayut**

Imaalu, naluliruvit haffuminga ihumaaluutigigunni hivayaqtaaqutit apiqutigilugit ukununga **Human Research Ethics Office** Hilatturharvingmi University of Victoria (250)472-4545 qaritauyakkulluuniit ethics@uvic.ca.

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you voluntarily consent to participate in this research project.

. Atiliurutinga haffumuuna angirutauyumut, Uvanga angiqhimayunga kangiqhimablugu hulidjutikhait naunaiyaidjutip aturniaqtangit, unipkaarnirmut, apiqhuqtaunirmullu. Kangiqhiyunga uqauhiriniaqtatka hiamitaiqtaulimaittut aallamullu atuqtaulimaittut. Qauyimayungalu tamaarumaguma taimaaqtaaqtinga hadjainnaq.

Ilauyup Atia Titirattiahimayanga

Atiliuqtanga

Ublua

Tautuktup Atinga

Ilaani Naunaiyaigaangata ilitarhiliqpangmata tunihiyunik qauhimayauhukhanik, naunaiqhimaniaqqutit ilvit qanuqtut ilitariyauyumayaakharnik :

Angiqhimayunga kinauyaakhamik atipkut / tuniqqutitka naunaikhimayuni: _____ (Ilauyup Atiata Titirangniit Hivullit)

Angiqhimayunga kiudjutitka ataniaqtut uvamnut atikkut naunaikhimayuni: _____ (Ilauyup Atiata Titirangniit Hivullit)

Hamna adjikkutaa pihimaniaqtat, Naunaiyaiyurlu pihimaniaqtuq pikhaanik.



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Supervisory Committee:
Dr. Charlotte Reading, PhD
Dr. Catherine Worthington, PhD

Faculty of Graduate Studies

Social Dimensions of Health
Program

Participant Consent Form

You are invited to participate in study called “**Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women’s Strengths and Resiliencies**” that is being conducted by Jenny Rand.

Jenny Rand is a **graduate student** in the Social Dimensions of Health Program at the University of Victoria. You can contact her if you have further questions by calling Jenny at (250) 857.2388 or by email at jrand@uvic.ca. As a graduate student, she is doing a research project as part of her degree requirements. This research project is being conducted under the supervision of Dr. Charlotte Reading (250)853.3109 and Dr. Catherine Worthington (250)472.4709.

This research is funded by the Canadian Centre for Health Research (CIHR), the University of Victoria, and The CIHR Social Research Centre in HIV Prevention (SRC), and Universities Without Walls.

Purpose and Objectives

The purpose of this study is to **better understand** what Inuit women in Kugluktuk believe to be the **causes that most influence their sexual health**, and the sexual health of their families. It is also to find out what would work best for sexual health promotion, and Sexually Transmitted Infections (STIs) and HIV prevention programming and policies for their community.

The specific questions **this research project aims to answer** are:

- What are the **perceptions** of Inuit women in Kugluktuk have about sexual health, Sexually Transmitted Infections and HIV in their community?
- What do Inuit women of Kugluktuk perceive to be the **determinants** that most influence the sexual health of women and communities?
- What do Inuit women in Kugluktuk think would **benefit** the community in regard to Sexual and Reproductive Health?
- What role does Inuit women’s **strength and resilience** play when it comes to informing how to take care of their sexual health and that of their family?

The goal of the study is to give women an opportunity to have their **voices heard** and to **contribute to the wider knowledge** of helping Inuit women and their families live with improved sexual health outcomes.

Importance of this Research

Although there is a lot of data and literature around (the statistical side of) sexual health among Inuit, very little is known as to what could work to address sexual health in communities. This study is

important because it will give women a chance to add to the literature and ensure their voices and opinions are heard. Often policies and programs are developed without considering what people who will be affected by the policies and programs think or feel. This research will contribute to the knowledge on how to most effectively approach community **sexual health promotion** and **HIV/STI prevention**.

Participant Selection

You are being asked to participate in this study because you have volunteered and expressed an interest in discussing the ideas this research study will be examining. You can participate in the project if you are **female over the age of 18, live in Kugluktuk** and if you are **interested in talking** about community sexual health promotion and STI and HIV prevention. Women who have stories they would like to share about what they believe determines sexual health, and what can be done to help improve community sexual health are invited to participate. The project will encourage females of several different age groups to participate. The project will include roughly 20 and 30 participants.

