Northern and Indigenous Health and Healthcare

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HEATHER EXNER-PIROT, BENTE NORBYE, AND LORNA BUTLER

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This Open Education Resource on *Northern and Indigenous Health and Health Care* is an initiative of the University of the Arctic Thematic Network (TN) on Northern Nursing Education.

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Introduction

Northern and Indigenous Health and Health Care

Heather Exner-Pirot, Bente Norbye and Lorna Butler, Editors

Welcome to this Open Education Resource on *Northern and Indigenous Health and Health Care*. With this volume, we hope to address a fundamental gap in nursing and health science education: a lack of textbooks or other resources that are focused on northern and Indigenous health care. Our goal is to respond to the needs of northern health care providers and the unique context in which they practice.

Northern health care is unique. The Circumpolar North is characterized by small communities in sparsely populated regions, separated by large distances and marked by distinct cultures. Weather – cold, snow, ice and wind – influences everything, including the practice of health care. Practitioners, such as paramedics, physicians, dentists, social workers, pharmacists, public health officers, and nurses, are more likely to work in small teams and in isolation from mainstream supports and specialists. They are more likely to take care of a larger range of social, economic and psychological issues. They are more likely to be considered as an important member, partner, and even a leader, of their northern community. Northern practitioners must be resilient, resourceful and collaborative. This volume aspires to help prepare them for those responsibilities.

This Open Education Resource has been led by the University of the Arctic Northern Nursing Education Network (NNEN). The NNEN includes twelve nursing schools in Canada, Finland, Greenland, Iceland, Norway, Sweden, and Russia, who deliver baccalaureate nursing programs in rural and remote northern regions. There are multiple intended audiences for this publication, but foremost amongst them are the NNEN's own northern nursing students, and other health science students studying in the North. This Open Education Resource aims to reflect what they can expect to see and experience in northern practice, rather than always having to adapt mainstream southern or urban practices to their own contexts. We see and value northern health care practice and seek to centre it here.

An additional intended audience includes health science students studying at large, traditional campuses who may be curious about or would benefit from an orientation to what practice in a different health care setting looks like. Almost every health professional program today seeks to develop cultural competency for their students, and many 'southern' health care practitioners working in the eight Arctic states will at some point be required to provide care to a northern client or work as part of a care team with northern practitioners. This volume may be useful in orienting them to the realities of health care in a northern context.

Finally, for the many southern practitioners who may assume roles in northern practice settings, either in locum or contract positions, for a few years of northern experience, or as a permanent settler, it is our hope that this volume may provide a useful introduction to northern clinical care and the unique expectations and responsibilities it entails.

There is a deliberate circumpolar flavour to these writings that reflect the diversity of the North and the ways in which northern health care differs even across similar geographic conditions. Our hope is that this comparative perspective will encourage readers to better understand what makes their own professional contexts unique, as well as be inspired by the things that are possible despite, or in many cases because, they are practicing in northern communities.

The learning objectives of this Open Education Resource include:

- Understanding the unique healthcare needs and professional responsibilities that result from remoteness and population sparsity;
- Identifying the social, environmental and cultural aspects of a community that inform and impact care needs;
- Appreciating traditional and Indigenous medicines and approaches to healing as part of a holistic health care system; and
- Exploring the similarities and differences in northern health care across the circumpolar region.

Much of this volume is written from a nursing perspective, reflective of the make-up of the health care workforce across the Circumpolar North. Nurses play a key role in providing primary care and services in small, rural communities. At the same time, northern health care is necessarily inter-professional as health care practitioners need to work together to address community health challenges. Collaboration outside of the traditional health care system is imperative: northern community leaders, elders, teachers, police and other community members play essential roles in supporting health and well-being. This Open Education Resource can be and should be relevant to all stakeholders who have a role to play in supporting northern community health and well-being.

Distinguishing Health and Health Care

Northern, or circumpolar, health is sometimes thought of as a niche field, but it has a large following. For example, the latest International Congress on Circumpolar Health, held August 2018 in Copenhagen, featured approximately 750 participants and 400 presentations. Northern health also features prominently in regional decision-shaping fora such as the Arctic Council.

However discussions on circumpolar health too often focus on public and environmental health policy, oftentimes to the detriment of health care practice and policy. Public health approaches to infectious diseases such as tuberculosis, the effect of climate change and Persistent Organic Pollutants (POPs) on Indigenous health, access to traditional foods, and the impacts of colonization such as suicide and substance abuse, feature heavily in northern policy discussions, as they should. But the practice of health care in the North, despite its expenditures accounting for between 5-21% of regional GDP (Ellsworth & O'Keefe, 2013), rarely gets systematic analysis or evaluation. Health care professionals are the core of health care systems: their role must be better understood, defined and revised in order to improve the effectiveness of the systems themselves. This Open Education Resource is the first to be developed by and for northern health care professionals.

At the same time, it is not only about health care, but also health, interpreted broadly. Health care services, after all, are only a means to achieve good health and well-being, and it is far from the only, or even the most important means. We often conceive of health care practitioners operating in a clinical setting, and most do so regularly. But there is also a need and a role for practitioners to promote health generally, especially in the North: empowering people to live their best lives, however they define it, with dignity, self-determination, and choice. Most of this living takes place outside the local nursing station, clinic or community hospital.

Centring the "Indigenous" in Northern and Indigenous Health and Health Care

This volume is entitled "northern and Indigenous health and health care" for good reason. We have consciously ensured Indigenous perspectives, authors, and issues are integrated in to this volume as a reflection of the fact that northern health care in many parts of the Circumpolar North cannot be assessed separately from the Indigenous context in which it is practiced. There is a long and discomfiting history of non-resident health professionals coming in to communities and problematizing or outright prohibiting traditional healing practices and beliefs. It is widely acknowledged that the imposition of Western-style health care has had damaging effects on patient, family and community agency. Many Indigenous residents avoid the health care system due to prior traumatic experiences, lack of trust and not being met with the knowledge required to understand their health issues in the relevant cultural context.

At the same time, advances in Western medical practice have contributed to a marked increase in life expectancy across the Circumpolar North compared to pre-colonial times, and many northern Indigenous residents want, expect, and deserve equitable access to such care. Most Indigenous northerners seek an integration of Western and Indigenous practices in the delivery of health care. This volume seeks to provide some examples on these efforts, with the hope that the next generation of northern health care professionals will better embrace the contributions of both Western and Indigenous perspectives.

Themes of this Volume

An open call for contributions from northern and Indigenous health care researchers and practitioners produced five distinct themes around which the publication is organized:

- Community Health in Northern and Indigenous Communities
- Social Determinants and Structural Impacts on Northern and Indigenous Health
- Culture and Health
- Innovations in Northern Health Care
- Professional Practice in Northern and Indigenous Communities

These themes represent the most salient issues and opportunities in northern health care in the early 21st century, as articulated in 38 peer-reviewed chapters written by 51 different experts, practitioners and researchers. Many different subjects are broached, and if not necessarily divergent from mainstream health education, there is certainly a uniquely rural and northern perspective to the chapters. One common theme emerges: northern health care cannot be practiced separately or in isolation from the community in which it is practiced.

This Open Education Resource is meant to be easily accessible, both in content and in format. Many readers may speak English only as a second or third language. As such, we have chosen to compose this volume with themes manifested by short chapters, and written at an academic level aimed at third year baccalaureate students. This publication reads differently than a traditional textbook or course material. But it is well placed to be shared, scanned, and read piecemeal or as a whole, serving different purposes for different audiences and contexts.

