



SOCIAL DETERMINANTS OF INUIT HEALTH IN CANADA

September 2014



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INUIT TAPIIRIT KANATAMI

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Executive Summary

Introduction

With the granting of funds from the National Collaborating Centre on Aboriginal Health (NCCAH) in 2013, Inuit Tapiriit Kanatami (ITK) has revised a discussion paper, first submitted to the World Health Organization (WHO) in 2007, outlining the social determinants of health relevant to Inuit populations in Canada today. This revised paper incorporates information from current data sources and expanded consultations among Inuit regions, primarily through discussions with members of the Inuit Public Health Task Group (IPHTG), a sub-committee of the National Inuit Committee on Health.

Overall, the purpose of this document is to act as a resource in support of public health activities across Inuit regions in Canada and to function as a reference for organizations and governments working within the Canadian health and social services sector.

Inuit Health Status in Canada

The roughly 59,500 Inuit in Canada live in the four Inuit regions (Inuit Nunangat): Nunavik (Northern Quebec), Nunatsiavut (Northern Labrador), Nunavut, and the Inuvialuit Region of the Northwest Territories (NWT), as well as outside of Inuit Nunangat in city centres such as Ottawa, Yellowknife, Edmonton, Montreal and Winnipeg. Overall, the Inuit population is relatively young and rapidly growing.

This paper highlights the need for taking a more holistic outlook on the overall health status of Inuit in contrast to commonly referenced indicators which focus on health deficits such as the higher rates of infant mortality, food insecurity, suicide, or infectious diseases relative to the total population in Canada.

Social Determinants of Inuit Health

Based on a broad review of the literature focusing on Inuit health and on recent consultations with representatives from Inuit organizations, agencies and governments, the following eleven factors have been articulated as key social determinants of Inuit health:

- quality of early childhood development;
- culture and language;
- livelihoods;
- income distribution;
- housing;
- personal safety and security;
- education;
- food security;
- availability of health services;
- mental wellness; and
- the environment.

Social determinants of health are “the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices” (World Health Organization, 2013). The following paragraphs summarize key challenges under each social determinant of Inuit health as well as some key efforts to address these challenges.

1. QUALITY OF EARLY CHILDHOOD DEVELOPMENT

Challenges

- Infant mortality;
- Food insecurity and poor nutrition;
- Overcrowded housing and stressful home environments;
- Poverty;
- Lack of access to quality health care facilities and support;
- Culturally appropriate screening and assessment for growth and development; and
- Substance abuse and smoking during pregnancy.

Key Positive Efforts

- Building a continuum of care for mothers and children from pre-pregnancy through pregnancy and childbirth to the early years of life;
- Encouraging breastfeeding and minimizing exposure to alcohol;
- Providing access to Inuit-specific early childhood education opportunities;
- Including Elders in child raising activities; and
- Expanding access to Inuit midwifery and bringing birthing closer to home.

2. CULTURE AND LANGUAGE

Challenges

- Rapid cultural and linguistic change among Inuit communities as a result of the legacy of residential schools and colonialism; and
- An increasing prevalence of English combined with a decline in the use of Inuktitut.

Key Positive Efforts

- Drafting of legislation to protect and support Inuit language and culture in Inuit regions;
- Expanding the use of Inuit language in work places and schools; and
- Supporting community-based Inuit language and culture programming.

3. LIVELIHOODS

Challenges

- Lack of adequate employment in Inuit communities.

Key Positive Efforts

- Supporting harvesting activities; and
- Establishing Impact and Benefit Agreements (IBAs) for major development projects in Inuit Land Claims areas.



4. INCOME DISTRIBUTION

Challenges

- Lack of adequate opportunities for generating income in Inuit communities; and
- High living costs across Inuit regions.

Key Positive Efforts

- Increasing numbers of Inuit in apprenticeship programs;
- Maximizing Inuit participation in training opportunities; and
- Increasing recruitment and retention of qualified Inuit.

5. HOUSING

Challenges

- Housing shortages and high rental costs;
- Poor quality housing and ventilation;
- High cost of home construction and repair in Inuit regions; and
- Homelessness.

Key Positive Efforts

- Expanding federal, provincial and territorial funding for housing construction in Inuit communities; and
- Developing and implementing multi-year initiatives for expanding social housing.

6. PERSONAL SAFETY AND SECURITY

Challenges

- Domestic violence and sexual abuse;
- Children as witnesses of violence; and
- Substance abuse and alcohol misuse.

Key Positive Efforts

- Increasing front-line workers and culturally appropriate community support, counselling, and healing;
- Raising awareness and reducing tolerance of abuse; and
- Expanding a harm reduction approach and associated strategies.

7. EDUCATION

Challenges

- Low education attainment levels;
- Relatively few post-secondary programs available in Inuit communities; and
- Continuing lack of Inuit teachers at all education levels.

Key Positive Efforts

- Developing leaders in Inuit education;
- Increasing the number of bilingual educators;
- Investing in Early Years programming;
- Expanding Inuit-centred curriculum and language resources; and
- Expanding post-secondary options in Inuit communities.

8. FOOD SECURITY

Challenges

- High rates of unemployment and underemployment;
- Low household incomes;
- Lack of access to adequate levels of quality foods including access to country foods; and
- High cost of living, including the high cost of store-bought foods in Inuit communities.

Key Positive Efforts

- Expanding employment opportunities in Inuit communities;
- Supporting programs to reduce the cost for shipping food and increasing access to country foods;
- Increase number of nutrition education initiatives that encourage Inuit to make more nutritious food choices;
- Developing food security strategies; and
- Establishing harvester support programs and other community initiatives.

9. AVAILABILITY OF HEALTH SERVICES

Challenges

- Less access to medical specialists and/or diagnostic testing;
- Lack of long-term / continuing care options, particularly for those requiring a high level of care;
- Medical transfers to the south can be isolating or a deterrent to seek care;
- Lack of adequate cultural orientation for health care providers; and
- Few Inuit nurses or other medical staff, and related staffing shortages.

Key Positive Efforts

- Supporting the recruitment and retention of health-care providers in Inuit communities;
- Increasing the use of telehealth;
- Orienting, and educating healthcare workers to provide culturally relevant health services; and
- Increasing the number of birthing centres staffed by Inuit midwives.

10. MENTAL WELLNESS

Challenges

- Intergenerational trauma relating to the legacy of residential schools;
- Addictions; and
- Youth suicide.

Key Positive Efforts

- Expanding culturally relevant mental wellness programs and supports;
- Supporting Inuit-specific research and training focusing on mental health; and
- Developing community-based initiatives in support of suicide prevention.



11. ENVIRONMENT

Challenges

- Contaminants entering the environment; and
- Climate change and associated changes to the land and sea environment.

Key Positive Efforts

- Increasing monitoring of environmental factors to support adaptive measures addressing environmental change; and
- Building capacity in Inuit health research through trainee support and strategic funding initiatives in key environmental health areas.

Conclusion

In spite of significant efforts to improve the current socio-economic conditions in Inuit communities, substantial work remains to address underlying conditions that influence Inuit health outcomes. A key action for future success is the support of increasing levels of self-determination in Inuit regions. In this way, Inuit will be able to enhance their culture, language, economy, and health. In parallel with these Inuit-specific and Inuit-led efforts, all levels of government must support Inuit by implementing Land Claim Agreements, involving Inuit in policy-making and program design, and providing long-term, adequate funding for development. As a result, coordinated and innovative approaches can be taken in a holistic manner, to not only treat the ill, but to address the critical factors contributing to the overall health status of Inuit.

1. Introduction

1.1 Background

Inuit Tapiriit Kanatami (ITK) takes a holistic view of Inuit health and strongly believes that significant improvements can be made by addressing current socio-economic conditions in Inuit communities. ITK plays a pivotal role in supporting such efforts and, as a priority, works toward the development of policies and initiatives that are Inuit-specific and which improve health conditions across Inuit Nunangat.

Efforts to improve the socio-economic conditions of Inuit are on-going in the face of significant health gaps that exist between Inuit and non-Inuit Canadians. For example, Inuit have much lower life expectancies than other Canadians, comparatively high rates of infant mortality, the highest suicide rates of any group in Canada, and disproportionately higher rates of infectious diseases. This health gap in many respects is a symptom of poor socio-economic conditions in Inuit communities which are characterized by high poverty rates, low levels of education, limited employment opportunities, and inadequate housing conditions.

1.2 Purpose of the Document

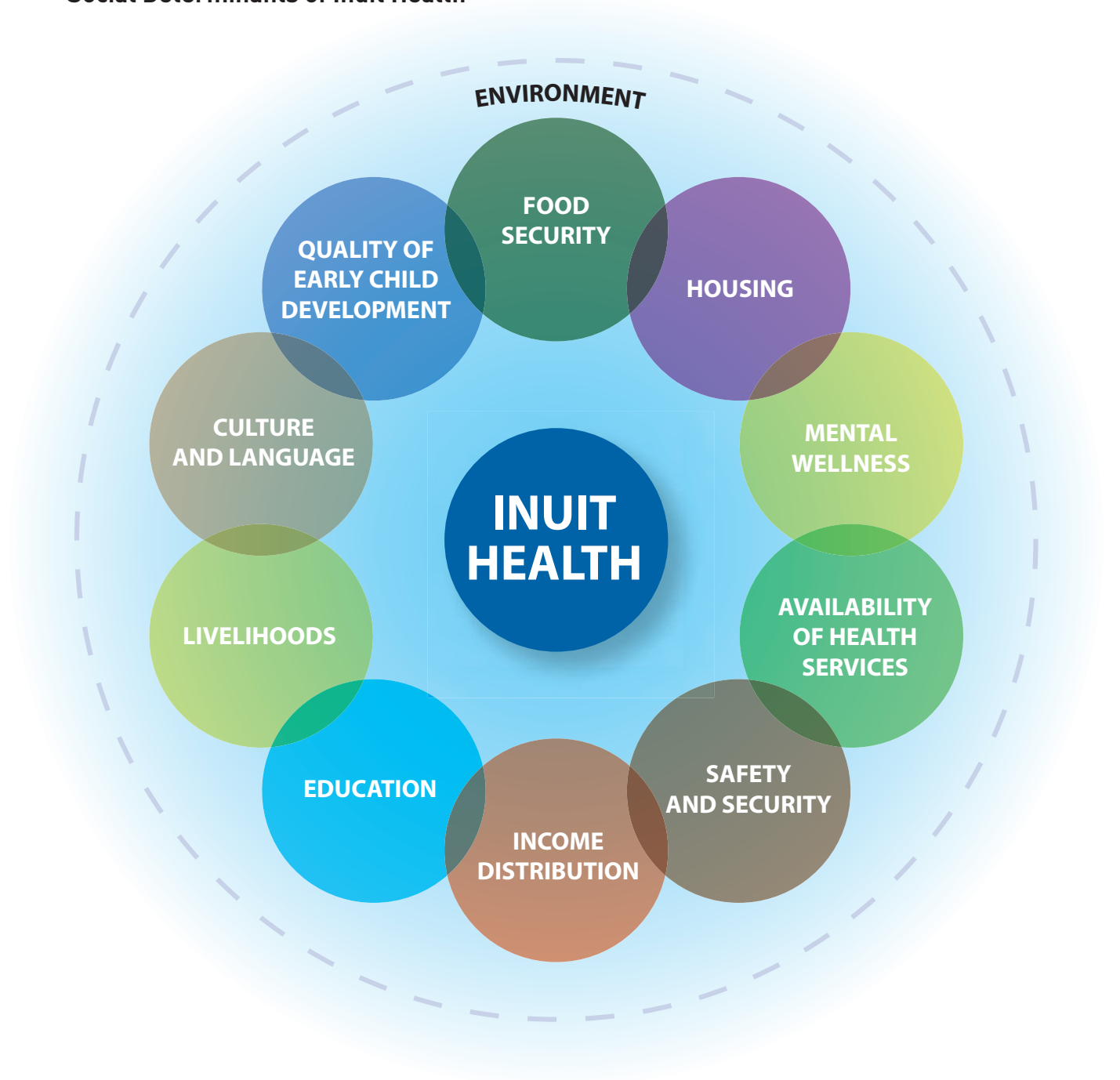
In 2007, ITK drafted a discussion paper outlining the key social determinants of Inuit health in Canada based primarily on consultations that took place in Nunavut between 2003 and 2004 and an overview of relevant research accessible at the time. That document was developed as a result of funding from the National Collaborating Centre on Aboriginal Health (NCCAHA) and submitted to the World Health Organization (WHO) Commission on Social Determinants in 2007. In 2013, ITK received additional funds from the NCCAHA to revise the original discussion paper. Similar to the previous version, this paper highlights the key social determinants of health that are relevant to Inuit populations in Canada today. The revised document incorporates information from current data sources and expanded consultations among Inuit regions, primarily through discussions with members of the Inuit Public Health Task Group (IPHTG), a sub-committee of the National Inuit Committee on Health. Consequently, the IPHTG has re-focused this discussion paper to act as a resource in support of its on-going work in public health activities across Inuit regions in Canada and to function as a reference for organizations and governments working within the health sector.