What is involved?

If you consent to voluntarily participate in this research, your participation will include participating in a **storytelling group** with other women. When you come to the storytelling session, you will be asked to share stories about: sexual health, what you think contributes to one's sexual health, or one to have poor sexual health, and what you think might work well to help improve sexual health of individuals and communities. You will also be expected to listen to others as they share their similar stories.

The researcher will ask if it is okay to record the group stories with a **digital audio and video recorder**. If all participants agree, the recorder will be turned on, if not, the researcher will take notes throughout the storytelling sessions.

After participating in a storytelling group, you **may** be asked to volunteer to **participate in an interview**. The interview will go into greater detail about the topics and themes that came out of the storytelling groups.

This research project is based on a **participatory design**, which means you as a participant can be involved with all aspects of the project from design, to making meaning of the information gathered, and sharing the knowledge from the project with others. If you are also interested in being involved in future phases of the research project, please discuss your involvement with the researcher.

Inconvenience

The data collection phase of this project will take **2-4 hours of your time**. Two hours with the storytelling group, and a possible two hours more for an interview. To ensure minimal inconvenience, you will determine the time of the storytelling group, and the study will also offer childcare if you need it. You are welcome to participate in further stages of the research project if you wish. The amount of time you spend on the other phases of the project will be determined by you.

Risks

This study takes a strengths and resiliency based approach. The way it is framed is to look at overcoming negative sexual health issues, and helping others avoid negative sexual health outcomes. Although this is the approach, it is possible that given the topics of discussion, participants **may become upset**. Several steps will be taken to minimize any risk of upsetting participants. These steps include: briefing the available counselling service providers and RCMP about the project and the possibility of triggers occurring, Elders will be made available to provide further support, and ensuring there is time built in for debriefing and follow up by the researcher. It is possible that talking about sexual health, and programming and community based sexual health promotion and education as well as **STIs and HIV may cause discomfort**. For example participants who have experienced sexual violence, or sexual coercion among other negative events, may be upset about talking about sexual health in a group. However, it may also be **helpful and healing**, and services will be readily available if any participant becomes upset by participating in this study.

Benefits

Participants of this study will contribute to information that will be used to **develop future sexual health programming**. Participants may benefit directly as this provides an opportunity to discuss sexual health and share stories with one another which can be empowering and educational for women, as well as provide some healing from discussing difficult times they have overcome. It will also provide the opportunity for women to gain skills in community based research projects. This project can benefit the community by contributing to more **effective programming and policies** around community sexual health promotion and disease prevention. This project can help the bigger Inuit community across Nunavut, and Canada, as it is seen as successful, it can contribute to territorial programming and even be transferrable to other Indigenous communities.

Compensation

As a way to compensate and to honour you for your contribution and participation, you will be given **honorarium / gift** of approximately \$50.00 value. If you consent to participate in this study, this gift should not be the reason you participate. It is unethical to provide undue compensation to research participants. If you would not participate if the compensation was not offered, then you should not participate.

Voluntary Participation

Your participation in this research must be **completely voluntary**. If you do decide to participate, you may withdraw at any time without any consequences or explanation. If you do withdraw from the study and you also want your data withdrawn from the study, steps will be taken to remove your data. Because of group discussion within the storytelling groups, your data may be summarized to ensure the context and cohesion of the group data. Your interview will be able to be completely removed if you wish to remove it. You will keep your honorarium if you withdraw.

Researcher's Relationship with Participants

The researcher may have a relationship to potential participants as an acquaintance, former teacher or former colleague. To help prevent this relationship from influencing your decision to participate, it is important to note here that your relationship with the researcher will in no way change whether or not you participate in this study. Your standing within the community, or relationships within the community will not be effected if you chose to or not to participate.

On-going Consent

To make sure that you continue to consent to participate in this research, I will discuss consent with you before, during and after the storytelling groups and interviews. You will have multiple opportunities to discuss consent, and to withdraw consent if you wish to do so.