What is an 'Open Education Resource'?

We have chosen to publish this collection as an 'Open Education Resource'. This means that the volume is free and as accessible as possible. The contemporary Open Education movement grew largely as reaction to the growing

unaffordability of textbooks. At the same time, the rise in internet access has made it possible to share knowledge in new and exciting ways. David Wiley (2014) defines Openness as:

- Retain – the right to make, own, and control copies of the content
- Reuse – the right to use the content in a wide range of ways (e.g., in a class, in a study group, on a website, in a video)
- Revise – the right to adapt, adjust, modify, or alter the content itself (e.g., translate the content into another language)
- Remix – the right to combine the original or revised content with other open content to create something new (e.g., incorporate the content into a mashup); and
- Redistribute – the right to share copies of the original content, your revisions, or your remixes with others (e.g., give a copy of the content to a friend)

Because we intend for this volume to be used by different post-secondary institutions, in different programs, countries and disciplines, as well as for different health care systems, it is essential that users could draw from the volume in ways that make the most sense for them. We are grateful to our authors for sharing their knowledge in this comprehensive way.

In addition, the Open Education Resource format will allow us to add and update this content as desired. If you would like to add your knowledge to this volume, please get in touch.

Because some northern communities don't have affordable or easily accessible internet connections, we can also print this volume on a cost recovery basis upon request.

Acknowledgments

THEME I – COMMUNITY HEALTH IN NORTHERN AND INDIGENOUS COMMUNITIES

1. Introduction

BENTE NORBYE

Communities across the Circumpolar North face challenges that often relate back to its history of colonialism, whereby Indigenous groups were forced to accept different ways of living with different values and, for many, a different language. These changes have been imbued with a western influence and an assumption by many that they represent an improvement. But in what ways can we say western ways of living have led to improvements for residents of the North? Do we accept the gaps in services and infrastructure that some areas experience because they are northern?

For decades we have reviewed statistics that show northern and Indigenous communities scoring amongst the lowest in terms of national socioeconomic indicators. Different actions have been taken to try to alter these statistics, some with less success than others. The question becomes one of accepting poorer health outcomes and life expectancy as natural and innate. This raises the concern of believing that poor health outcomes are an individuals' responsibility to cope. When the water supply, is of such poor quality in colour, smell and taste, that you think it is unhealthy to drink, the alternatives are limited. The northern reality is that bottled water is more expensive than sugary drinks such as soda and juice concentrates, and when income is low, families do what is possible, even if the effect may have other health implications such as poor oral care. Many would not accept this standard and yet for many northern residents it is a fact of life. Importantly, this is not a chosen way of living; it is a systematic imposition on people less visible and further away from decision-making bodies and funding agencies given their eye are in the rural, northern location.

As health professionals, and as nurses we care for individuals but we must consider each person in their surrounding and in society, in order to understand what influences each situation. Dating back to Florence Nightingale (1959) we know that hygiene affects each person's ability to heal and to prevent illnesses. We know that the houses need fresh air, clean water, discharge of sewage, hygienic standard, and light to prevent illness and disease. Sadly, we see that many poor health outcomes are the direct result of not fulfilling these basic standards even with the extensive knowledge and resources we have today.

For health professionals working under challenging conditions in remote and rural areas, it is important to remember that the basic principles of nursing and health care, as described by Henderson (1997), need to guide professional conduct in meeting each individual patient. However, each individual is part of a society with his or her family, with their values, and their views of the world. Health professionals' aim of providing holistic care should consider the social and physical environment each person lives in and understand the patient and their family as a partnership. Initiatives from professionals can be counter-productive if they do not consider that each person might have suggestions of healing practices that benefit both the individual and their family.

The articles on this theme confirm that remote and northern communities do have unique challenges. Many of these challenges are historically linked to years of oppression and making people feeling inferior to people in positions of power who had and perhaps still have values that contradict those of northerners.

Health professionals are in a privileged role of seeing and meeting individuals where they live and have the opportunity to understand the impact on peoples' circumstances; without clean and sufficient water supply, for example, one can anticipate complex and long-term health problems to follow. Each of these theme's chapters show both the challenges, but also successful and ongoing initiatives for improving people's health where they live. The proper respect owed to residents of remote and rural communities, including their resilience and success in such harsh climatic conditions is critical. These articles are all context specific, but with knowledge and learning applicable across the Circumpolar North and beyond. The challenges around safe and clean water and adequate food supply is directly connected to health related outcomes, both physically and mentally. These chapters highlight different strength-based approaches; they can be read individually, but read as a whole the reader will see inter-connectedness, to the relationship with Indigenous people's history and health. An overarching theme is that a collaborative approach is the best means by which to deal with health and other issues in the North.

Oral health is sadly still problematic when it comes to untreated dental carries and sever periodontitis in the northern

regions. Oral health issues cause discomfort and are closely connected to other health issues as shown in the article, *Oral Health and Health Promotion in Northern and Indigenous Communities* by Sisko and Eino Honkala. However, statistics show that different countries and regions have been successful in dealing with those problems. Community development and empowerment draws on existing resources in the community to ensure authentic partnership and ownership in solutions.

Oral health is also closely connected to *Food Security in Greenland*, by Gert Mulvad. Food is not only about nutrition, but has huge cultural importance as coming together as family and friends are essential to building social connections. Mulvad explains how the traditional Greenlandic diet is mainly based on marine mammals, birds, fish, and land-based animals, but that there has been a drastic change in recent times to a more western diet. This means that most food is now imported and processed. This has impacted not only health outcomes in terms of nutrition, but also the social aspects of preparing and eating meals. The advice from the Greenlandic Board of Food and Environment referred to by Bjerregaard and Mulvard (2012) is to promote traditional foods, especially fish, but especially to prepare and enjoy meals together as a family. In this way, the food should continue to have its place in cultural, business and social conditions.

Clean water is often taken for granted, but the article, *Indigenous Water Poverty: Impacts Beyond Physical Health*, by Lalita Bharadwaj and Lori Bradford, shows that even in Canada, a water wealthy nation, safe drinking water supplies are not dependable for many Indigenous communities. Bharadwaj and Bradford show through a community based PAR (participatory action research) project what inadequate water supplies mean for communities, including their effects on personal hygiene and the inability to meet basic household needs. Further, water also has spiritual meaning and its inadequacy leads to loss of cultural practices related to the water as well as restricts good health in the holistic sense. The article concludes that Canada as a nation should remedy these inequities and reconcile ways of knowing, valuing and managing water.

Giving birth is a natural and often a happy occasion for women. Ideally, it happens in secure surroundings with support from a competent health care professional such as a midwife and with family nearby, who have an understanding and appreciation of relevant ceremonies and traditional birth practices. The chapter on *Indigenous Birth* by Angela Bowen and Carrie Pratt explores the state of Indigenous birth in Canada and the impact on the mother and society. Indigenous women living in the north may feel particularly vulnerable during childbirth as they often must leave their homes and families due to the lack of access to birthing units in their own communities. The article stresses that there is an urgent need to find ways to support culturally safe birth experiences for women whether it takes place in their home community, in a rural setting or in an urban centre.