The paper is organized into three sections: Inuit health status in Canada; overview of the social determinants of Inuit health; and a conclusion. Based on a broad review of the literature focusing on Inuit health and on recent consultations with representatives from Inuit organizations, agencies and governments, the key social determinants have been revised to the following eleven factors: *quality of early childhood development, culture and language, livelihoods, income distribution, housing, personal safety and security, education, food security, availability of health services, mental wellness and the environment.*

The following diagram outlines the key social determinants of the health for Inuit in Canada to be described in this document.



Social Determinants of Inuit Health



2. Inuit Health Status in Canada

2.1 Overview of the Inuit population in Canada

The majority of the 59,500 Inuit living in Canada reside in 53 remote communities in the four Inuit regions (Inuit Nunangat): Nunavik (Northern Quebec), Nunatsiavut (Northern Labrador), Nunavut, and the Inuvialuit Region of the Northwest Territories (NWT) (see map in Appendix 1). A growing number of Inuit (22% in 2006 and 27% in 2011) are taking up residence outside of Inuit Nunangat in city centres such as Ottawa, Yellowknife, Edmonton, Montreal and Winnipeg. The Inuit population is relatively young and rapidly growing. According to Statistics Canada, the median age of the Inuit population is 23 years, compared with 41 years for non-Aboriginal people. The Inuit population is also younger than First Nations, whose median age is 26 years, and Métis, whose median age is 31. (The median age is the point where exactly one-half of the population is older, and the other half is younger) (Statistics Canada, 2011a). Between 2001 and 2011, the Inuit population grew by 32%, about three times the rate of the total population which increased by 11% (Statistics Canada 2001 Census, 2011 National Household Survey).

2.2 Data on Inuit Health Status

Many health indicators currently in use at the national level in Canada reflect the significant challenges currently impacting the health of Inuit in Canada. Life expectancy in Inuit Nunangat is well below the Canadian average. For residents of Inuit Nunangat (including non-Inuit), it is 70.8 years, compared with 80.6 years for all Canadians (Statistics Canada, 2012a). The infant mortality rate for those living in Inuit Nunangat is nearly 3 times that of the total Canadian population (14.9/1,000 vs. 5.2/1,000) (Statistics Canada, 2012b).

Another indicator of the poor health outcomes in Inuit communities is the high number of youth suicides. Suicide is a demonstrative sign of socio-economic distress and a strong manifestation of social exclusion, especially among Inuit males between the ages of 15 and 24 where suicide is most prevalent. From 1999 to 2003, the suicide rate among Inuit was 135 per 100,000; four times higher than that of First Nations (24.1) and eleven times higher than the rate for all Canadians (11.8) (ITK and ICC, 2007). Between 2004-2008, children and teenagers in Inuit Nunangat were more than 30 times as likely to die from suicide as were those in the rest of Canada. Furthermore, half of all deaths of young people in Inuit Nunangat were suicides, compared with approximately 10% in the rest of Canada (Statistics Canada, 2012c).

An increasing amount of literature outlines the higher rates of chronic illnesses and infectious diseases among Inuit infants and children such as respiratory infections. These studies link many health problems to crowded and poor quality housing, unemployment, marginal access to health services, food insecurity, as well as behavioural and environmental factors. A study in Nunavut found 306 of 1000 infants were hospitalized for bronchiolitis during their first year of life (Banerji, 2001), while results from the 2007-2008 Nunavut Inuit Child Survey indicated that 42% of children had to seek medical attention during the previous year for a respiratory illness (Egeland, 2010). These high rates of bronchiolitis and other respiratory tract infections have been attributed to risk factors such as household crowding, exposure to tobacco smoke, and defects in immunity (Jenkins et al., 2003). At the same time,



past research in Nunavik states that 60% of babies aged 9-14 months are anaemic, primarily due to insufficient nutrition and by age 5, 1/4 of children suffer significant hearing loss in at least one ear (Hodgins, 1997).

The tuberculosis rate for Inuit in Canada is significantly higher than that for the Canadian-born non-Aboriginal population — 262/100,000 compared to 0.7/100,000 (Public Health Agency of Canada, 2013). For many chronic conditions such as diabetes, high blood pressure and heart disease, rates for Inuit are similar to those for the total Canadian population. Given the changes in diet and lifestyle, ongoing monitoring and increasing awareness of the need for more effective approaches to prevention, control, and care for Inuit is essential.

Substance abuse is another challenge facing Inuit communities. Inuit adults have among the highest rates of smoking in Canada, with 54% of adults (ages 18 years and over) being daily smokers. Furthermore, 56% of Inuit women who were pregnant in 2012 smoked daily (Statistics Canada, 2012d). This raises concerns for increasing risk of complications with miscarriage, fetus development, low birth weight, premature delivery, and new-born withdrawal symptoms (Wong, 2006).

While high-risk behaviours such as alcohol abuse and smoking are known to negatively impact health, their prevalence in Inuit communities is symptomatic of deeper social and economic issues, as well as the legacy of colonialism (Nelson, 2012). Thus, underlying socioeconomic inequalities causing serious daily stress and unhealthy coping mechanisms should be viewed as key factors in the fundamental determinants of health.

3. Social Determinants of Inuit Health

3.1 Current State of Research

While longitudinal data on Inuit health and socio-economic indicators in Canada remain scarce (Cameron, 2011), an increasing number of regional studies and research projects exploring Inuit health have been undertaken since this discussion paper was first published in 2007. Key examples of such studies include the Nunavik Inuit Health Survey (2004), the International Polar Year (IPY) Adult Inuit Health Survey and the Nunavut Inuit Child Health Survey (2007-2008). Data from these surveys along with a growing number of publications focusing on Inuit and Aboriginal health from organizations such as the National Collaborating Centre for Aboriginal Health (NCCA) and the now-discontinued National Aboriginal Health Organization (NAHO) have built a critical mass of information to support more effective evidence-based decisions for improving Inuit health outcomes.

With respect to health indicators and factors contributing to the determinants of health, an increasing amount of literature can be found on topics such as food security (Chan et al., 2006; Lambden et al., 2006; Lawn and Harvey, 2003), access to appropriate health care (O’Neil et al., 1988), housing (Young and Mollins, 1996), acculturation (Condon, 1990; Steenbeek et al., 2006), literacy and health (Korhonen, 2006); mental wellness (Little, 2006); community well-being (Senecal, 2006); subsistence harvesting (Statistics Canada, 2006), and suicide (Hicks, 2007). This literature and the data collected within the studies they describe increasingly allow for a more holistic outlook on the overall health status of Inuit beyond the commonly referenced indicators which focus on health deficits such as infant mortality or prevalence of infectious diseases.

3.2 Definitions

As defined by the World Health Organization (WHO), the social determinants of health are “the conditions in which people are born, grow, live, work and age, including the health system. These circumstances are shaped by the distribution of money, power and resources at global, national and local levels, which are themselves influenced by policy choices. The social determinants of health are mostly responsible for health inequities — the unfair and avoidable differences in health status seen within and between countries” (World Health Organization, 2014a).

For the purposes of this document, the WHO definition above for social determinants of health will be adapted to target those key factors which are seen to specifically impact the health outcomes of Inuit in Canada. The specific determinants of health discussed in this document, while informed by the WHO definition above, take on a much more Inuit-specific focus. These determinants are based on discussions held during a Nunavut Department of Health and Social Services (NDHSS) workshop in May 2005 and later revised during an IPHTG meeting in February 2013. The key health determinants as discussed during those meetings and finalized by the IPHTG include the following 11 key determinants: *quality of early childhood development, culture and language, livelihoods, income distribution, housing, personal safety and security, education, food security, availability of health services, mental wellness and the environment*. The sections of this document are structured according to the 11 determinants outlined above. Each section is divided into segments to describe:



- Background information on the determinant;
- The challenging factors associated with the determinant; and
- Actions underway to address challenges relating to the determinant.

For Inuit, the determinants of health are highly interconnected. Therefore, the document emphasizes a holistic approach and uses examples when possible to highlight the relationship between the various determinants.

3.3 Quality of Early Childhood Development

Early childhood development is used in this section as a term to encompass all issues relating to maternal, fetal, infant, and children's health and wellness. Addressing the factors that contribute to healthy development in early childhood will have a long-term impact on mental and physical health and well-being.

3.3.1 Background

The World Health Organization (2005) suggests that a continuum of care for mothers and children is crucial, from pre-pregnancy through pregnancy and childbirth to the early days and years of life. Research suggests that good prenatal care, breastfeeding, minimizing exposure to alcohol and smoking are key activities that contribute to high quality early childhood development in Inuit communities (NCCAH, 2012). Cameron (2011) further suggests that access to early childhood education opportunities, sex education and family planning in schools, the inclusion of Elders in child raising activities, and access to Inuit midwifery as an option in Inuit communities are also positive factors. The positive impacts of these activities can support coping skills; lifestyle behaviours; immunity to illness; overall well-being; employment prospects; income; and education for infants and children (Friendly, 2004).

3.3.2 Challenging Factors

The most prevalent challenging factors affecting early life in Inuit communities are infant mortality, food insecurity and poor nutrition, overcrowded housing, poverty, stressful home environments and lack of access to quality health care facilities and support (NDHSS, 2005; Hodgins, 1997; UNICEF Canada, 2009). High rates of anaemia, respiratory tract infections and otitis media among Inuit infants are also attributable to inadequate prenatal and postnatal nutrition and widespread smoking in crowded homes.

Fetal Alcohol Spectrum Disorder (FASD) is also of great concern to Inuit communities. Although there are no reliable statistics about its occurrence among Canadian Inuit, the risk of its occurrence is a cause for concern with the proportion of Inuit women who report heavy drinking. Data from the 2006 Aboriginal Peoples Survey suggests that 14% of all Inuit women across Canada reported heavy drinking (defined as five or more drinks a day, one or more times per week) (Pauktuutit, 2010). Furthermore, there is very limited access to FASD diagnosis services, educational and social supports, and long term intervention strategies for Inuit children and families living in communities throughout Inuit Nunangat (CPS, 2002).