Confidentiality

Given the fact that the storytelling groups are indeed groups, complete **confidentiality** cannot be guaranteed. However, at the beginning of each of the storytelling groups, a discussion around confidentiality will be held. We will discuss keeping what is said in the group confidential, not sharing information with others after the group is finished. I urge you to consider the stories you share, and since we cannot guarantee others will not leave the group and reveal what has been said, to be carefully consider the stories they share. I would also urge you to not use names to identify those who may be involved in your stories but, whom are not present, to protect their confidentiality. Your confidentiality will be protected by storing data in a secure cabinet within a locked office when in Kugluktuk.

When the researcher leaves Kugluktuk, the data will be stored in a secure filing cabinet, in a locked office when not in use. Once the data has been transcribed, the raw (audio/video recordings) will be destroyed. The only people that will have access to the named information will be Jenny Rand and a professional transcriptionist who will sign a confidentiality agreement. For analysis and dissemination identifiers will be removed and pseudonyms will be in place of the names of the participants.

This is a participatory research project, which means participants are invited to take part in the data analysis and dissemination portion of the project. Your storytelling and interview data will have all identifiers removed, and may be shared with another participant who has volunteered to work as an analyst. If you wish to participate as a community analyst, you will be asked to sign an additional consent form and confidentiality agreement.

Transportation of data to the transcriptionist will happen by courier and data will be sent on a password protected encrypted memory stick.

Although all topics discussed during the group interview will remain confidential, the researcher has a duty to report harm to a minor such as, suspected child abuse or neglect, or the abuse or neglect of an adult in need of protection to the nearest RCMP detachment.

Dissemination of Results

It is anticipated that the results of this study will be **shared** with others in the following ways: directly to the community at a presentation at a community feast; within published articles, within the thesis

produced from this project, presentations at conferences, presentations at territorial government and scholarly meetings.

Disposal of Data

The raw data from this study which consists of the audio and video recordings and identified notes will be permanently deleted and shredded one year after recording.

Contacts

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the **Human Research Ethics Office** at the University of Victoria (250)472-4545 or ethics@uvic.ca.

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you voluntarily consent to participate in this research project.

By signing this consent form, I agree I have been fully informed of the objectives of the project being conducted. I understand these objectives and consent to participating in a storytelling group and being interviewed for the project. I understand that steps will be undertaken to ensure that the stories and interview will remain confidential unless I consent to being identified. I also understand that, if I wish to withdraw from the study, I may do so without any repercussions.

Printed Name of Participant

Signature

Date

Witness Signature

As it is sometimes customary for participants to be named and credited in a study, please indicate whether you would like to be named by initialing below:

I consent to be identified by name / credited in the results of the study: _____ (Participant to provide initials)

I consent to have my responses attributed to me by name in the results: _____ (Participant to provide initials)

A copy of this consent will be left with you, and a copy will be taken by the researcher.



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Supervisory Committee:
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Dr. Catherine Worthington, PhD

Faculty of Graduate Studies

Social Dimensions of Health
Program

Community Analyst Consent and Confidentiality Agreement

You have participated in the **data collection phase** of the research study “**Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women’s Strengths and Resiliencies**” that is being conducted by Jenny Rand.

You are invited to **voluntarily** participate in the analysis and dissemination phase of the project as a **community analyst** and to take part in **dissemination activities**. You may be asked to **review data** from the study. You may be asked to participate in conversations about the data and **making meaning** of the collected data. Although all identifiers will be removed from the data prior to the analysis phase, you may recognize who told the stories or who the stories are about.

Please sign below as your consent to participate as a community analyst and that you agree to keep what you read and review as an analyst confidential.

1. Confidential Information

The ‘Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women’s Strengths and Resiliencies’ Research Project hereby confirms that it will disclose certain of its confidential and proprietary information to their community analyst, _____.

Confidential information may include all data, materials, and other information disclosed or submitted, orally, in writing, or by any other media, to _____ by Jenny Rand.

2. Obligations of Analyst

_____ hereby agrees that the confidential data/ research activities from the research study is to be used solely for the purposes of this study. Any confidential information should only be disclosed to persons involved with the research study.

_____ hereby agrees not to disclose, publish or other participants of the project to any other party whatsoever except with the specific prior written authorization of Jenny Rand.

Your signature below indicates that you understand the above conditions of participation in the data analysis phase of this study, and that you agree to the confidentiality agreement as a community analyst. It also indicates that you have had the opportunity to have your questions answered by the researcher, and that you voluntarily consent to participate as a community analyst in this phase of this research project.