Following, Elizabeth Cooper and S. Michelle Driedger's *Working with Unbounded Communities: A Metis Case Study*, helps to explicate the lesson that Indigenous peoples do not exist in homogenous circumstances; rather, within Manitoba, Canada, Metis and First Nations people often live side-by-side, but have unequal access to health services and supports due to differences between federal and provincial fiduciary responsibilities. These different fiduciary responsibilities reproduce health inequities and challenges the uptake of research, policies, programming, and services. Cooper and Driedger explore that issue thoroughly and offer important points to consider for health professionals engage with Metis communities.

Living everyday life with chronic and long-term illness affects the lives of both individuals and their families. Tine Aagaard takes us through an ethnographic field study from Greenland, explores *Everyday Life with Chronic Illness: Physical Health or Wellbeing?*- how chronic illness needs to be taken into account not only as a medical disease that needs treatment, but also in relation to aspects of everyday life. The Danish model of patient participation might not fit the Greenlandic way of living and dealing with everyday events. Both the patient and the family needs support and for health professionals to discuss their everyday problems connected to living with chronic illness. This requires health professionals to seek the patient's and family's knowledge, and to understand the patients' needs, wishes and resources. A critical analysis of the disease orientation of health care, as well as the unequal valuation of patients' knowledge, is highlighted in this chapter.

Tuberculosis (TB) is still a global healthcare problem. The way in which TB prevention and treatment is dealt with in remote Russian communities is described in the article, *The Role of Nurses in Preventing Tuberculosis in Russia's Remote Northern Territories of Residence* by Nikolay Diachovsky and Aleksandra Obutova. The extreme north of Russia has one

of the highest incidences of TB and is still a leading cause of death among infectious diseases. Nurses are often the only available health personnel in these areas. This article describes how a Feldsher-Midwife Station, delivering prehospital primary care in remote areas, became a preferred model in Yakutia. The aim was to have a "Village Free from TB" and to prevent and to treat TB in a structured and nurse-led manner.

Community development entails a process of developing strengths-based approaches that can contribute to sustainability in a community. The article *Community Development in Canada's North* by Kerry Lynn Durnford, Cathy Bradbury, Susan Starks, Marnie Bell, and Pertice Moffitt describes how to establish working relationships, and use population-based and social determinants approaches to engage in community advocacy for better living conditions. It further discusses how the provision of culturally safe care is an important competency for health professionals working with northern communities. Ongoing education and the understanding of people's history and culture is essential in order to reduce health disparities.

Overall, this theme demonstrates how northern health professionals must work together with patients and families to improve community health, living conditions, and address health disparities in a collaborative rather than hierarchical manner.

2. Oral Health and Health Promotion in the Northern and Indigenous Communities

SISKO HONKALA AND EINO HONKALA

Untreated dental caries and severe periodontitis in permanent teeth and untreated caries in deciduous teeth are among the most prevalent chronic non-communicable diseases world-wide. Oral diseases can cause pain and discomfort, increase absenteeism from school/work, and reduce quality of life. Untreated dental decay further affects child growth. Both, dental caries and periodontal disease, are behavioral diseases which could be prevented by reducing use of sugar and by good oral hygiene. Dental caries is more common among Indigenous than non-Indigenous communities. Resources in oral health care (e.g. lack of dentists) are scarce in most places in the Circumpolar area. Therefore, the role of nursing personnel is very important in preventing oral diseases. Oral diseases share risk factors with other chronic, non-communicable diseases. Promoting oral health also benefits general health.

Key Terms: oral health, health promotion, general health, quality of life, Indigenous populations

Introduction

The mouth is a part of the body, although its diseases have been treated by dental personnel rather than by general health care workers. This situation was created when dental caries started to become common along with the increased consumption of sugar during the 18th century. Oral diseases are highly prevalent everywhere. They cause pain and discomfort, increase absenteeism from school and/or work, and reduce quality of life.

Oral Health as a Part of General Health, Well-Being and Quality of Life

Untreated caries (active tooth decay) and severe periodontitis (advanced gum disease) in permanent teeth are the most prevalent chronic diseases (global prevalence of 35%) and among the 291 most common diseases and injuries (Marcenes et al., 2013). Untreated caries in primary teeth is almost equally common. Dental caries is caused by certain bacteria (most often streptococcus mutans) in biofilm attached to teeth (Kidd & Fejerskov, 2016). These bacteria form acids when sucrose, other sugars, or redefined starches are present, and can cause dissolution of tooth surface which lead to cavities (tooth decay, caries lesions). If caries lesion is left untreated, it can lead to a serious infection inside the tooth, which can cause a formulation of abscess or tooth loss (Kidd & Fejerskov, 2016). The main cause of periodontal diseases is also certain bacteria in biofilm (Mueller, 2015). If left untreated, infection can destroy the attachment fibers and supporting bone around root surfaces of teeth, and lead to tooth loss (Mueller, 2015).

As described in Table 1, dental caries is more prevalent among Indigenous people than non-Indigenous in the

circumpolar region, such as in Alaska (MMWR, 2011), Canada (Schroth et al., 2005), Greenland (Ekstrand & Qvist, 2014), the northern parts of the Nordic countries (Widström et al., 2010), and north-west Russia (Gorbatova et al., 2012).

Table 1. Dental caries experience and severity among 12-year-olds in the countries of the circumpolar region

Country	Caries experience (DMFT)	Caries experience (DMFT)	Severity level of dental caries	Severity level of dental caries
	– whole country1	– northern areas	– whole country6	– northern areas6
Canada	1.0	9.52	Very low	Very high
Denmark	0.4	–	Very low	–
Finland	0.7	1.63	Very low	Low
Greenland	1.7	–	Low	–
Iceland	1.4	–	Low	–
Norway	1.7	1.83	Low	Low
Russia	2.5	3.24	Low	Moderate
Sweden	0.8	0.93	Low	Very low
United States	1.2	5.55	Low	High

DMFT = The mean number of Decayed, Missing or Filled Teeth in permanent dentition

Sources: 1Malmö University, 2016; 2Schroth et al., 2005; 3Widström et al., 2010; 4Gorbatova et al., 2012; 5MMWR, 2011; 6WHO, 2000

Unfortunately, oral health has not improved over the past 25 years. In contrast, the cumulative burden of oral conditions has dramatically increased between 1990 and 2015 throughout the world (Kassebaum et al., 2017). During that period, the number of untreated oral conditions rose from 2.5 billion to 3.5 billion (Kassebaum et al., 2017). Treatment of oral diseases is also expensive. In 2010, the direct treatment costs due to oral diseases worldwide equaled 4.6% of the global health expenditure (Listl et al., 2015).

Total tooth loss has been shown to have a great impact on general health. Compared to dentate people (i.e. persons with teeth), edentulous people (persons without any teeth) consume fewer vegetables and fruits; more foods with less fiber; more cholesterol and saturated fats; and have a lower carotene intake. Moreover, they typically have low plasma vitamin C levels and increased amounts of inflammatory reactants, such as plasma C-reactive protein (Lowe et al., 2003; Okoro et al. 2005). The excessive intake of highly processed high fat and high carbohydrate foods further contributes to obesity and obesity-related diseases, such as insulin resistance, cardiovascular disease, and hyperlipidemia (Te Morenga & Mann, 2012). Tooth loss is strongly associated with impairment of oral health-related quality of life (OHRQoL) (Gerritsen et al., 2010). Having fewer than nine teeth has more impact on OHRQoL than having cancer, hypertension, or allergy (Gerritsen et al., 2010). Having one's own teeth for as long as possible is important. The prevention of oral diseases in the remaining teeth, i.e. reduction of pain (toothache), as well as functional and esthetic discomfort, will improve the quality of life of the population.