3.3.3 Recent Actions to Address this Determinant

Greenwood and de Leeuw (2012) state that a critical starting point in addressing the quality of early life is by creating “awareness of the social and historical context in which Aboriginal people find themselves” (p.383). Taking this approach and focusing on improving the quality of early childhood development for Inuit means recognizing the need to address all social determinants of Inuit health, particularly access to care, education, housing, income, and food security. The 2011 National Strategy on Inuit Education tabled by ITK recommends an expansion of high quality early years programming that is culturally and linguistically appropriate in all Inuit communities. This could impact the early identification of infants and young children at risk for delayed development or those with greater developmental issues and ensure parental support.

Improving access to services and programs targeted at children, youth and their parents must be a priority in efforts to address the health inequities faced by Inuit. This includes access to community-based programs and services such as quality Inuit early childhood education, support for parents and families, involvement of Elders in child rearing and bringing birth closer to home through midwifery services. One example of Inuit-specific programming that supports early identification of children at risk is the FASD screening available in Nunatsiavut through a multidisciplinary Regional FASD Diagnostic Team coordinated by Labrador Grenfell Health. Another is the long-standing maternity program at the Inuulitsivik Health Centre in Puvirnituq which is a successful example of how the reintroduction of perinatal services on the Hudson coast has provided an opportunity for Inuit women to give birth closer to home.

A 2005 Social Determinants of Health workshop in Nunavut recommended a number of actions to support better outcomes for early childhood development that could take place at three levels: federal, regional and community level. Furthermore, it was suggested that the federal government ensure that public policies made in every government department support early life programs. Government departments need to increase prenatal support to pregnant women through counselling, prenatal nutrition and FASD education, and home visits (NDHSS, 2005).

The above recommendations coupled with a review of current literature and direction from the Inuit Maternal Child Health Working Group have fed into the following eight priority themed area recommendations to support the best start to early life for Inuit children in Canada:

- To ensure access to collaborative, culturally appropriate healthcare;
- To support healthy pregnancy and birthing by bringing birthing closer to home and preventing children being born with FASD;
- To increase breastfeeding rates and develop strategies for food security;
- To increase support for parenting and offer Inuit-specific early childhood development programming in order for children to develop to their full potential;
- To develop strategies which address inadequate housing;
- To create Inuit specific developmental screening and assessment tools for young Inuit children and ensure there is support;
- To ensure there is support for pregnant mothers and young Inuit children to achieve better oral health outcomes; and
- To increase data and research in the area of maternal, infant and child health.



3.4 Culture and Language

Inuit culture and language are seen as a crucial and inter-connected determinant of health. Overall, the current state of Inuit culture and language can be generalized as one of rapid change.

3.4.1 Background

Before 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. Men and women held their respective traditional roles. Inuit identity was strongly tied to the natural environment with traditional knowledge and cultural values passed from elders to youth through storytelling, example-setting and life experience.

Although settlement happened at different points in time in the Arctic, the Canadian government began to actively encourage Inuit to settle in permanent communities where cheap housing, medical facilities, and modern stores were built. Although permanent settlement has led to a decline in mortality rates and certain diseases over the past 60 years, Inuit have experienced dramatic socio-cultural changes which undercut overall well-being in several ways. Now fewer Inuit live solely off the land and many have become dependent on the limited job opportunities that exist in communities and social assistance. The movement from traditional forms of subsistence to a dependence on a wage economy has radically disrupted Inuit social and environmental relationships and is recognized as contributing to social marginalization, stress and a higher incidence of suicide (O'Neil, 1994, Kirmayer et al., 1998 and Wexler, 2006).

Maintenance of language and cultural traditions are important in fostering a sense of individual and community identity. Cultural continuity in particular has been identified as a strong component of good mental health and well-being (NCCAH, 2012). In the Inuit context, one particular indicator of cultural well-being remains strong in many regions: the use of the Inuit language. Today, the Inuit language still remains one of the most resilient Aboriginal languages in the country. In 2001, 71% of Inuit were conversant in the Inuit language (Statistics Canada, 2001), while in 2011 63% of the Inuit population could converse in the Inuit language. Defined regional variations can be observed, however, with knowledge of the Inuit language almost universal among Inuit in Nunavik (99%) and Nunavut (89%), while in Nunatsiavut, one-quarter (25%) and in the Inuvialuit region one-fifth (20%) of Inuit can speak the language well enough to converse (Statistics Canada, 2011b).

3.4.2 Challenging Factors

One of the critical factors encompassing the rapid cultural and linguistic change among Inuit communities is colonialism (Nelson, 2012). More specifically, the stigmatization, marginalization and racism associated with colonialism have been known to cause detrimental and irreversible effects on health and longevity (NCCAH, 2012). Furthermore, the erosion of culture can adversely affect mental health and well-being, leading to depression, anxiety, substance abuse and even suicide (Kirmayer, Brass & Tait, 2000).

One occurrence during the colonialism process that significantly impacted Inuit culture and language is the legacy of Canada's residential school system (Kirmayer et al., 2003; Royal Commission on Aboriginal Peoples, 1995). The last residential school for Aboriginal children in Canada closed in the 1990s but the impacts have continued to affect many generations of Inuit and their communities (Aboriginal Healing Foundation, 2002). Resulting circumstances have included intergenerational trauma that has in turn led to language loss, assimilation and family upheavals.

The 2001 Aboriginal Peoples Survey (O'Donnell and Tait, 2003) shows that a substantial proportion of Canadian Inuit attended residential schools in their youth: 16% of those aged 35 to 44 at the time of the survey; 44% of those aged 45 to 54; 26% of those aged 55 to 64; and 39% of those aged 65 and over. Inuit children often lived at the residential schools that were run by missionaries. Having to live hundreds or thousands of kilometers from home for nine months out of the year, many Inuit children lost their familial, communal, and socio-cultural connections, had no opportunity to eat country foods, were banned from speaking Inuit languages, and were forced to follow southern norms.

Residential school experiences created a rift between elders and youth, inhibiting the intergenerational exchange of traditional knowledge, cultural values, parenting skills and language that is crucial to healthy relationships and identity formation. Physical, sexual, and mental abuse of pupils were also not uncommon in residential schools. Cultural repression, assimilation, and abuse combined to make some Inuit feel ashamed of their identities, alienated, and disconnected from their families (Wexler, 2006; Kirmayer et al., 2003; Royal Commission on Aboriginal Peoples, 1995). Ultimately, the legacy of the residential school system is often cited as a source of 'community trauma' that continues to affect the health and mental well-being of Inuit today.

An additional impact can be seen in the loss of Inuit language and the increasing use of English in the home. For example, recent data from the 2007 - 2008 Nunavut Child Health Survey highlight the trends in language use suggesting that of those children surveyed, more than one-half (54%) were spoken to by adults in Inuktitut, whereas 36% were spoken to in English, and 10% were spoken to in both English and Inuktitut (Egeland, 2010).

As a result of the increasing influence of schools (which are mostly modeled after southern schools), peer groups, and southern media, many elders have observed that generational roles have changed (Condon, 1990). Elders have also articulated this change by suggesting that youth "do not listen to Elders anymore" (Wexler, 2006). With this change comes challenges, as noted by one elder who writes, "as a result of not knowing what to do, many [young people] turn to alcohol and drugs to feel good" (Wexler, 2006).



3.4.3 Recent Actions to Address this Determinant

The finalization of the Indian Residential School Settlement Agreement (IRSSA) in 2005 was a key step to address the legacy of residential schools. The Agreement required Canada to set aside \$1.9 billion in a fund for Common Experience Payments (CEP) to be available for eligible former residential school students including Inuit. As of 2013, approximately 79,179 First Nations and Inuit individuals had received CEP payments from the fund, receiving on average \$19,412 per person (AANDC, 2014).

In the area of language support, numerous Inuit organizations and governments are encouraging the use of Inuktitut at the national and regional level. ITK and the Inuit Circumpolar Council (ICC), for example, have proposed a number of plans and policies to promote Inuit language and culture and have outlined a long-term, intensive approach to the protection and enhancement of the Inuit language (ITK and ICC, 2007; ITK, 2011). The Government of Nunavut and Nunavut Tunngavik Incorporated, the organization that represents Inuit under the Nunavut Land Claims Agreement, have also been working together to make Inuktitut the dominant language in their institutions (Government of Nunavut, 2011; Nunavut Tunngavik Incorporated, 2006). For example, these efforts have led to the establishment of the 2008 Inuit Language Protection Act in Nunavut. Along with the associated right to education in the Inuit language up to the third grade by 2009 and for all other grades by 2019, this act has included the following goals linked to language: establishment of a new Language Authority Inuit Uqausinginnik Taiguusiliuqtii to develop language standards; the right for Inuit to work for the Government of Nunavut in their own language; and municipalities services offered in the Inuit language (Office of the Languages Commissioner of Nunavut, 2013). In an effort to support regional initiatives on the Inuit language, ITK is currently investigating the feasibility of standardizing the Inuit writing system as part of the recommendations outlined in the 2011 National Strategy on Inuit Education. (ITK, 2014).

Efforts are also being taken to support Inuit language and culture at the community level. For example, women in Nunatsiavut have developed culture and language programs for youth by holding Cultural Days to highlight the uniqueness of Inuit culture (Aboriginal Women's Conference, 2006). Language camps for Inuit youth and adults are also increasingly in use to give youth the opportunity to develop language and cultural skills. Furthermore, at the national level, information and policy materials are regularly made available in a number of dialects of Inuktitut as seen in the document titled, *Tukisiviit*, a sexual health resource for Inuit, published in five dialects and produced by Pauktuutit Inuit Women of Canada.

3.5 Livelihoods

The ways in which Inuit make their livelihoods was identified as an important Inuit-specific social determinant of health. The concept of livelihoods is used in this document to encompass a wide range of social factors beyond concepts such as employment in order to include all ways in which families are generating income and supporting themselves. This conceptualization has been adopted since many Inuit men and women continue to work 'informally' by harvesting country food, producing goods, handicraft and artwork, and providing voluntary services in their communities. Although these activities are not usually considered employment, they should still be considered when addressing the social determinants of Inuit health (Elliott and Macaulay, 2004).

3.5.1 Background

While the ways in which many Inuit make their livelihoods remain diverse, employment has increasingly become a key means by which Inuit families support themselves. Accordingly, access to employment opportunities is an important factor in positive health outcomes (RCAP, 1995). And yet, according to Statistics Canada data, Inuit are less likely to be employed in higher-paying positions that require more advanced levels of education. While data suggest that the non-Aboriginal population in Inuit regions worked more in management, health, natural and applied sciences, and financial or business positions, Inuit were more likely to be employed in sales and services, trades and primary industry positions (Gionet, 2008). Based on data from the 2011 National Household Survey, employment rates for men and women in Inuit Nunangat are about the same in all regions with the exception of Nunatsiavut where women have a higher rate (44.3%) than men (33.9%). This is divergent from the rest of Canada where the employment rate is higher for men (64.9% versus 57.0%) (Statistics Canada, 2011c).