By signing this consent form, I agree I have been fully informed of the objectives of the project being conducted. I also understand that, if I wish to withdraw from this phase of the study, I may do so without any repercussions.

With his/her signature, _____ shall hereby adhere to the terms of this agreement.

Signature and Date

This research project has received funding from the Canadian Centre for Health Research (CIHR), the University of Victoria, and The CIHR Social Research Centre in HIV Prevention (SRC), and Universities Without Walls.

Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women's Strengths and Resiliencies

Jenny R. Rand B.Sc., M.Sc. (Candidate)
University of Victoria

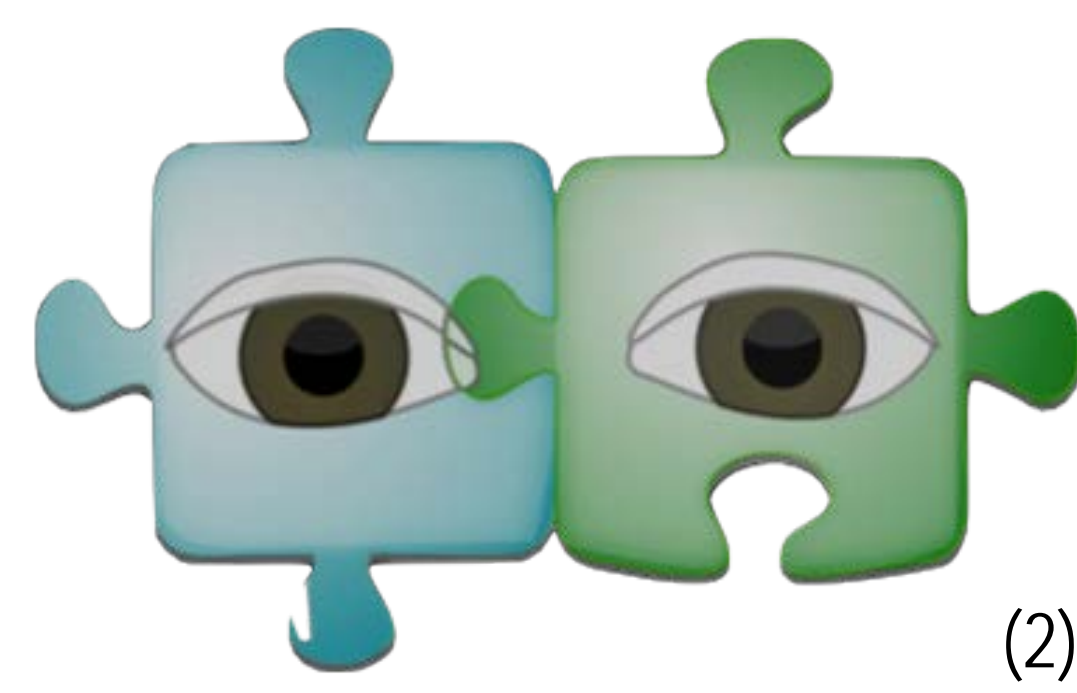
Background & Introduction

This research project combines the art and science of Inuit knowledge with community based, participatory research to reduce inequitable access to HIV/STI prevention programs for Inuit women and their families. The objective of the study was to address the lack of information available for the basis of programming to improve sexual health of Inuit in isolated communities in the Canadian Arctic. In addition to addressing an issue clearly articulated by Inuit women, the utilization of an Indigenous model of community-based research demonstrates respectful and active collaboration with the community.

Methodology

Theoretical Framework

The theoretical basis of the research project comes from the guiding principle of Two-Eyed Seeing brought forward by



Mi'kmaw Elder Albert Marshall (1,2). Two-Eyed Seeing encourages contribution of both Indigenous and Western worldviews (1,2). This project draws on Inuit women's world view, and the principles of *Inuit Qaujimajatuqangit* (IQ) (3) whereas academic structure and postcolonial research theory (4) represent the Western influences.