The most common oral diseases, dental caries and periodontal disease, can be considered as behavioral diseases, which means they have the same risk factors for one's long-term health as other chronic, non-communicable diseases (Sheiham & Watt, 2000). For instance, poor oral health and oral hygiene have been associated with higher levels of cardiovascular diseases (Buhlin et al., 2003); diabetes and hypertension (Fujita et al., 2009); and metabolic syndrome (Kobayashi et al., 2012). A strong association between inflammatory oral diseases (periodontal disease) and the four main non-communicable diseases: diabetes, cancer, cardiovascular diseases, and respiratory diseases, has been confirmed (UN, 2011).

Sugar is the main risk factor for dental caries, which is the most common chronic disease in the world (Sheiham, 1983, 2001; Petersen, 2003a; Moynihan & Petersen, 2004; Marcenes et al., 2013). The intake of free sugars (added sugars) or

sugar sweetened beverages is also a determinant of body weight (Te Morenga et al., 2012). High consumption of sugar beverages is associated with metabolic syndrome and type 2 diabetes (Malik et al., 2010).

Smoking is one of the most common risk factors for chronic diseases, a leading cause of preventable deaths (WHO, 2015), and harms nearly every organ of the body (ASH, 2016). It is considered as a major risk factor for poor periodontal health (Stoltenberg et al., 1993; Petersen, 2003b; Edman et al., 2015). Unfavorable health behaviors tend to cluster together. Irregular toothbrushing is related with high consumption of sweets, smoking, and use of alcohol (Rajala et al., 1980; Currie et al., 1989; Honkala et al., 2011).

Prevention of Oral Diseases

The most common oral diseases could be prevented by the adoption of healthy behaviors (Löe, 2000). Removal of dental plaque by tooth brushing twice-a-day has been accepted as an international recommendation for maintaining good oral hygiene and periodontal health (Sheiham, 1970; Löe, 2000; Zimmerman et al., 2015). Dental caries and erosion of the teeth can be prevented by using fluoride toothpaste when brushing (Walsh et al., 2010; CDC, 2014) and restricting the frequency of between-meal sugar consumption (Sheiham, 2001; Perez et al., 2016). A traditionally healthy diet has been rapidly changed among Indigenous populations to the sugar-rich western type diet after sugary products became easily available (Bang & Kristoffersen, 1972).

Relatively stable patterns of tooth brushing are usually established during childhood and adolescence (Kuusela et al., 1996; Åstrøm & Jakobsen, 1998). Thus, family members, especially parents, can play a vital role in encouraging the adoption of regular tooth brushing habits of their children (Honkala et al., 1983).

Utilizing a population strategy rather than a high-risk-group strategy in health promotion has been shown to be the most cost-effective approach to reduce both the prevalence and the severity of the common chronic diseases (Rose, 2001). Health promotion is, thus, based on a community approach. Community development and empowerment draws on existing human and material resources in the community to facilitate self-help, social support, participation, and ownership. The main focus of oral health promotion activities should be targeted towards children, but a population strategy should also target adults. The Oral Health Program of the World Health Organization (WHO) recommends the development of programs for oral health promotion, which highlights implementation of community-based demonstration projects for oral health promotion, along with a special reference to poor and disadvantaged population groups (Petersen, 2009).

Oral Health Services

There is enormous variation in how oral (dental) health services have been organized worldwide (Arjnljot et al., 1985, Chen et al., 1997). There are also big differences in the number of oral health personnel (i.e. dentists, dental hygienists/ therapists, dental nurses/assistants) providing these services (please see Table 2). In the Nordic countries, the governments have been mainly responsible for providing oral health services for their citizens, especially for children under 18 years of age, who have had these services free of charge. Full coverage and preventive orientation of these services have been emphasized (Honkala et al., 1991) and the preference for public funding of oral health services continues to be very strong amongst the Nordic countries (Widström et al., 2005). As a result, low caries prevalence has been achieved among the Nordic children (Johansson et al., 2007). It is also a great achievement that the socioeconomic inequalities in the use of oral health services were totally abolished among Finnish children in the 1990's, 20 years after the Public Health Law was implemented (Honkala et al., 1997). Children from families with the lowest level of education in Finland and in Norway were found to use dental services more frequently than children from families with higher education (Virtanen et al., 2007). In other words, children with the highest need were more frequently

receiving the treatment needed in those two counties. This Nordic public health policy clearly reflects the national strategies of targeting the oral health services according to the needs and to reduce inequalities in oral health. However, socioeconomic inequalities still exist among the adults (Johansson et al., 2007; Raittio et al., 2015), especially among older adults (Holm-Pedersen et al., 2005; Vikum et al., 2012).

Table 2. Number and density of dentists (per 1,000 persons) in the countries of the circumpolar region

Country	Number of practicing dentists	Density of dentists/1,000
Canada1	19.334	0.57
Denmark1	4.244	0.75
Finland1	3.925	0.72
Greenland2	30	0.54
Iceland1	278	0.84
Norway1	4.434	0.85
Russia3	29.400	0.32
Sweden1	7.777	0.80
United States1	196.400	0.61

Sources: 1OECD, 2016; 2Ekstrand & Qvist, 2014; 3Eurostat, 2006

There have been huge difficulties in the northern areas for providing oral health services because of the sparsely distributed vast areas (Abelsen, 2008; Widström et al., 2010). This is especially the case in oral health services in Greenland, Alaska and northern Canada. To address this problem, Alaska established a special school in their capital ten years ago to educate dental health aid therapists by admitting the students from the distant rural areas for being able to get workforce for these regions (ANTHC, 2018). Nevertheless, there continues to be a lack of dental personnel in all the Indigenous regions, not only in Alaska, because dentists prefer to work and live in affluent, typically urban areas. Thus, also other health professionals should participate in oral health promotion, which serves the general health and quality of life of northern communities. International organizations, like the World Dental Federation and the World Health Organization, have published on their webpages toolkits for preventing oral diseases (see Additional Resources). In addition, several national organizations have published online training resources and toolkits for promoting oral health. For example, the Rural Health Information Hub has created an evidence-based toolkit with seven modules, which helps to identify and implement an oral health program in rural communities (RHIhub, 2002-2018). These toolkits can be introduced and promoted amongst local health teams in northern and Indigenous communities to create collective responsibility for oral health promotion, rather than relying on dentists.

Conclusion

Oral health is an important part of general health. Indigenous populations suffer from poor oral health (high prevalence of dental caries) and a shortage of oral health personnel. Therefore, oral health promotion should be emphasized and all health care personnel should support these activities and communities.

References

Abelsen, B. (2008). What a difference a place makes: Dental attendance and self-rated oral health among adults in three counties in Norway. *Health & Place* 14(4), 827-40.

Action on Smoking and Health (ASH). (2016). Fact sheet: *Smoking statistics: Smoking and Disease*. Retrieved from: *http://ash.org.uk/category/information-and-resources/fact-sheets/*

ANTHC, Alaska Native Tribal Health Consortium. (2018). *Alaska Dental Therapy Educational Programs*. Retrieved from: *https://anthc.org/alaska-dental-therapy-education-programs/*

Arnljot, H. A., Barmes, D. E., Cohen, L. K., Hunter, P. B. V., & Ship, I. I. (1985). *Oral health care systems. An International Collaborative Study*. Geneva: World Health Organization.