Participation in traditional harvesting practices also has a positive impact on Inuit health outcomes. Not only does the consumption of traditional food (e.g. seal, caribou and fish) act as a benefit since it is highly nutritious (Lawn and Harvey, 2003), but the practice of harvesting itself can occasionally provide some economic benefits which in turn enables a family to purchase less store-bought foods and enhance household food security. The socio-cultural aspects of harvesting are vital to Inuit well-being since they reinforce a connection with the land that traditionally cultivated Inuit culture, identity, and feelings of self-reliance. Post-harvesting activities are also important for strengthening familial and communal bonds because Inuit have a deeply embedded practice of sharing country food with family and community members (Statistics Canada, 2006). The Inuvialuit Regional Corporation parallels this view by suggesting that “consuming country foods is important to Inuvialuit identity, and the culmination of a series of cooperative activities — harvesting, processing, distributing and preparing — that require behaving in ways that emphasize Inuvialuit values of cooperation, sharing and generosity” (Inuvialuit Regional Corporation, 2007).

Additionally, the production of arts and crafts using harvested materials is an opportunity for elders to pass on skills and knowledge to younger generations and generate additional income. Thus, traditional food use has deeper implications than nutrition. It buttresses cultural practices and social norms that emphasize sharing, cooperation, and generosity (Willows, 2005) and is holistically entwined with culture and personal identity, as well as with physical and mental health.

3.5.2 Challenging Factors

The prevalence of traditional activities is also linked to the availability of meaningful employment in many Inuit communities. Furthermore, data from the 2006 Aboriginal Peoples Survey suggest that 79% of Inuit respondents felt unemployment was a problem in their communities (Little, 2006). In 2011, the unemployment rate was almost six times higher for Inuit adults of core working age in Inuit Nunangat (19.9%) than for their non-Aboriginal counterparts in this region (3.4%). Unemployment rates for Inuit varied across regions. In Nunavut, the figure was 20.5% while the rate for Nunavik was 14.4%. Rates were higher in Nunatsiavut (33.7%) and the Inuvialuit region (21.3%). Outside Inuit Nunangat, the unemployment rate for Inuit was 11.1% (Statistics Canada, 2011f).



Anecdotal evidence suggests that scarce employment opportunities in Inuit communities contribute to feelings of low self-esteem, listlessness, violence and suicide. O'Neil (1994) found that in the Kivalliq region of Nunavut suicidal behaviour was pronounced in households whose male head was unemployed. By constraining income, unemployment may also affect one's educational opportunities, food security, ability to provide good childcare and other social health factors.

3.5.3 Recent Actions to Address this Determinant

At the regional level, concrete steps have been taken to increase employment prospects with the use of Impact and Benefit Agreements (IBAs) for major development projects in Inuit Land Claims areas. IBAs between the developer and community are considered an essential measure for Inuit to achieve self-determination, diversify their local economies, earn revenue, gain training and employment opportunities, and minimize deleterious impacts of development projects. IBAs have recently been negotiated for several mining projects in Inuit regions, including the Jericho Diamond Mine in the Kitikmeot region of Nunavut and the Voisey's Bay Nickel Mine (VBNC) in Labrador, ensuring Inuit involvement in and oversight of the projects. In 2005, it was estimated that 40 to 116 jobs were to be created during different phases of the Jericho project, largely to be filled by Inuit (Indian and Northern Affairs Canada, 2005). As of December 2005, the Voisey's Bay project had recruited 419 people, 211 of whom were either Innu or Inuit (VBNC, 2005).

At the community level, vocational training, career counselling, and other employment programs exist, however more support is needed. Additionally, to establish long-term sustainable employment opportunities in communities, growth and diversification of the private sector is vital (ITK, 2004). ITK stresses the importance of maximizing the "capital assets" of Inuit regions, improving physical capital (buildings, infrastructure), human capital (training, education, social circumstances), natural capital (mineral resources), and organizational capital (strengthening local and regional Inuit organizations) (Ibid).

Traditional harvesting continues to be very much alive in Inuit communities. For example, the Aboriginal Peoples Survey of 2006 indicated that 68% of adults in Inuit Nunangat communities harvested country foods, while at least 80% of Inuit households in Nunavut, Nunavik, and Nunatsiavut had at least one member that was involved in harvesting activities (Statistics Canada, 2008b). These data were mirrored by findings from the 2007-2008 Inuit Health Survey stating that more than two-thirds of households in Nunavut had an active hunter in the home, three quarters of households with children had an active hunter and more than 75% of households shared their country food with others in their community (Egeland, 2010).

Harvesting activities are being supported by regions through Harvester Support Programs, which provide financial assistance to harvesters who need hunting equipment and sewing supplies. One example of this type of program is the Nunavut Tunngavik Incorporated (NTI) Nunavut Harvester Support Program — Atugaksait Program. This program is designed to provide financial assistance to teach survival skills, harvesting knowledge or traditional sewing techniques that contribute to the preservation of Nunavut Inuit harvesting or lifestyle at the community level. Although focus groups organized by NTI and the Government of Nunavut identified the "strong impact" the program had on harvesters, it has been suggested that additional programming should be offered to teach Inuit youth harvesting, survival and equipment maintenance skills (NTI and GN, 2006).

3.6 Income Distribution

Another key determinant of Inuit health is income distribution. In fact, Health Canada has described income as “the most important determinant of health” (Little, 2006). Drawn from its health impact assessments, the World Health Organization similarly states that higher incomes are linked to better health (WHO, 2013). Access to higher incomes allow for greater disposable income within families and can alleviate cycles of poverty. Overall, the impacts of income on health are strongly connected with a number of other determinants such as education attainment and employment status.

3.6.1 Background

A significant gap exists between the median income of Inuit and non-Aboriginals in Canada. In 2010, Inuit for example, had a median income of \$20,961 compared to \$30,195 for the non-Aboriginal population (Statistics Canada, 2011d).

Data from the 2007-2008 Inuit Health Survey offer one of the most current portraits of the sources of income within Inuit families. For example, 53% of participants in Nunavut, 65% in Nunatsiavut and 69% in Inuvialuit region received their income from wages and salaries, self-employment, carving, sewing, crafts/arts and home daycare. This contrasts with the income derived from other sources such as employment insurance, workers’ compensation, hunters support program and child support found to be 24% in Nunavut, 23% in Nunatsiavut and 12% in the Inuvialuit region. An additional 5% in Nunavut and the Inuvialuit region, and 6% in Nunatsiavut stated that their main source was the income support program (Egeland, 2010).

3.6.2 Challenging Factors

It is well recognized that socio-economic inequalities lead to marginalization, limiting access to education, employment, good housing and nutritious food. Poverty also weighs heavily on mental well-being by lowering self-esteem, increasing dependence, and limiting one’s ability to participate fully in society (NDHSS, 2005; Auger et al., 2004). Specifically in relation to Aboriginal communities, Tjepkema (2002) found that Aboriginal Canadians living in low-income situations have significantly higher levels of fair or poor health (34%) than do middle- (26%) or high-income (14%) Aboriginal Canadians. These potential impacts are intensified within single-parent families as demonstrated by 2006 data from Nunavik suggesting that 34% of those living in the low income range were in single-parent families (Nunavik Regional Board of Health and Social Services, 2011).

The dearth of jobs in Inuit regions is a critical factor relating to the generation of income. Income disparities are particularly pronounced between regional centres and smaller communities. Senecal (2007) indicates that Inuit men are underrepresented in the skill level A category of occupations, which includes senior and middle managers and professionals. Inuit men are also underrepresented in full-time positions, since many work part-time or seasonally. In Nunavik, one-third of full-time jobs are held by non-Inuit, who comprise only 10% of the population (Hodgins, 1997, 123). Hodgins (1997) further notes that the majority of Inuit who are employed full-time are still disadvantaged because they may work for municipalities, co-ops and local businesses that provide fewer benefits and lower pay, or within the traditional economy without benefits.



A final factor to consider when examining income and its relationship to Inuit health is high living costs across Inuit regions. The cost-of-living in these regions is much higher than in southern Canada with heating, electricity, water, gasoline, household goods and grocery foods costing significantly more. For example, a family of four in an isolated Nunavut community would spend \$395 to \$460 a week to buy a basic nutritious diet. This equates to spending \$226 a week in a southern city such as Ottawa (AANDC, 2010).

Overall, this elevated cost-of-living stresses low-income households and prevents families from investing in activities relating to other social health determinants such as education, quality foods, harvesting activities and child care.

3.6.3 Recent Actions to Address this Determinant

Actions that address Inuit education and employment problems will likely have a positive effect on income and its distribution in Inuit regions. An action plan released by ITK in 2007 (ITK and ICC, 2007) outlines a common set of goals for both Inuit and the Government of Canada. The plan presents the following priorities to remedy employment and, by extension, income shortfalls:

- Increase numbers of educated and trained Inuit filling jobs across a broad range of occupational categories;
- Increase numbers of Inuit in apprenticeship programs;
- Maximize Inuit participation in training opportunities; and
- The Government of Canada must identify resources for the recruitment and retention of qualified Inuit in gainful employment within Inuit regions and other parts of Canada.

To address the high cost-of-living in the north and other Inuit-specific factors affecting the adequacy of their incomes, the Nunavut Employees Union recommends that salaries, incomes, and social assistance be adjusted to account for factors such as: household size; high food costs; commodities; utilities and travel; and whether housing is private or subsidized (Rogan, 2003).

3.7 Housing

Adequate housing refers to housing that is affordable (costing less than 30% of before-tax income), does not require major repairs and is not overcrowded (Lewis and Jakubec, 2004). The link between adequate housing and positive health outcomes is strong (CPHO, 2008). For Inuit, the overcrowding of housing is viewed as a clear non-medical health indicator (ITK, 2004) with direct connections to a number of related determinants. Since the majority of Inuit live in social housing units, the availability of adequate and safe social housing is a key concern. The issue of housing has become even more pressing since 1993 when the federal government cut spending to Inuit for social housing, such that all Inuit regions have witnessed a growing housing crisis, especially in Nunavut and Nunavik.

3.7.1 Background

Inuit as a group suffer the worst overcrowding in Canada. It is estimated that 53% of Inuit households are overcrowded, and it is not uncommon for seven or more people to inhabit a single household (ITK, 2004). In Nunavut, 15% of the population is on a waiting list for public housing. ITK estimates that 3300 houses are needed to address the current housing shortage in Nunavut, and an additional 250 units per year would be required thereafter (Ibid). In Nunavik where almost the entire population lives in social housing units, the Nunavik Regional Board of Health and Social Services reported in 2009 that the housing situation posed a major risk to the population's psycho-social and physical health (Déry, 2009). For example, Statistics Canada National Household Survey data for 2011 suggest that 49% of Nunavik Inuit were living in crowded dwellings, while 30% of all Inuit in Canada lived in crowded homes (homes with more than one person per room), compared to 4% of the total population in the country (Statistics Canada, 2011e).

The situation in Nunatsiavut is no different with a 2014 Housing Needs Assessment finding that 15% of households in Nain and 14% in Hopedale are overcrowded. This is roughly 5 times higher than the national average. Moreover, nearly 3 in 4 homes (74%) are in need of major or minor repairs. Data from the 2007-2008 Inuit Health Survey also indicates that 1 in 5 homes provided temporary shelter to homeless visitors (Minich et al, 2011).

3.7.2 Challenging Factors

Housing shortages and poor quality housing are urgent public health priorities for all Inuit regions in Canada. One of the key health impacts relating to poor quality housing is the correlation between cold, dampness and mould and respiratory ailments, particularly in children (Bouchard, 2013). This issue is highly significant since, among Inuit children under the age of 15, 40% lived in crowded homes, about six times the proportion among all children in Canada (7%) (Tait, 2008).