Design

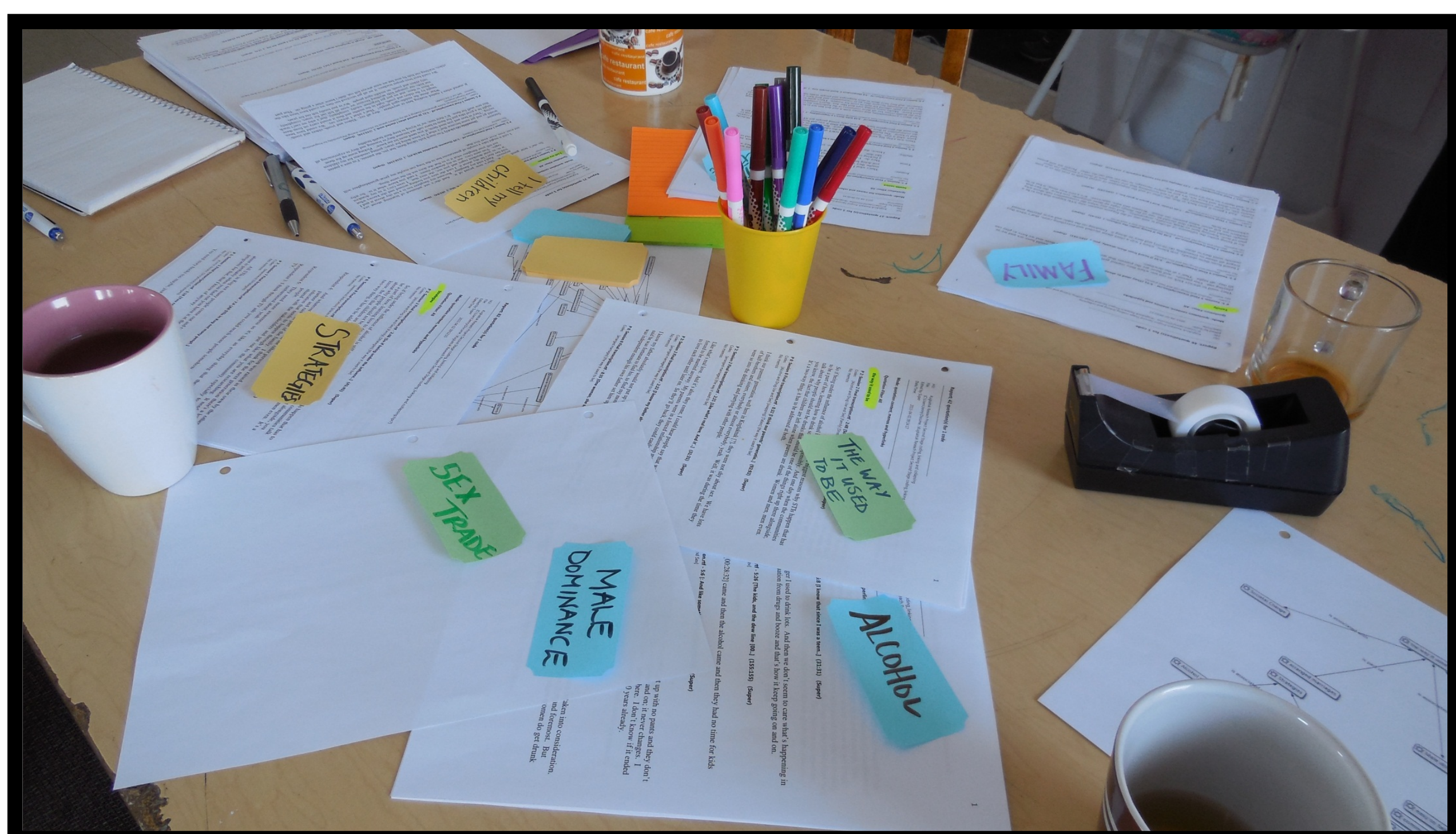
This research project follows a community-based participatory research (CBPR) design(5). This design situates Inuit women at the centre, guiding each stage of the research process; from initial design through to data collection, analysis and dissemination and on-going knowledge translation.

Methods

Nine story sharing sessions took place with 21 Inuit women ages 18-60. Women shared stories of their lived experiences and perceptions of sexual health as well as their perceptions of what might constitute effective community based prevention and promotion programming.

Participatory Analysis

Three participatory analysis sessions took place with 13 women. The researcher organized the data and conducted initial coding so the data could be utilized for group analysis activities. Through group participatory analysis, codes were combined, themes were generated, and findings were refined. Women who participated in the analysis groups were able to further reflect on the data, and collectively contribute to the conclusions that were drawn.