Åstrøm, A. N., & Jakobsen, R. (1998). Stability of dental health behavior: a 3-year prospective cohort study of 15, 16- and 18-year-old Norwegian adolescents. *Community Dentistry & Oral Epidemiology* 26(2), 129-38.

Bang, G., & Kristoffersen, T. (1972). Dental caries and diet in an Alaskan Eskimo population. *Scandinavian Journal of Dental Research* 80(5), 440-4.

Buhlin, K., Gustafsson, A., Håkansson, J., & Klinge, B. (2003). Self-reported oral health, dental care habits and cardiovascular disease in an adult Swedish population. *Oral Health & Preventive Dentistry*, 1(4), 291-9.

Centers for Disease Control and Prevention (CDC). (2016). *Hygiene-related diseases – Dental caries*. Atlanta (GA): CDC. Retrieved from: *https://www.cdc.gov/healthywater/hygiene/disease/dental_caries.html*

Chen, M., Andersen, R. M., Barmes, D. E., Leclercq, M.-H., & Lyttle, C. S. (1997). *Comparing oral health care systems. A second international collaborative study*. Geneva: World Health Organization.

Currie, C., Schou, L., & McQueen, D.V. (1989). Dental health-related behaviour in Scottish schoolchildren aged 11, 13 and 15 from Edinburgh City. *Health Bulletin* 47(4), 182-91.

Edman, K., Öhrn, K., Nordström, B., Holmlund, A., & Hellberg, D. (2015). Trends over 30 years in the prevalence and severity of alveolar bone loss and the influence of smoking and socio-economic factors — based on epidemiological surveys in Sweden 1983-2013. *International Journal of Dental Hygiene* 13(4), 283-91.

Ekstrand, K. R., & Qvist, V. (2015). The impact of a national caries strategy in Greenland after 4 years. *International Journal of Paediatric Dentistry* 25(4), 255-66.

Eurostat. (2006). Statistic Explained. *File: Main indicators for health resources* V2.*png*. Retrieved from: *http://ec.europa.eu/eurostat/statistics-explained/index.php/File:Main_indicators_for_health_resources_V2.png*

Fujita, M., Ueno, K., & Hata, A. (2009). Lower frequency of daily teeth brushing is related to high prevalence of cardiovascular risk factors. *Experimental Biology and Medicine* 234(4), 387-94.

Gerritsen, A. E., Allen, P. F., Witter, D. J., Bronkhorst, E. M., & Creugers, N. H. J. (2010). Tooth loss and oral health-related quality of life: a systematic review and meta-analysis. *Health and Quality of Life Outcomes* 8, 126. doi: 10.1186/1477-7525-8-126.

Gorbatova, M. A., Gribovsky, A. M., Gorbatova, L. N., & Honkala, E. (2012). Dental caries experience among 12-year-old children in North-west Russia. *Community Dental Health* 29(1), 20-4.

Holm-Pedersen, P., Vigild, M., Nitschke, I., & Berkey, D. (2005). Dental care for aging populations in Denmark, Sweden, Norway, United Kingdom, and Germany. *Journal of Dental Education* 69(9), 987-97.

Honkala, E., Paronen, O., & Rimpela, M. (1983). Familial aggregation of dental health habits in Finland. *Journal of Pedodontics* 7(4), 276–90.

Honkala, E., Karvonen, S., Rimpelä, A., Rajala, M., Rimpelä, M., & Prättälä, R. (1991). Oral health promotion among Finnish adolescents between 1977 and 1989. *Health Promotion International* 6(1), 21-30.

Honkala, E., Kuusela, S., Rimpelä, A., Rimpelä, M., & Jokela, J. (1997). Dental services utilization between 1977 and 1995 by Finnish adolescents of different socioeconomic levels. *Community Dentistry & Oral Epidemiology* 25(6), 385-90.

Honkala, S., Honkala, E., Newton, T., & Rimpelä, A. (2011). Toothbrushing and smoking among adolescents – aggregation of health damaging behaviours. *Journal of Clinical Periodontology* 38(5), 442-8.

Johansson, V., Soderfeldt, B., & Axelius, B. (2007). *Caries prevalence among children, adolescents and adults, and periodontal conditions among adults in Denmark, Finland, Norway and Sweden.* Oral B's Nordic Report on Oral Health. Malmö: Malmö University, Sweden.

Kassebaum, N. J., Smith, A. G. C., Bernabe, E., Fleming, T. D., Reynolds, A. E., Vos, T., Murray, C. J. L., Marcenes, W., & GBD 2015 Oral Health Collaborators. (2017). Global, regional, and national prevalence, incidence, and disability-adjusted life years for oral conditions for 195 countries, 1990-2015: A systematic analysis for the global burden of diseases, injuries, and risk factors. *Journal of Dental Research* 96(4), 380-7.

Kidd, E., & Fejerskov, O. (2016). *Essentials of Dental Caries*, 4th ed. New York: Oxford University Press. ISBN: 9780198738268.

Kobayashi, Y., Niu, K., Guan, L., Momma, H., Guo, H., Cui, Y., & Nagatomi, R. (2012). Oral health behavior and metabolic syndrome and its components in adults. *Journal of Dental Research* 91(5), 479-84.

Kuusela, S., Honkala, E., & Rimpelä, A. (1996). Toothbrushing frequency between the ages of 12 and 18 years – longitudinal prospective studies of Finnish adolescents. *Community Dental Health* 13(1), 34-9.

Listl, S., Galloway, J., Mossey, P. A., & Marcenes, W. (2015). Global Economic Impact of Dental Diseases. *Journal of Dental Research* 94(10), 1355-61.

Lowe, G., Woodward, M., Rumley, A., Morrison, C., Tunstall-Pedoe, H., & Stephen, K. (2003). Total tooth loss and prevalent cardiovascular disease in men and women: possible roles of citrus fruit consumption, vitamin C, and inflammatory and thrombotic variables. *Journal of Clinical Epidemiology* 56(7), 694-700.

Löe, H. (2000). Oral hygiene in the prevention of caries and periodontal disease. *International Dental Journal* 50(3), 129-39.

Malik, V. S., Popkin, B. M., Bray, G. A., Despres, J.-P., Willett, W.C., & Hu, F.B. (2010). Sugar-sweetened beverages and risk of metabolic syndrome and type 2 diabetes. *Diabetes Care* 33(1), 2477-83.

Malmö University. (2016). Oral Health Database. *Country Oral Health Profiles.* Retrieved from: https://www.mah.se/CAPP/Country-Oral-Health-Profiles/

Marcenes, W., Kassebaum, N. J., Bernabé, E., Flaxman, A., Naghavi, M., Lopez, A., & Murray, C.J. (2013). Global burden of oral conditions in 1990–2010: a systematic analysis. *Journal of Dental Research* 92(7), 592-7.

MMWR. (2011). Dental caries in rural Alaska Native children – Alaska, 2008. *Morbidity and Mortality Weekly Report* 60(37), 1275-80.

Moynihan, P., & Petersen, P.E. (2004). Diet, nutrition and the prevention of dental diseases. *Public Health Nutrition* 7(1A), 201-26.