Insufficient housing leads to a number of other health issues such as overcrowding, deficient sanitation and ventilation, the spread of infectious diseases, psycho-social stresses, and violence (CPHO, 2008; Bryant, 2004). Among Inuit, housing problems have been associated with low achievement levels in schools, spousal abuse, respiratory tract infections among infants, depression, and substance abuse (ITK, 2004; NTI, 2005). Hodgins (1997) associates crowded housing with high levels of domestic violence in Nunavik, explaining that a lack of privacy and personal space can increase stress levels to the point at which tense family situations become inescapable violent crises. Women who are victims of family violence and



often their children can seldom find alternative accommodation in their communities due to the lack of housing and shelters (ibid) (currently there are only 15 shelters located in all Inuit regions).

Furthermore, crowded housing and poor ventilation increase the risk of transmission and progression of Tuberculosis (TB). This effect is strongly felt in Nunavik where the incidence of active TB has risen steadily since 2007 to 320.4 cases per 100,000 persons per year in 2012 (Bouchard, 2013). The Chief Public Health Officer of Canada (2008) supports this claim by stating that the number of people per dwelling has been known to greatly impact the physical and mental health of inhabitants, including raising the risk of acquiring tuberculosis.

The high cost of construction in Inuit regions is a contributing factor to the challenges of providing adequate housing to the growing population in Inuit communities. It has also been suggested that overcrowding and extreme weather conditions raise the costs of repairing homes (Gionet, 2008; OAGC, 2011; Tait, 2008). The 2011 National Household Survey shows that about 30% of the total Inuit population lived in homes needing major repairs such as plumbing or electrical work. In contrast, the figure was 7% for the non-Aboriginal population across Canada. In Inuit Nunangat, 36% of Inuit lived in homes in need of major repairs (Statistics Canada, 2011e). Additionally, ITK (2007a) estimates that the average costs for major repairs to one house is \$150,000.

Homelessness is also an increasing challenge that has significant impacts on the health of Inuit. Although Northern homelessness is primarily characterized by relative and hidden homelessness, absolute homelessness (not having a place to sleep at night) does exist (NSWC, 2007). The Nunavut Status of Women Council (2007) has studied the connections between housing and women's health suggesting that women are among the fastest growing groups in the homeless and at-risk population. The Council goes on to state that "abused and abuser are forced to remain in the same dwelling for lack of other accommodation" (38), while many women "couch surf in the homes of relatives or friends, or are living in unhealthy and unsafe conditions, or having to sacrifice other necessities of life (such as food, clothing and medical care) in order to keep a roof over their heads (and often that of their children)" (44).

3.7.3 Recent Actions to Address this Determinant

While the announcement in the 2013 federal budget for funding of \$100 million over two years to support the construction of approximately 250 housing units in Nunavut (AANDC, 2013) is a positive step, a major barrier to establishing social housing programs is the exclusion of Inuit from the federal government's Aboriginal housing programs. Although Inuit and First Nations are often grouped under the same umbrella, there is often a failure to finance and deliver programs equitably among them with the majority of resources being directed to on-reserve First Nations. Between 1993 and 2004, for example, the federal government invested \$3.8 billion in First Nations housing, averaging 2600 new houses per year and the renovation of 3300 more, but no houses were built or renovated in Nunavut during this period (ITK, 2004b).

The Makivik Corporation in Nunavik successfully challenged this social housing inequity by filing a dispute against the Government of Canada, regarding its failure to comply with sections 2.12 and 29.0.2 of the James Bay Northern Quebec Agreement. These sections

state that federal and provincial programs and funding shall apply to the Inuit of Quebec “on the same basis as to other Indians and Inuit of Canada” (ITK, 2004). In July 1999, Canada finally acknowledged its obligation to provide on-going support for social housing to Inuit in Nunavik, and under a new agreement, the Governments of Canada and Quebec each pledged \$10 million annually for the cost of constructing Inuit housing from 2000 to 2005 (Ibid).

This positive result has prompted other Inuit regions to commit the federal government to funding an Inuit and Northern housing package in their regions (NTI, 2006). NTI and the Government of Nunavut submitted a Ten Year Inuit Housing Action Plan to the Department of Indian and Northern Affairs Canada (now Aboriginal Affairs and Northern Development Canada) in August, 2004. The Plan estimates the number of units that are in immediate need of renovation and construction in Nunavut, the number of new units needed per year over the next decade and the plan’s average annual cost. It also outlines the socioeconomic benefits stemming from a long-term housing strategy. A well-coordinated housing program could accomplish the following: provide training opportunities for locals in a variety of trades, including plumbing, carpentry, and electrical; create full-time employment for approximately 1500 people; increase local community expenditures; build capacity and give communities a sense of empowerment; and mitigate health and social problems tied to overcrowding (ITK, 2004b).

In its Annual Report on the State of Inuit Culture and Society, NTI (2006) recommends several other actions be taken to redress Inuit housing problems: the federal, territorial, and municipal governments should clearly define their respective roles in relation to housing; health authorities should work together with housing authorities to explore Inuit-appropriate building designs; and the federal government should develop and implement a multi-year initiative for social housing that identifies immediate and long-term funds, and factors transportation and logistical challenges into its budget.

3.8 Personal Safety and Security

Personal safety and security is seen as a key determinant of Inuit health and for the purposes of this document is defined broadly to comprise the concept of personal safety from violence for both males and females of all ages.

3.8.1 Background

Family, friends and a feeling of belonging to a community give people the sense of being a part of something larger than themselves. Satisfaction with self and community, problem-solving capabilities and the ability to manage life situations can positively influence long-term physical and mental health (CPHO, 2008). One’s social safety net is a critical component to maintaining one’s safety. Participants at the Social Determinants of Health Workshop in Nunavut (NDHSS, 2005) identified one’s social safety net as a key factor relating to Inuit health. This term refers to the availability and quality of family, community and societal supports. The social structure of Inuit communities has changed dramatically from small family networks of approximately 20 individuals, to larger populations. Family relationships have changed in the last 50 years due to changing social conditions and loss of language resulting from close contact with the dominant culture. Some Inuit grandparents and grandchildren may have difficulty communicating because of language loss. The removal of



children to residential schools has also had lasting impacts. These children, now adults, and their families may be negatively affected by problems arising from the early separation from their parents and community and the treatment they received at the schools.

Some family networks have suffered from factors such as addictions and violence or contact with the justice system. For example, the rate of deaths by homicide in Nunavik from 1980 to 1994 was seven times higher than for Quebec as a whole, while in Nunavut, the rate of family-related homicide is over 10 times the national average (Pauktuutit, 2011). Also, data from Nunavik suggest that in 2004 32% of adults stated having been forced or having faced attempts made to force them to perform a sexual act during childhood or adolescence, while 49% of women indicated that they had been victims of sexual assault or attempts to commit sexual assault as a minor (Anctil, 2008). Nevertheless, Inuit surveyed in Nunavik report having at least a small network of people whom they can turn to in times of need (Hodgins, 1997), while only 3% reported having no friends. This situation with respect to support may exist since 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.

3.8.2 Challenging Factors

Rates of domestic violence within Inuit communities are significantly higher compared to other regions in Canada and often violence and maltreatment occur in places where individuals should expect to feel the safest (CPHO, 2008). For example, Nunavut's reported violent crime rate was eight times the Canadian average in 2004. Accordingly, the use of shelters for women victims of violence in the region grew by 54% between 2001 and 2004 (NCCAH, 2012).

Data focusing on Aboriginal women in general from the 2006 Census further indicate that 34% of Aboriginal women in a marital or common-law relationship or who have had contact with an ex-partner in the previous five years reported that they had been emotionally or financially abused by their partner. This level was twice the percentage of non-Aboriginal women who reported being victims of emotional or financial abuse (17%). In 2009, 58% of Aboriginal women who experienced spousal violence reported that they had sustained an injury compared to 41% of non-Aboriginal women (O'Donnell and Wallace, 2012). Additionally, in 2007 the rate of reported sexual assault in Nunavut was significantly higher at 669 reported assaults per 100,000 compared to national averages that year of 65 per 100,000 (NCCAH, 2012).

Forms of domestic violence can additionally extend into later years taking the form of elder abuse. Abuse of elders refers to violence, mistreatment, or neglect experienced in private residences or institutions at the hands of spouses, children, other family members, caregivers, service providers or other individuals in situations of power or trust (Department of Justice, 2009) and can also include financial abuse which in turn can result in elders going hungry.

Another significant negative factor associated with safety is substance use and alcohol misuse which have been identified by Inuit as a primary health and social concern in their communities. Alcohol and some substances can be both contributing factors in problem behaviour, and consequences — a way of coping with violence, abuse and suicidal thoughts. Furthermore, substance use and alcohol misuse are downstream symptoms of societal, cultural and economic disruption and dysfunction (NAHO, 2007).

3.8.3 Recent Actions to Address this Determinant

Increasingly Inuit are working to find ways to strengthen social supports to deal with the issues that are currently impacting personal safety in their communities. Shelters, day care centres, and other social service centres are being expanded. Also, as with health services, social services are actively engaging youth and families in the development of their programs, integrating Inuit-specific knowledge and traditions, and increasing awareness among community members about available services (ITK and ICC, 2007).

The Tukisigiavik Centre in Iqaluit is one example of a culturally appropriate community support centre that offers counselling, healing and other social services. The staffing includes two counsellors and elder advisors who assist people with a variety of issues including homelessness, family problems, parenting, anger management, employment strategies, and acquiring traditional skills. The centre benefits the community in several ways: it offers services close to home; it provides local employment opportunities for youth and elders; and it reduces the need for expensive medical transfers to the south (George, 2004).

At the regional level, a number of government financial supports exist such as Employment Insurance and Social Assistance. However, overall financial assistance from the federal government is insufficient as a result of not being adjusted to the high cost-of-living in the North. Ultimately, the federal government must tailor its assistance programs to the unique needs of Inuit living in the North.

In order to address substance abuse, a harm reduction approach and associated strategies are seen as a necessary part of treatment and problem-resolution. These strategies include a broad continuum of responses, from safer substance use to abstinence (NAHO, 2007). With respect to addressing the prevalence of abuse, Pauktuutit (2011) has tabled a National Strategy to Prevent Abuse in Inuit Communities. This report identifies the following priorities:

- Make abuse in Inuit communities a priority issue;
- Raise awareness and reduce tolerance of abuse;
- Invest in training and capacity development;
- Sustain front-line workers and community services;
- Deliver services that heal Inuit; and
- Expand programs that build on Inuit strengths and prevent abuse.

3.9 Education

An increasing amount of literature (Bjerregaard and Young, 1998; Kirmayer et al., 1998; Korhonen, 2006; Little, 2006; NCCAH, 2012, Young, 1996) indicates a strong correlation between education attainment and Inuit well-being. More specifically, education is closely linked with socio-economic status and income security for individuals and their families (NCCAH, 2012). As a result, increases in the level of educational attainment among Inuit will have a positive impact on Inuit health.

Education in this document refers to learning throughout the life span and includes early childhood development initiatives, primary school, secondary school, post-secondary school and job skills training as well as learning in informal settings such as while participating in on-the-land activities.



3.9.1 Background

While notable advances have been made by Inuit in gaining formal education and school attendance over the past three decades, there is still a pronounced disparity between the educational attainment of Inuit and non-Inuit Canadians. Overall, access to formal education is limited in the North. There is a particularly strong need to enhance child care infrastructure and early childhood programming in Inuit communities.