Results

Women identified several key factors that contribute to negative sexual health outcomes for themselves and their communities. These factors included alcohol use, lack of housing, lack of awareness programming, and lack of education.

“Because there's so much alcohol and sex mixed that once you get drunk you don't even know if you had sex or no. It's scary right there.”

“All STIs in Kug... not many people come out and talk about it right, and the only time you talk about is probably when you find out you have it at the health centre. There's not really awareness programs for that, that I know of anyway.”

Women discussed what they thought their community would benefit from to improve sexual health outcomes and help prevent STI and HIV within their community. They identified several strategies they thought would be effective, as well as who is responsible for programming and support.

“So I'd like to see things like that come about People making little videos of topics even of, say, HIV say STI if they are willing to, little videos that could sit in the health centres and that people could watch”

“I think for the next generation there's a lot of education that needs to happen through like what you are researching. It needs to be shared with the stakeholders and put out to the community, especially to the young people”

Ella: Programs for men, not only for women, but for men also.
Joanne: We need that, and somehow we need to go out and tell the community it's okay to communicate with your children about sexual health.

Tania: Maybe that should be a lesson in the parenting classes... if there was a script...

Another theme that was heard throughout the story sessions was change from the way it used to be.

“For me, I noticed that awareness is more now, like from the past when, you know, it was a different way of life. Yeah, it happened long ago but they weren't aware of it; they didn't know what it was. But now people are more aware of the sexually transmitted diseases and are starting to take precautions, but it used to be bad long ago 'cause they didn't know what it was and what was going on. But now there's more education on it, so that's good, but there's still lots of outbreak in the communities. They need more education or somehow to get the people aware of the diseases.”

Discussion & Next Steps

Women reported the research process as being beneficial to them. They learned more information about STI, and felt good about the ability to contribute to what can come in the future. Many felt it was a healing experience, and wished more groups like the story sessions and participatory analysis groups could take place for women. They felt supported and that they were making important contributions for future generations.

“I know what happened to me and I take ownership of that and in doing so, I want to make sure that my granddaughter doesn't go through the same thing that her mother and I went through, and my mother”

The next steps with this project is further knowledge translation. There will be meetings held in Ottawa as well as Iqaluit to share the results of this project with government officials, Inuit agencies, partners and community. This will ensure the women's voices are heard by the policy makers and program planners who are in positions to address the issues.



This project would not be possible without the women of Kugluktuk, Nunavut. Koana.

References

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Contact

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Conflict of Interest Disclosure:

I have the following potential Conflicts of Interest:
I have received various forms of support, including financial, for this research project from the following:
Canadian Institutes of Health Research (CIHR),
The CIHR Social Research Centre in HIV Prevention,
University of Victoria,
Universities Without Walls,
Centre for Aboriginal Health Research





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Supervisory Committee:
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Dr. Catherine Worthington, PhD

Faculty of Graduate Studies
Social Dimensions of Health
Program

Confidentiality Agreement

Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women's Strengths and Resiliencies

1. Confidential Information

The 'Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women's Strengths and Resiliencies' Research Project hereby confirms that it will disclose certain of its confidential and proprietary information to their interview transcriptionist, **Transcription Divas**.

Confidential information shall include all data, materials, products, technology, computer programs, specifications, manuals, software and other information disclosed or submitted, orally, in writing, or by any other media, to **Transcription Divas** by **Jenny Rand**.

2. Obligations of Transcriptionist

A. **Transcription Divas** hereby agrees that the confidential audio data/ research activities from the research study and is to be used solely for the purposes of said study. Said confidential information should only be disclosed to employees of said research study with a specific need to know.

Transcription Divas hereby agrees not to disclose, publish or otherwise reveal any of the Confidential Information received from **Jenny Rand**, to any other party whatsoever except with the specific prior written authorization of **Jenny Rand**.

B. Materials containing confidential information must be stored in a safe location so as to avoid third persons unrelated to the project to access said materials. Confidential Information shall not be duplicated by **Transcription Divas** except for the purposes of this Agreement.

3. Completion of the Work

Upon the completion of the work and at the request of **Jenny Rand**, **Transcription Divas** shall return all confidential information received in written or tangible form, including copies, or reproductions or other media containing such confidential information, within ten (10) days of such request. The transportation of this data will occur as follows: Data will be password protected and stored on a memory stick. The memory stick will be couriered to

Jenny Rand and will require a signature upon receipt. Or it will be uploaded and accessed through a secure website.