Mueller, H.-P. (ed.) (2015). *Periodontology – The Essentials*, 2nd ed. Thieme Publishers Stuttgart. Print ISBN: 9783131383723. E-book ISBN: 9783131648723.

Okoro, C.A., Balluz, L. S., Eke, P. I., Ajani, U. A., Strine, T. W., Town, M., Mensah, G. A., & Mokdad, A. H. (2005). Tooth loss and heart disease – Findings from the behavioural risk factor surveillance system. *American Journal of Preventive Medicine* 29(5 Suppl 1), 50-6.

OECD, Organisation for Economic Co-Operation and Development. (2016). *Health Care Resources: Dentists.* Retrieved from: http://stats.oecd.org/Index.aspx?DatasetCode=HEALTH_STAT

Perez, M., Sheiham, A., Liu, P., Demarco, F. F., Silva, A. E. R., Assunção, M. C., Menezes, M., Barros, F. C., & Peres, K. G. (2016). Sugar Consumption and Changes in Dental Caries from Childhood to Adolescence. *Journal of Dental Research*, 95(4), 388-94.

Petersen, P. E. (2003a). The World oral health report 2003: continuous improvement of oral health in the 21st century – the approach of the WHO Global Oral Health Programme. *Community Dentistry & Oral Epidemiology* 31(Suppl 1), 3-24.

Petersen, P. E. (2003b). Tobacco and oral health – the role of the World Health Organization. *Oral Health & Preventive Dentistry* 1(4), 309-15.

Petersen, P. E. (2009). Global policy for improvement of oral health in the 21st century – implications to oral health research of World Health Assembly 2007, World Health Organization. *Community Dentistry & Oral Epidemiology* 37(1), 1-8.

Raittio, E., Kiiskinen, U., Helminen, S., Aromaa, A., & Suominen, A. L. (2015). Income-related inequality and inequity in the use of dental services in Finland after a major subsidization reform. *Community Dentistry & Oral Epidemiology* 43(3), 240-54.

Rajala, M., Honkala, E., Rimpelä, M., & Lammi, S. (1980). Toothbrushing in relation to other health habits in Finland. *Community Dentistry & Oral Epidemiology* 8(8), 106-13.

RHIhub, Rural Health Information Hub (2002-2018). *Rural Oral Health Toolkit.* Retrieved from: https://www.ruralhealthinfo.org/community-health/oral-health

Rose, G. (2001). Sick individuals and sick populations. *International Journal of Epidemiology* 30(3), 427-32.

Schroth, R. J., Smith, P. J., Whalen, J. C., Lekic, C., & Moffatt, M. E. K. (2005). Prevalence of caries among pre-school-aged children in a northern Manitoba community. *Journal of Canadian Dental Association* 71, 27. Retrieved from: http://www.cda-adc.ca/jcda/vol-71/issue-1/27.pdf

Sheiham, A. (1970). Dental cleanliness and chronic periodontal disease. Studies on population in Britain. *British Dental Journal* 129(9), 413-8.

Sheiham, A. (1983). Sugars and dental decay. *Lancet* 1(8319), 282-4.

Sheiham, A., & Watt, R. G. (2000). The Common Risk-Factor Approach: a rational means of promoting oral health. *Community Dentistry & Oral Epidemiology* 28(6), 399-406.

Sheiham, A. (2001). Dietary effects on dental diseases. *Public Health Nutrition* 4(2B), 569-91.

Stoltenberg, J. L., Osborn, J. B., Pihlstrom, B. L., Herzberg, M. C., Aeppli, D. M., Wolff, L. F., & Fischer, G. E. (1993). Association between cigarette smoking, bacterial pathogens, and periodontal status. *Journal of Periodontology* 64(12), 1255-30.

Te Morenga, L., & Mann, J. (2012). The role of high-protein diets in body weight management and health. *British Journal of Nutrition* 108(Suppl 2), S130-8.

Vikum, E., Krokstad, S., Holst, D., & Westin, S. (2012). Socioeconomic inequalities in dental services utilization in a Norwegian county: The third Nord-Trøndelag Health Survey. *Scandinavian Journal of Public Health* 40(7), 648-55.

Virtanen, J. I., Berntsson, L. T., Lahelma, E., Kohler, L., & Murtomaa, H. (2007). Children's use of dental services in the Nordic countries. *Journal of Epidemiology & Community Health* 61(12), 1080-5.

United Nations (UN). (2011). *Political Declaration of the High-level Meeting of the General Assembly on the Prevention and Control of Non-communicable Diseases.* Resolution A/66/L.1. New York: United Nations. Retrieved from: http://www.who.int/nmh/events/un_ncd_summit2011/political_declaration_en.pdf

Walsh, T., Worthington, H. V., Glenny, A. M., Appelbe, P., Marinho, V. C., & Shi, X. (2010). Fluoride toothpastes of

different concentrations for preventing dental caries in children and adolescents. *Cochrane Database Systematic Reviews* (1), CD007868. doi: 10.1002/14651858.CD007868.pub2.

WHO. (2000). Oral Health Programme. Global data on dental caries prevalence (DMFT) in children aged 12 years. Geneva: World Health Organization. Retrieved from: *http://www.who.int/iris/handle/10665/66520*

WHO. (2015). *WHO report on the global tobacco epidemic, 2015. Raising taxes on tobacco.* Geneva: World Health Organization. Retrieved from: *http://apps.who.int/iris/bitstream/10665/178574/1/9789240694606_eng.pdf?ua=1&ua=1*

Widström, E., Ekman, A., Aandahl, L. S., Pedersen, M. M., Augustsdottir, H., & Eaton, K. A. (2005). Developments in oral health policy in the Nordic countries since 1990. *Oral Health & Preventive Dentistry* 3(4), 225-35.

Widström, E., Koposova, N., Nordengen, R., Nergdahl, M., Eriksen, H., & Fabrikat, E. (2010). Oral health care and dental treatment needs in the Barents region. *International Journal of Circumpolar Health* 69(5), 486-99.

Zimmermann, H., Zimmermann, N., Hagenfeld, D., Veile, A., Kim, T. S., & Becher, H. (2015). Is frequency of tooth brushing a risk factor for periodontitis? A systematic review and meta-analysis. *Community Dentistry & Oral Epidemiology* 43(2), 116-27.

3. Food Security in Greenland

GERT MULVAD

Introduction

Food security can be defined as "physical and economic access to sufficient, safe and nutritious food that meets the dietary needs and food preferences for an active and healthy life." (World Food Summit, 1996). Access to sufficient, safe, and culturally appropriate food is dependent on many interconnected factors, including education, food preferences, poverty, unemployment, household crowding, food costs, harvesting costs, and environmental conditions. Furthermore, in any community, it is important how food is produced, how it is prepared, and how it is consumed. These things are important to the individual and for the way people come together. That is why food is more than just getting the necessary nutrition; it is also essential for social life and the way families function. In turn, these factors need to be situated in the context of transformations in livelihoods and socio-economic conditions, colonial history, and land dispossession, which provide the underlying context for many of the challenges facing Arctic Indigenous food systems today.

Food sovereignty is a keyword when we are talking about our local food. There are four main components recognized in the context of Inuit food systems: *availability* (sufficient quantities available consistently), *accessibility* (enough resources to obtain food), *quality* (adequate nutritional and cultural value), and *use* (required knowledge of how to utilize food). Food insecurity has been identified to be at crisis levels.