Most Inuit communities now offer schooling up to the end of high school with a growing number of Inuit completing high school and moving on to post-secondary studies (Statistics Canada, 2008). However, dropout rates continue to be higher in Inuit communities than the Canadian average. In 2011, 67% of Inuit in Inuit Nunangat aged 20 to 24 years had less than a high school diploma (Statistics Canada, 2011f). When asked why they did not finish elementary or high school, the most common responses given by Inuit men were that they wanted to work (18%), they were bored (18%) or they had to work (14%). The most commonly cited reason by Inuit women was pregnancy/taking care of children (24%) (Statistics Canada, 2008).

In 2011, among Inuit aged 25 to 64, 36% had a post-secondary degree or diploma. While 13% had a trades or apprenticeship certificate, 16% had a college diploma. At the university level, 2% had a degree below the bachelors level and 5% had a bachelors degree or higher (Statistics Canada 2011f).

There is also a strong geographic component to educational attainment among the Inuit population. For example, 53% of Inuit adults aged 25 to 64 living outside Inuit Nunangat had a postsecondary education. In Nunatsiavut and the Inuvialuit region, one third (33% and 32%) of Inuit adults had a postsecondary certificate, compared to 29% in Nunavut and 24% in Nunavik (Statistics Canada, 2011f).

Another positive factor is the increase in efforts to use Inuit language in schools. For example, Nunavut Tunngavik Incorporated (NTI) policy documents have indicated that “full bilingualism in the Inuit language and English is the desired outcome for Inuit students who participate in the Nunavut education system” (NTI, 2007) and that the teaching workforce should increasingly be made up of Inuit teachers. Similarly in practice, Nunavut schools currently offer Inuktitut instruction from Kindergarten to grade 3. Statistics Canada data further suggest that Inuit children are being exposed to Inuktitut in schools and are being trained by a growing cohort of Inuit teachers. For example, among Inuit aged 15 and over who had gone to school, nearly four in 10 (38%) indicated that they had an Inuk teacher in their final year of school. This was more likely among younger generations of Inuit as about half (48%) of those aged 15 to 24 had an Inuk teacher in their last year of school compared to 14% of those aged 45 to 64 (Gionet, 2008).

3.9.2 Challenging Factors

A number of factors can be associated with low education levels. One such factor is poor literacy which in turn can threaten health both directly and indirectly. Directly, it can lead to accidents and injuries when warning labels, operating instructions, and safety manuals are misunderstood, or the exacerbation of illnesses when patients misunderstand information on the use medications and information given to them by a healthcare practitioner (Korhonen, 2006). Indirectly, low literacy contributes to poor health outcomes by influencing other social health factors, such as employment, income, access to housing, and access to societal supports.

People with limited literacy are more likely to be unemployed and to be working for minimum wage (Ronson and Rootman, 2004). They are also more likely to live and work in unhealthy environments. Furthermore, people with limited literacy are not as aware of societal supports and make less use of preventive services (Ibid). Consequently, they tend to have higher stress levels and feel more vulnerable and alienated, and they may resort to adverse coping practices. On the positive side, educational attainment and literacy can facilitate one's access to health-related knowledge, rewarding employment, higher income, better housing and further education, which in turn can foster self-empowerment (Korhonen, 2006).

Inuit are challenged by numerous barriers to attaining high levels of education in connection to other determinants of health. Crowded housing, for example, is one factor which makes it difficult for young Inuit to find a quiet study space in their homes. Also, some Inuit youth feel unsupported by their parents, especially if their parents dropped out of school at an early age. Another educational barrier confronting Inuit are school curricula that may have been developed in the south and which lack cultural relevance. Thomas Berger's final report on the implementation of the Nunavut Land Claims Agreement states, "a broken school system is at the root of Nunavut's problems" (McCluskey, 2005), pointing to the lack of a comprehensive, well-designed bilingual education system that can produce graduates who are competent in both Inuktitut and English. Instead, many Inuit who go through the school system feel proficient in neither. Expanding the number of Inuktitut-speaking teachers is a key action necessary in order to establish a fully bilingual K to 12 education system in Inuit regions.

In addition, very few Inuit high school students take advanced courses in science, math and English and consequently do not have the prerequisites necessary to progress to many post-secondary programs. Some suggest that this is related to typically lower educational standards in Inuit schools. For example in Iqaluit, Nunavut, teachers claim that three-quarters of grade 8 students read below their grade level, and many students who do graduate complain that they are ill-prepared for university and have to spend a year or two taking college courses to improve their literacy (Korhonen, 2006).

A further factor inhibiting Inuit educational achievement is the relative absence of post-secondary programs in Inuit communities. While post-secondary institutions do exist such as Nunavut Arctic College and Aurora College, Inuit interested in pursuing higher education degrees usually have to move to city centres in the south to attend college or university, which can be a significant deterrent.

In the Inuit context, education as a social influence on health should not refer solely to formal education and literacy. When evaluating education among Inuit, traditional knowledge should also be taken into account, as possession of traditional knowledge and survival skills likely benefits one's health. No Inuit-specific study exists which correlates the degree of traditional knowledge to health, though such a correlation has been delineated in other populations. Furthermore, Inuit organizations emphasize that the endurance of traditions and the existence of opportunities for Elders to pass knowledge and skills to youth are essential to community well-being. Thus, the relationship between traditional education and Inuit health should be included in any discussion of educational determinants of health.



3.9.3 Recent Actions to Address this Determinant

Addressing education gaps is critical for improving the health status, employment prospects, and self-governance of Inuit. The Government of Nunavut (2004), the Task Force on Aboriginal Languages and Cultures (2005), Thomas Berger, NTI (2007) and ITK (2011) have all put forward reports and strategies over the last decade outlining policies and programs that can assist Inuit in meeting their educational objectives. The most recent of which has been the National Strategy on Inuit Education tabled by ITK in 2011. These reports and the National Strategy in particular highlight a number of shared priorities and important strategies, some of which have been acted upon and others which still remain to be realized.

One commonly expressed need is for the development of a bilingual education system that reflects the history, values, and beliefs of Inuit, while fostering students who are equally competent in English and Inuktitut and in high-level academic courses by the time they graduate. The 2006 Berger Report for example recommends that Inuit schools help students establish a strong foundation in their Inuit language first, and then introduce English/French as a second language. In this way, it is suggested that fluency in one language will facilitate learning of the second language.

Overall, the development of bilingual education strategies in all Inuit regions involves a tremendous amount of work and requires significant resources from territorial, provincial and federal governments. One key component of a successful bilingual education system is the training of greater numbers of Inuit teachers for the school system (Government of Nunavut, 2004; ITK, 2011). While teacher training programs working in Inuit regions, such as the one administered through the Kativik School Board of Nunavik, have produced a significant number of Inuit teachers, considerable effort is still necessary to ensure a workforce of Inuktitut speaking teachers at all grade levels. The Nunavut Masters of Educational Leadership degree which in 2013 resulted in the graduation of a second cohort of Inuit students exemplifies the recent efforts to support capacity building in the area of educational leadership and expand the academic offerings available in Inuit regions.

Additionally, the National Strategy on Inuit Education tabled by ITK in 2011 is a notable example of recent efforts to expand the discussion of Inuit education to a national scope. This document includes ten recommendations to address the key areas of Inuit education. The ten recommendations include the following:

- Mobilizing Parents;
- Developing Leaders in Inuit Education;
- Increasing the Number of Bilingual Educators and Programs;
- Investing in the Early Years;
- Strengthening Kindergarten to Grade 12 by Investing in Inuit-Centred Curriculum and Language Resources;
- Improving Services to Students Who Require Additional Support;
- Increasing Success in Post-Secondary Education;
- Establishing a University in Inuit Nunangat;
- Establishing a Standardized Inuit Language Writing System; and
- Establishing a National Capacity for Standards and Applied Research in Inuit Education for Measuring and Assessing Success.

The National Committee on Inuit Education has prioritized four of the National Strategy's ten recommendations for implementation. These include: Mobilizing Parents; Improving Access to Quality Early Childhood Education; Measuring and Assessing Success; and a Unified Inuit Writing System (ITK, 2014).

3.10 Food Security

Food security is a key determinant of physical and psychological health. A commonly accepted definition of food security that was endorsed by the Government of Canada comes from the 1996 World Food Summit which states that "food security exists when all people, at all times, have physical and economic access to sufficient, safe, and nutritious food to meet their dietary needs and food preferences for an active and healthy life". Overall, food security suggests that "better nutrition means stronger immune systems, less illness and better health" (World Health Organization 2014b). Accordingly, individuals who are food insecure are more susceptible to malnutrition, infection, chronic health problems, tend to be preoccupied with food access, feel a loss of control, and struggle psychologically (Lambden et al., 2006). Severe food insecurity is defined as disrupted eating patterns and reduced food intake among adults and / or children (Office of Nutrition Policy and Promotion, 2007). Other noted effects of food insecurity include a reduced ability to learn, depression, and social exclusion.

3.10.1 Background

An alarming percentage of Inuit are food insecure (Council of Canadian Academies, 2014). Recent data available on food security comes from the Inuit Health Survey conducted in 2007-2008 and the Qanuippitaa 2004 health survey in Nunavik. Results from both surveys indicate that food insecurity remains a significant issue in Inuit communities. Results from the Inuit Health Survey in Nunavut highlight that less than one-third of households reported that they had enough food to eat (were food secure), while 35% of households reported severe food insecurity. According to the Qanuippitaa health survey, 24% of the population of Nunavik reported experiencing food insecurity during the month preceding the survey, reaching 32% on the Hudson coast (Nunavik Regional Board of Health and Social Services, 2012).

In contrast, according to the 2004 Canadian Community Health Survey (CCHS), only 9% of all Canadian households reported moderate or severe food insecurity. Comparisons between this data and earlier studies looking at the similar topic point to food insecurity as a consistent problem such that data drawn from questionnaires conducted in Inuit communities in 2004 suggest that 58.3% of Inuit respondents between the ages of 20 and 40 reported that their family could not afford to buy all the food they needed from the store (Lambden et al., 2006). Data from the 2007-2008 Inuit Health Survey parallels this description of food insecurity such that 61.1% of respondents indicated that they were worried that food for them and their family would run out before they had enough money to buy more (Rosol et al, 2011).

Since unemployment, low income and the high cost of food were cited as the primary reasons for food insecurity by respondents in the Inuit Health Survey, access to and consumption of traditional food becomes increasingly important (Egeland, 2011). The eating and sharing of country foods remains strong (Egeland, 2010). Continued access to country foods additionally suggests that Inuit are benefiting from the cultural factors associated with taking part in harvesting activities discussed in sections above.



3.10.2 Challenging Factors

Some key factors that contribute to food insecurity include low income, changing dietary habits, high cost of food, lack of awareness of healthy eating habits (Boult, 2004) as well as climate change, overcrowding, and environmental contamination. Another barrier to food security relates to education since some Inuit are unable to harvest country food because they lack the appropriate hunting skills. Other individuals lack knowledge in how to prepare nutritious meals with less expensive ingredients, or how to budget expenses (NDHSS, 2005; Chan et al., 2006). In addition, low availability and quality of market food exists since many Inuit communities have only one grocery store and perishable foods must be shipped long distances. As a consequence, healthy perishable foods are often rotten or damaged by the time they reach community stores.