Any copies of confidential documents or other media developed by **Transcription Divas** and remaining in their possession after the completion of his work need to be destroyed so as to protect the confidentiality of said information. **Transcription Divas** shall provide a written certificate to Owner regarding destruction within ten (10) days thereafter.

With his/her signature, _____ shall hereby adhere to the terms of this agreement.



Trisia Hesse-Tresider, Project Manager
Transcript Divas

Dec. 28, 2012
Date



**University
of Victoria**

Human Research Ethics Board

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Administrative Services Building
PO Box 1700 STN CSC
Victoria British Columbia V8W 2Y2 Canada
Tel 250-472-4545, Fax 250-721-8960
Email ethics@uvic.ca Web www.research.uvic.ca

Certificate of Approval

PRINCIPAL INVESTIGATOR: Jenny Rand	ETHICS PROTOCOL NUMBER 12-432
UVic STATUS: Master's Student	ORIGINAL APPROVAL DATE: 13-Nov-12
UVic DEPARTMENT: SDH	APPROVED ON: 13-Nov-12
SUPERVISOR: Dr. C. Reading; Dr. C. Worthington	APPROVAL EXPIRY DATE: 12-Nov-13
<p>PROJECT TITLE: Building Community-Based HIV and STI Prevention Programs on the Tundra: Drawing on Inuit Women's Strengths and Resiliencies</p> <p>RESEARCH TEAM MEMBERS: Co-supervisors (UVic): Dr. Charlotte Reading, Dr. Cathy Worthington</p> <p>DECLARED PROJECT FUNDING: CIHR – Master's Award - HIV/AIDS Community-Based Research: Aboriginal Stream; CIHR Social Research Centre in HIV Prevention (LaVerne Monette Award) (SRC); Universities Without Walls (Fellowship) (UWW)</p>	
CONDITIONS OF APPROVAL	
<p>This Certificate of Approval is valid for the above term provided there is no change in the protocol.</p> <p>Modifications To make any changes to the approved research procedures in your study, please submit a "Request for Modification" form. You must receive ethics approval before proceeding with your modified protocol.</p> <p>Renewals Your ethics approval must be current for the period during which you are recruiting participants or collecting data. To renew your protocol, please submit a "Request for Renewal" form before the expiry date on your certificate. You will be sent an emailed reminder prompting you to renew your protocol about six weeks before your expiry date.</p> <p>Project Closures When you have completed all data collection activities and will have no further contact with participants, please notify the Human Research Ethics Board by submitting a "Notice of Project Completion" form.</p>	
Certification	
<p>This certifies that the UVic Human Research Ethics Board has examined this research protocol and concluded that, in all respects, the proposed research meets the appropriate standards of ethics as outlined by the University of Victoria Research Regulations Involving Human Participants.</p> <p style="text-align: center;">Dr. Rachael Scarth _____ Associate Vice-President, Research</p>	


12-432 Rand, Jenny

Nunavummi Qaujisaqtulirijikkut / Nunavut Research Institute

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

SCIENTIFIC RESEARCH LICENSE

LICENSE # 04 065 12N-M

ISSUED TO: Jenny Rand
 University of Victoria


TEAM MEMBERS: J.Rand,C.Reading,C.Worthington

AFFILIATION:

TITLE: Building Community-Based HIV and STI Prevention Programs on the Tundra:
 Drawing on Inuit Women's Strengths and Resiliencies

OBJECTIVES OF RESEARCH:

This study is a community based participatory research project (CBPR) that explores Inuit women's ideas around community based HIV and STI prevention and sexual health promotion. The project aims to reduce the inequitable access to HIV/STI prevention programs for Inuit women and their families. In addition to addressing an issue clearly articulated by Inuit, the use of an Indigenous model of community based research will ensure respectful and active collaboration with the community. Rooted in my long term relationship with and humble respect for, the women of Kugluktuk, this research will be conducted with a strong emphasis of reciprocity. I will learn more about Inuit specific research protocols and will ideally be able to bring some of my experience in sexual health promotion, and disease prevention to the community.

TERMS & CONDITIONS:**DATA COLLECTION IN NU:**

DATES: November 01, 2012-July 31, 2013
 LOCATION: Kugluktuk

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