Greenlandic Diet

In Greenland, the traditional Inuit diet is mainly based on marine mammals, birds, fish, and land-based animals. However, during the last century, a rapid dietary transition took place and Greenland shifted to a more modern economy. This transition has created competition between traditional food consumption and a more westernized diet. Today, the Greenlandic diet comprises a mixture of traditional food and imported foods. Due to *inter alia* weather conditions, most of Greenland's fresh food source comes from wild animals or fish. Greenland has a production of lamb and a limited supply of vegetables, but most produced foods are imported from outside. In fact, imported foods provided 75-80% of the energy consumed in adult Greenlanders in 2013. A variety of imported foods are available at government-subsidized prices that are relatively uniform across the country, but still with variations between the larger towns and the smaller settlements (Hansen et al, 2017). In addition, imported, processed foods are expected to continue to take over an increasing part of the Greenlanders energy consumption.

Since food in Greenland is increasingly imported and coming fully or almost fully processed, the quality of nutrition has changed. Public health may be affected, as well as the social aspect of eating and preparing the meals. Nevertheless, the traditional diet remains very important to the Greenlandic population, both culturally and financially. The traditional Greenlandic diet is also important from a population health standpoint, as a means for people to get sufficient nutrients because, in many places, imported food is available mostly in poor quality.

When identifying adaptation strategies related to food security in Greenland, a central issue must be considered and that is the high level of long-range transported contaminants in the natural environment. Several emerging contaminants have been detected in Arctic biota, including mercury and Persistent Organic Pollutants (POPs). High contents of organic contaminants are now found in people's diet and the pollution has reached a level where it is of concern to health experts, as the levels are in excess of internationally accepted guidelines for safe intake (AMAP Assessment, 2015). The Greenlandic Board of Food and Environment has taken part in this human health research for the

Arctic Monitoring and Assessment Programme (Adlard et al. 2018). Food security is simultaneously affected by climate change through impacts on food availability, accessibility, quality, and use. Climate change is affecting the availability of food resulting from shifts in biodiversity, as well as in the ranges of animal and plant species, which are important to communities. In a changing environment, incorrect preparation and storage of Greenlandic food may present a risk of food-borne diseases (Hansen et al, 2017). As a result, Greenland's food supply strategy and the trend that traditional foods is being actively replaced by substandard imported food needs careful consideration.

Contaminants

As the Greenlandic Board of Food and Environment advises, '…don't replace current food with worse food'; 'Eat still traditional food, especially fish'; 'Follow the season'; and 'Prepare the food and eat together in the family' (Bjerregaard & Mulvad, 2012). Health authorities highly recommend local fish products; terrestrial mammals; and new local food products, such as berries, seaweed, herbs, and vegetables, including angelica and mushrooms.

Following, current human exposure to hazardous contaminants can be reduced in two ways. First, there should be agreement on measures, such as international conventions, to eliminate or reduce production and use of the most dangerous chemicals. This is important; however, this will only be fully effective many years in the future. Thus, a second and concurrent strategy can be to implement intermediate intervention strategies locally, in order to protect the highest exposed populations. In the Arctic, the main source of anthropogenic contaminants of concern is from consumption of marine mammals. Consequently, the most efficient way to reduce human exposure is to replace consumption of highly contaminated marine mammals with fish and terrestrial mammals. Nevertheless, Elders still regard marine mammals as part of the traditional food and their cultural integrity. To continue the intake of any kind of traditional food after reproductive age is not a health problem.

Pregnant and nursing women can continuously eat varied Greenlandic food, but should be cautious with especially polar bear, teethed whales, seabirds, and aged seals, due to the contaminants they contain. These food subjects can be substituted with fish and terrestrial mammals. It is recommended that children and young people follow the same advice as pregnant women. In addition, it is recommended to all that they follow the ten dietary advice devised by the Greenlandic board of Food and Environment (see table 1) (Bjerregaard & Mulvad, 2012).

Conclusion

Ultimately, the vision is for all the people in Greenland to have sufficient knowledge about which food that is healthy and what is unhealthy, so everyone has the opportunity to choose a diet that prevent disease and promote a long life with good quality of life. (Bjerregaard & Mulvad, 2012) A changing diet and lifestyle to Western food will mean change in intake of energy, energizing nutrients, vitamins, minerals, and other biologically active substances. At the same time, it will diminish the importance of dietary context of cultural, business, and social conditions.

Table 1: Ten dietary advice by the Greenlandic board of Food and Environment

When considering food security, the goal is:

- that Greenlandic food items is included in the public institutions' food choices,

- to increase the general knowledge about which foods are healthy,
- to increase the general knowledge of food hygiene (proper storage and handling),
- to increase the general knowledge of cooking methods that create variation and meets culinary and nutritional needs
- reduction of pollution and promotion of food security,
- to obtain local and international initiatives that reduce the discharge of pollutants to the environment,
- to secure infrastructure that promotes the use of Greenlandic food in homes, in retail, in institutions and in social settings,
- to inform and train on food hygiene, storage and preparation of both Greenlandic and imported food.
- to give manual / training on how Greenlandic and imported food can be part of a diet that meets nutrient recommendations,
- to secure local initiatives to increase food safety (Bjerregaard & Mulvad, 2012).

As per the Food Policy Statement 2004 from Government of Greenland (only in Danish and Greenlandic), it must be possible for all the people of Greenland to choose a healthy, balanced diet, consisting of safe food, food that is produced in Greenland by our own raw materials, and obtained in a sustainable way.

Additional Resources

Inuit Food (First Peoples of Canada)

Contaminants in the Arctic Food Chain (PBS)

Food and Water Security in the Arctic (UArctic)

References

AMAP. (2015) *AMAP Assessment 2015: Human Health in the Arctic.* Arctic Monitoring and Assessment Program (AMAP), Oslo, Norway.

Adlard B et al (2018) Future directions for monitoring and human health research for the Arctic Monitoring and Assessment Programme. *Global Health Action*, 11(1),

Bjerregaard P, Mulvad G. (2012). The best of two worlds: how the Greenland Board of Nutrition has handled conflicting evidence about diet and health. *Int J Circumpolar Health.*

Hansen, A. M., Ingebrigtson, L., Edmunds-potvin, S., Mulvad, G., Weiler, H., Ford, J., Healey. (2018). Chapter 4. Health and well-being. In *Adaptation Action for a Changing Arctic: BAFFIN BAY/DAVIS STRAIT REGIONAL REPORT*

World Food Summit (1996). *Rome Declaration on World Food Security.*

4. Indigenous Water Poverty: Impacts Beyond Physical Health

LALITA BHARADWAJ AND LORI BRADFORD

In Canada, a water wealthy nation, the provision of safe drinking water is a pressing health issue confronting Indigenous communities. Many reserve communities live with long-term drinking water advisories and high-risk water systems. As a result, community members experience health and water quality below that of non-reserve populations. While there is recognition of wider issues and we discuss them below, we focus this chapter on a case study to help practitioners understand how they can play a role in overcoming barriers. Over the course of several years, and in cooperation with several communities, a research program was undertaken to examine perceptions about drinking water and health on reserves as well as heighten understanding and gather information from the voices of the communities on existing drinking water and health-related challenges. Water quality and supply were key challenges. The challenges led to health consequences across individual and community levels which included more than physical symptoms. Inadequate drinking water has widespread implications for the wellbeing of Indigenous people. To better inform health care service and policy decisions for drinking water provision, a more holistic understanding of the relationship between drinking water challenges and Indigenous health is needed.