Inuit are undergoing a dietary transition as a result of numerous societal and environmental changes. This transition is characterized as a move away from traditional food which has notable consequences for diet quality, nutrient intakes and nutritional status since consuming even small amounts of traditional food can be of benefit (Egeland, 2011). For example, results from the 2007-2008 Inuit Health Survey suggest that Inuit are consuming a greater portion of their calories from sugar-rich foods such that on days when traditional food was consumed 22.7% of energy came from protein and 37.2% of energy came from carbohydrates as opposed to 13.9% of energy from protein and 50.8% of energy from carbohydrate when no traditional food was consumed (Egeland et al, 2011). Overall, the circumstances outlined above underline the need for addressing food security via a holistic approach that tackles food costs, unemployment, income levels, and other Inuit-specific needs, such as harvesting support and access to traditional foods.

3.10.3 Recent Actions to Address this Determinant

A number of initiatives have been undertaken in an attempt to address factors associated with food security. One program set up to reduce the cost of food with a focus on nutritious perishables is the Nutrition North Canada Program which replaced the Food Mail Program in 2012. Initiated by Aboriginal Affairs and Northern Development Canada in collaboration with Health Canada, this program has subsidized shipping costs for nutritious perishable food and other items. It is noteworthy, however, that the Nutrition North Canada program no longer provides an air transportation subsidy through Canada Post, but instead provides subsidies directly to retailers. This change has yet to be evaluated to assess whether it has met the program's objectives and is in fact leading to a decrease in food costs for Inuit consumers.

Across Inuit Nunangat, the education-related factors impacting on food insecurity are being addressed through nutrition education programs, which encourage Inuit to make more nutritious food choices as seen in the community-based Healthy Foods North program (<http://www.aghr.org/healthy-foods-north/>), which promotes healthy eating and lifestyles in Nunavut and the Northwest Territories, and to use healthier cooking methods as observed by the Government of Nunavut's efforts to offer information such as recipes to encourage the purchase of healthier foods. Education initiatives led by Health Canada have also been included in the Nutrition North Program.

In Nunavut, government departments, Inuit organizations, non-governmental organizations and the private sector have formed the Nunavut Food Security Coalition. In 2014, the Coalition released the Nunavut Food Security Strategy and Action Plan which aims to provide

all Nunavummiut with an adequate supply of safe, culturally preferable, affordable, nutritious food, and incorporate a food system that promotes Inuit Societal Values, more self-reliance and environmental sustainability (Nunavut Food Security Strategy and Action Plan 2013-2016).

As mentioned earlier, harvester support programs are also in place to improve access to country foods by offering financial assistance to individuals and Hunters and Trappers Associations for equipment or to organize community events such as feasts. However, there is an overarching need for more funding for these programs. Furthermore, a great need remains for addressing the broader socio-economic determinants of food insecurity in order to achieve long-term food security. Facilitating Inuit regions' access to funding, changing the wage-to-cost ratio, and reducing disparities in employment, income, and housing are key priorities for improving Inuit food security and health (Lawn and Harvey, 2003; Chan et al., 2006), while at the international level efforts to reduce the impacts of contaminants and climate change on the northern food system are necessary.

3.11 Availability of Health Services

The ability to access health care services is a critical social determinant of Inuit health. Despite Canada's universal health care system that aims to protect the health of all citizens, not all Canadians have equal access to high quality care. Canadian Inuit face significant challenges in accessing health services, not only relating to physical access, but also the nature, quality and appropriateness of the services (NCCAH, 2011).

3.11.1 Background

Access to health services is limited in Inuit Nunangat. Apart from regional centres, the majority of Inuit communities lack hospitals. Health care is alternatively delivered through community health centres primarily staffed by Community Health Nurses and Nurse Practitioners (ITK, 2010). For dental care, the majority of communities do not have resident dental therapists and must rely on periodic visits from contracted dental professionals (Health Canada, 2011). Other specialist services are often not available, requiring patients to leave their communities and travel to southern cities for care (ITK, 2010).

As a result of accessibility challenges in the regions, Inuit are less likely to have contact with health care professionals. Data from the 2006 Aboriginal Peoples Survey indicate that only 56% of Inuit adults had contact with a medical doctor in the previous year compared to 79% for non-Aboriginal Canadians (Statistics Canada, 2008). According to the Inuit Oral Health Survey, only 50% of Inuit visited a dental care provider in the previous year compared to 75% of southern Canadians (Health Canada, 2011). Limited access to health care professionals can result in diagnosis and treatment delays (NCCAH, 2011). It is also in part reflected by the significant health disparities that exist between Inuit when compared to rest of the Canadian population.

3.11.2 Challenging Factors

Inuit often face multiple barriers in accessing the Canadian health care system. Challenges relating to geography, culture and language, and health human resourcing have led to poor health outcomes among the population.



Characterized by their remoteness, Inuit communities are geographically isolated in Canada's North which generates a unique set of health delivery challenges. A reduced number of health services and health professionals result in patients having to leave their communities to access more specialized care. Inuit are regularly flown to southern centres for medical emergencies, hospitalization, appointments with medical specialists, diagnosis and treatments (ITK, 2004a). Medical travel results in a significant cost to the health care system, not only for the medical services but also the expenditures related to the travel and accommodation. There are also collateral impacts to individuals and families who may be required to spend longer periods of time away from their communities and support networks (NCCAH, 2011).

The figure below depicts travel routes between outlying Inuit communities and regional "hubs" (starred) where Inuit must travel to access health care services that are integral to care. When consultation with a specialist is needed, Inuit must travel long distances to centres outside of Inuit Nunangat such as Happy Valley-Goose Bay, Ottawa, Montreal, Winnipeg, or Edmonton.

Inuit Medical Travel Map



Another key factor that impacts health services is the cultural appropriateness of services. Inuit frequently face cultural and language barriers, which can leave patients feeling misunderstood, marginalized, and mistreated (Archibald and Grey, 2006). The concept of health for Inuit embodies a holistic view between the mind, body, spirit and emotion. However, health care services are often based on westernized medical systems, and may not be culturally responsive to Inuit by incorporating traditional practices (NCCAH, 2011). Additionally, for individuals who communicate exclusively in Inuit dialects, language barriers may hinder care (Archibald and Grey, 2006).

Sufficient health human resources are another ongoing challenge in Inuit Nunangat. The remoteness of communities often engenders low recruitment and retention rates of permanent health professionals. The shortage of medical staff results in less continuity of care, which in turn reduces the overall effectiveness of the health care system (NCCAH, 2011). Inuit health care professionals can bring an innate understanding of the cultural context within communities. However, there are very few Inuit working in the health care system. For non-Inuit health care professionals, training is often not sufficient to bridge Inuit beliefs and traditions with modern practices in the health care setting (ITK, 2010).

3.11.3 Recent Actions to Address this Determinant

A layered approach must be taken to address the challenges Inuit experience when accessing health services. Actions will be required to remove the immediate challenges that can inhibit Inuit in receiving high quality care by a medical professional. Moreover, associated social determinants of health need to be addressed since they frequently predispose Inuit patients to inadequate access to health care services. A community member articulated the need for a holistic approach by stating that “until housing shortages are gone, until there is an economy that can support the growing number of young people reaching working age, until the education system can produce more high school graduates, and until a wide range of post-secondary opportunities are available in the north, the situation is unlikely to change.” (Archibald and Grey, 2006).

A number of efforts are being focused on strengthening the overall health care system for Inuit. Inuit are calling for a change in the structure of health care through legislation that grants autonomy in the design, development and delivery of services (ITK and ICC, 2007). Currently, provincial/territorial and other agencies provide health services to Inuit communities in an ad hoc fashion through a variety of delivery methods. Inuit-specific treatment programs and services could better meet the needs of communities by incorporating traditional healing approaches, responding to priorities, and provide a continuum of care (Nunavut Department of Health and Social Services, 2005; Archibald and Grey, 2006).

Initiatives are also highlighting the need to reform human health resources in Inuit communities such as in the *Inuit Health Human Resources Framework and Action Plan*. The document prioritizes the need to increase the number of Inuit health professionals, improve culturally safe and relevant health services and support the recruitment and retention of health-care providers in Inuit communities. (ITK, 2010). Notable progress has already been made at addressing some of these human health resource challenges. The Nunavut Arctic College in Iqaluit continues to offer a nursing program in partnership with Dalhousie University that focuses on Inuit graduates. As a result, birthing centres staffed by Inuit midwives are now more common in various Inuit communities. The Inuulitsivik Health Centre in Puvirnituq started a maternity program in 1986 that reintroduced perinatal services to the Hudson coast which has given women an opportunity to give birth closer to home. The Nunavik Regional Board of Health and Social Services has reported that similar services are now available in four communities in Nunavik.



Overall, in the face of high turnover and persistent shortages of health professionals, increasing access to culturally appropriate, quality health services will have a positive impact on Inuit health. As the availability of services increase, so can the benefits from disease prevention and health promotion activities, disease screening, advice on healthy living and mental health counselling (CPHO, 2008).

The document titled *Building Inuit Nunaat: The Inuit Action Plan* (ITK and ICC, 2007) emphasizes the need for long-term funding based on demand, operating costs, and remoteness, instead of the per capita allocations that are used now. With this in mind, the federal government must recognize the unique realities of Inuit such as the high costs of medical transportation, the difficulties associated with retaining southern practitioners and training new Inuit health staff.

3.12 Mental Wellness

Mental wellness is a key determinant of health for Inuit. Mental wellness encompasses a wide range of factors such as mental health, suicide prevention, mental illness, violence reduction, and prevention and treatment of addictions and substance abuse. For Inuit, mental wellness refers to “physical, emotional, mental and spiritual wellness, as well as strong cultural identity” (NAHO, 2013). Accordingly, this determinant is strongly connected to a great many of the other determinants discussed in this paper such as safety, access to health services, livelihoods, education and culture and language.

3.12.1 Background

Supporting mental wellness among Inuit is central to addressing a wide range of issues associated with health. However, there are insufficient funds to support a comprehensive Mental Wellness continuum of programs, especially with respect to facilities and infrastructure as well as in the areas of intervention and treatment (ITK, 2007c). Research summarized by Health Canada (2005) indicates the following factors are supports to positive mental health: family and community support; sense of belonging; positive self-esteem; skills in problem solving; cultural values and religious beliefs; positive attitude toward school; early identification and appropriate treatment of psychiatric illness; and easy access to a variety of medical and psychological services.

3.12.2 Challenging Factors

As mentioned in the Culture and Language section above, the ‘trauma’ brought on by colonization, relocation, dog-slaughter and the legacy of residential schools remains a key barrier to building both the community and family supports to address mental wellness. This unresolved trauma has compromised many individuals to cope with stress in an unhealthy manner and has been referred to as the intergenerational transmission of historical trauma (Suicide Prevention Strategy Working Group, 2010). Moreover, a key driving force of mental illness, particularly in young men, may in part be due to environmental changes and the consequent cultural change in the form of loss of traditional roles and values associated with a move away from subsistence activities such as hunting (Kirmayer et al, 2000).

Other challenges to addressing mental health in Inuit communities stem from factors such as “lack of recognition, poverty, housing issues, violence, abuse, addictions, and inter-generational trauma related to residential schooling” (Cameron, 2011). The many dimensions

of violence against women, men and children are of critical concern. Additionally, youth suicide is of high concern for Inuit since suicide rates for Inuit youth are among the highest in the world, at 11 times the Canadian national average (Statistics Canada, 2008). Hicks (2004) suggests that in Nunavut between 1989-1993 the rate was 79 cases in 100,000, but had risen to 119.7 cases for the years 1999-2003. As a result, many Inuit communities today experience loss and grieving on a regular basis (Nelson, 2012).

In addition, access to appropriate and timely mental health services is a key factor due largely to the circumstances in Inuit communities described in the above Access to Health Services section. Addictions are another related factor since substance abuse can intensify the negative factors impacting mental health. Moreover, addictions to alcohol and other substances have been linked specifically to poor housing, low income, unemployment, and single parenting (NDHSS, 2005). Suggestions for addressing addictions include: developing community-based de-tox programs that are land-based and involve elders; increasing community capacity to deal with addictions; improving socioeconomic conditions; and enacting stronger policies on the illegal trade of alcohol, drugs, and tobacco (Ibid).

3.12.3 Recent Actions to Address this Determinant

Increasingly, actions are being taken at the community, regional and national levels to address key factors that influence mental health in Inuit communities. For example, Cameron (2011) outlines a number of projects and initiatives that have begun across Inuit Nunangat in support of suicide prevention (Ajunnginiq Centre 2006c; Inungni Sapujjijit: Task Force on Suicide Prevention and Community Healing 2003; National Inuit Youth Council, Inuit Tapiriit Kanatami, and Ajunnginiq Centre 2005; National Inuit Youth Council et al. 2009; Stevenson and Ellsworth 2004). In the area of addictions, initiatives such as the Nunavut Suicide Prevention Strategy, finalized in 2010, represents a recent example of a government policy created to address the factors impacting mental wellness, while the 12-week Inuit Intergenerational Trauma and Addictions Healing Program offered in 2012 by the Nunatsiavut Department of Health and Social Development represents a successful example of community-based programming to support mental wellness.

With respect to Inuit Nunangat, the Alianat Inuit Mental Wellness Action Plan published by ITK in 2007 outlines a number of strategic goals designed to focus actions in this area. These goals are:

- To ensure a continuum of culturally relevant mental wellness programs and supports, including traditional/cultural and clinical approaches;
- To recognize the community as the best resource in addressing mental wellness and invest in community capacity;
- To increase resources at the community level for the mental wellness continuum;
- To ensure Inuit-specific data, research, information, knowledge and training are available; and
- To enable implementation through strong partnerships with stakeholders at all levels.



3.13 Environment

The environment is not conventionally considered a “social” determinant of health, but for Inuit it is a key determinant of health and worthy of mention. Environment as a concept is defined for this document as the land, sea and air environments surrounding Inuit communities, but also includes the indoor environments within homes and workplaces. Inuit across Canada have witnessed significant environmental changes in recent decades with extensive research concretely showing that the Arctic environment is stressed and undergoing irreversible changes. These environmental changes closely affect human health, especially in Inuit communities which have close ties to the land.

3.13.1 Background

The Government of Nunavut’s Department of Health and Social Services (2005) writes “if the health of the land is endangered then so is the health of the people” (17). This statement holds true especially for Inuit due to the close and lasting relationship they have with the environment compounded by their continued reliance on a subsistence way of life. Major threats to the Arctic environment such as global climate change and the presence of contaminants can strongly affect Inuit food security, as well as social, economic, spiritual, and cultural conditions. Building public awareness of the relative risks from a changing environment and associated health impacts is one key factor in supporting a sustainable environment.

3.13.2 Challenging Factors

A key factor impacting the environment of Inuit regions is the presence of contaminants (NCCAH, 2012). Research suggests that major health problems such as cancer, diabetes and low infant weight may be related to the amount of chemical contaminants in the environment. High levels of contaminants in the environment, therefore, have critical implications for Inuit who experience chronic exposure (ITK, 2007a).

Climate change represents another key factor that will have significant impacts on the environment in Inuit regions. Already, significant changes such as reductions in the sea ice cover, snow cover, glaciers and the Greenland ice sheet are affecting climate and ecosystems throughout Inuit Nunangat (NOAA, 2013). These changes in turn have a significant impact on Inuit communities and overall economic development within the region. For example, Inuit hunters are traveling further, or along adjusted routes, to harvest country foods as a result of altered migration and travel routes. This adaptation to environmental changes has had a significant impact on food security in Inuit communities by increasing household expenditures to access country foods, and threatening the safety of hunters using new and increasingly risky travel routes (Nickels et al, 2005).

Long-term climate change may also lead to other health impacts. For example, sea level rise and changes in the distribution and composition of permafrost (which is already documented) may increase the risk of communities becoming flooded or moved. These disruptions in turn could increase dietary problems associated with impacts from these and other ecosystem changes and lead to psychological disruptions for Inuit associated with infrastructure damages and population displacements (ITK, 2007b).

3.13.3 Recent Actions to Address this Determinant

In the face of rapid environment changes in Inuit regions, Inuit themselves are well aware of climate changes and the need for adaptation. The Inuit perspective on climate change was outlined in a 2005 consultation process titled, *Unikaaqatigiit: Putting the Human Face on Climate Change: Perspectives from Inuit in Canada* (Nickels et al, 2005). Results from this project outline the responses provided during a series of workshops on issues relating to climate change. Inuit observations state that climate change has to date mostly resulted in negative impacts that, in some cases, require significant adaptive measures (ITK, 2007a).

Increased monitoring of environmental factors is another action which can support adaptive measures addressing environmental change. A number of organizations and government programs have been conducting research to supply data in order to help inform adaptation strategies and policies responding to environmental change. Examples of multidisciplinary research and training centres focusing on environment, health and food security issues include the Centre for Indigenous Peoples' Nutrition and Environment (CINE) located at McGill University, Quebec and the Nasivvik Centre for Inuit Health and Changing Environments based at Laval University and Trent University (Note: Canadian Institutes of Health Research funding provided to the Nasivvik Centre is due to sunset in March 2014). Some of the other key federal government programs supporting data collection on aspects of the environment in Inuit Nunangat include the Arctic Monitoring and Assessment Program and the Northern Contaminants Program.



4. Conclusion

Over the last 10 years, Inuit have been engaged in significant efforts to improve the current socio-economic conditions in their communities. Progress is being made. However, substantial work remains to address conditions that lead to high rates of suicide, respiratory tract infections, smoking, and other ailments. These conditions correlate with widespread housing shortages, unemployment, acculturation stress, inadequate incomes and low educational attainment throughout the Inuit regions. These social factors in turn influence other determinants of Inuit health such as early childhood development and food security, which compound existing health challenges.

With the understanding that the most effective actions will be those that can address the driving forces behind socio-economic conditions, increasing and improving data collection on Inuit health must be a major focus for Inuit governments and organizations since “accurate information is one of the cornerstones of the health planning process” (Elliott and Macaulay, 2004).

Historically, programs and research on Inuit health have focused on narrow indicators of health status without investigating a holistic view of social determinants of health as they relate to Inuit specifically. Therefore, future health initiatives must focus on issues such as food security, acculturation, and livelihoods as well as specific health outcomes. This change in focus would facilitate a more realistic perspective of Inuit health for Inuit organizations and governments.

In spite of continuing pressures, Inuit have developed a considerable political voice and organizational capacity, swiftly progressing toward self-determination through the signing of Land Claim Agreements, a Partnership Accord, and the election of Inuit governments. By increasing levels of self-determination in their regions, Inuit will be able to restructure and enhance their socio-economic sectors, integrating Inuit culture, language, and knowledge in a way that is conducive to Inuit pride, dignity, harmony, and health. During this process, the Government of Canada must support Inuit by implementing Land Claim Agreements, involving Inuit in policy-making and program design, and providing long-term, adequate funding for development.

With adequate financial support from all levels of government, coordinated, holistic and innovative approaches can be taken, to not only treat the ill, but to address those factors contributing to the health status of Inuit. More specifically, regional Inuit associations are ideally situated to discern the priorities and assets of each community and to assist communities in developing employment opportunities, health programs, social housing projects, education programs, and other social supports that will improve Inuit health. Whether for the design of a new education system or the administration of culturally appropriate health services, Inuit governments and organizations will continue to actively advocate for Inuit-specific policies, Inuit-designed programs, and Inuit employment.

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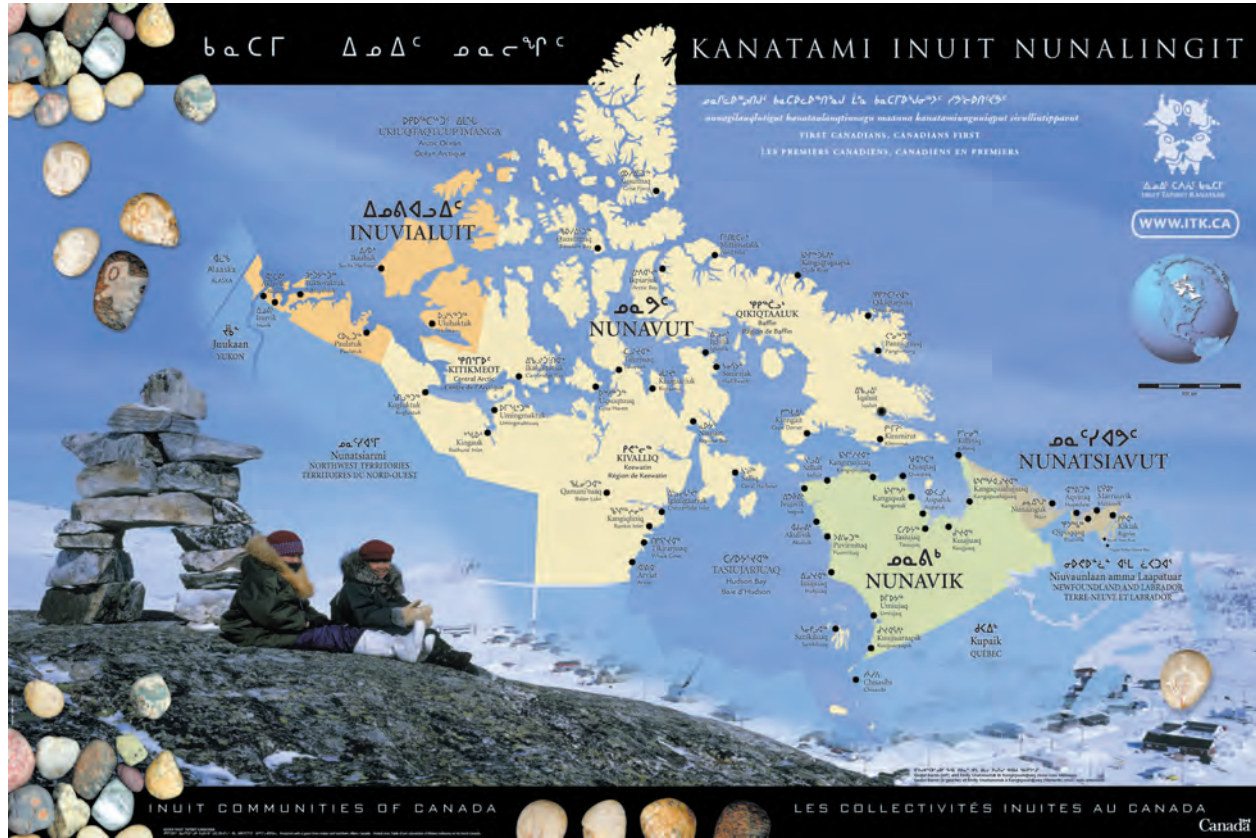


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Appendix 1. Map of Inuit Regions



From ITK website: <http://www.itk.ca/publications/index.php>



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