Key Terms: Indigenous Communities, Drinking Water, Community-Based Participatory Research, Health and Wellbeing

Water: An Indigenous Worldview

Clean, accessible, and sustainable drinking water is a basic necessity of life, and indispensable for meeting national and international standards of health, justice, equality, and responsibility. While much research has focused on identifying and preventing contaminants in drinking water, Indigenous teachings point out that water has various meanings and uses for people including its aesthetics; a symbol of fertility and purity; a home for living beings; a life-enriching cleansing agent; an element of interconnection; and a symbol of both strength and softness. Water "… is life; …sacred; …power; … our first medicine; and, water connects all things" (Sanderson, 2004, p. 93). Elders also describe that when water sources are no longer usable, life suffers and cultural health is threatened. Elders stress that, "Water cannot be separated into one realm. In the same way, water is important to life, health, education, the laws that govern our lives, and the environment." (Sanderson, 2004, p. 113)

In freshwater-rich Canada, providing safe drinking water on reserves is a pressing issue for Indigenous communities and the federal government. The ongoing effects of colonization have contributed to the erosion of Indigenous peoples' livelihood systems, culture, and resources (Adelson, 2005; Arquette, 2002; Waldram, Herring, & Young, 2006). The erosion of water resources has a negative impact on the wellbeing of communities and contributes to the current inequity in the health status of Indigenous Canadians (Waldram et al., 2006). Indigenous communities are known to have

the poorest quality water in the country (see O'Connor 2002a, 2002b; Commissioner of the Environment and Sustainable Development, 2005).

Inequities in Drinking Water Provision

There has been very little research on drinking water and health outcomes in Indigenous communities in Canada (Bradford, Bharadwaj, Okpalauwaekwe, & Waldner, 2016). Some of the evidence from the research suggests that in Indigenous communities, exposure to waterborne parasites and bacteria that cause intestinal infections and other illnesses is significantly higher (Clark, 2002). At any time over the last decade, between 20 – 30 percent of reserve water systems posed a high risk of producing unsafe drinking water (Environment and Climate Change Canada, 2016). Some of the worst conditions are inexplicable given Canada's reputation in the developed world; for example, Shoal Lake 40 First Nation in Manitoba has been on a boil water advisory for more than 20 years, and Nazko First Nation, British Columbia, has been under a 'do not consume' advisory for 17 years (Health Council of Canada, 2005; David Suzuki Foundation, 2017). Errors in implementation of water systems are also glaring; for example, despite having a new water treatment plant in the Six Nations of the Grand Reserve in Ontario, only 9% of community members' houses are hooked up to the piped system and can access the water (Pavia, 2017). From this work, one could conclude that safe drinking water is not simply a technical or health prevention problem.

Poor drinking water quality on reserve is also related to poor quality source water; inadequate access or quantity of water; a lack of funding for infrastructure, training, and maintenance; inadequate or inconsistent disinfection; inadequate distribution and operational issues; high risks of contamination due to rural and remote locations of reserves; gaps in regulatory frameworks; and negative human risk perceptions for treated water which compels communities to seek out other sources (for example, Mascarenhas, 2007; 2012; McCullough & Farahbakhsh, 2012; Plummer, de Grosbois, Armitage, & de Loë, 2013). Despite recent funding commitments by the federal government, access to safe drinking water continues to be a problem in Indigenous communities nationwide, suggesting that in addition to technical problems and clashing worldviews, the current management approaches and the policies guiding implementation of systems remain flawed (McCullough & Farahbakhsh, 2012).

Inequities in the provision of safe water leaves communities vulnerable to boil water advisories, waterborne diseases, stress, and associated health effects. There is evidence that once affected with a health impact, Indigenous community members are further burdened by unequal access to health care services to help them cope with water-borne illness and effects on wellbeing. Health care professionals play a key and central role in improving the access and quality health care for individuals, families, communities and populations, and yet, many Indigenous communities are without regular health care workers. Health care professionals should be aware of these holistic-level water related health effects which have much to do with access to care. Health care practitioners play a valuable role in the provision of preventing ongoing water-related health care services by advocating for better access overall to health care for Indigenous people.

To help demonstrate how these wide barriers play out on the ground, we explore results from a case study investigating on-reserve people's perceptions of these flaws to help better understand the problems in Treaty 4, 6 and 10 Territories and the Homelands of the Métis, in Saskatchewan, Canada. This particular example serves as a depiction of the realities lived by Indigenous communities across Canada. The case study provides anchor points from which practitioners can increase advocacy efforts, recommend educational campaigns, and build capacities. A case study examining the state of drinking water and health impacts in Saskatchewan is also an important choice for the following reasons; a higher than average proportion of people living in the province identify as First Nation or Métis and the population is growing at a greater rate than other provinces. Indigenous people in Saskatchewan are more likely to live on reserves (and in crowded homes in need of major repairs) than other provinces, and more than half that report living on reserve suffer from chronic illness. It is clear that this is a province in need of advocacy for multiple determinants of health.

The Case of Eight Indigenous Communities in Saskatchewan

After failed attempts to gain improved drinking water through various channels (applications to the federal government, media coverage, and peaceful protesting), several water officers from Saskatchewan First Nations communities approached researchers at the University of Saskatchewan for their help in understanding why they were experiencing high rates of drinking water issues. Research partnerships with eight Indigenous communities were established and a community-based participatory research approach was co-designed, and co-implemented with Indigenous community-based coordinators and data gatherers. Data gathering events were completed in each community about on-reserve water related health issues. It was also important to community partners that we looked at the results together to make sense of what participants talked about. That way, we could build capacity to monitor water related issues within communities and overcome biases researchers might have from being 'outsiders.' Co-analysis (content and thematic coding) occurred as a shared practice among community coordinators, and research personnel (as per Vaismoradi, Turunen, & Bondas, 2013).

Overall Findings

Individuals spoke about their water-related health challenges openly and with concern. Health consequences were related to both drinking water quality and quantity. Health challenges extended from the individual to community levels. Gastrointestinal illnesses were described; individual and family-level stress was reported; relationship difficulties were explained; and breakdowns in community functioning were made clear. The descriptions of impacts included consequences beyond physical effects, such as ongoing stress and mental illness; economic challenges such as having to purchase bottled water, missing work, and replace filters in treatment plants more often than typically scheduled; and undesired cultural and spiritual shifts like losing the ability to have water ceremonies or continue traditional teachings. Participants bore witness to be stereotyped as incompetent by non-Indigenous water treatment plant experts, and frustrations with federal policies were described in detail by Indigenous community councilors. Discussions of how drinking water linked to health effects were centered on aesthetics, perceived risks, and a desire for improving the situation for future generations, as well as a focus on Canada's role in improving the holistic wellbeing of Indigenous people.

Below, we present a snapshot of the themes shared by our partnering communities with quotes from participants who agreed to share their words. The themes emerged from lived realities of Indigenous peoples on the reserves involved, but are scalable across Treaty territories. In Saskatchewan, the focus of the impacts was on water quality and quantity, however, the broader inequities that resulted in these two foci exist elsewhere. An example could be that while in Saskatchewan, access to experts to support repairs in treatment facilities is limited and access to drinking water is reduced until repairs can be completed; in other places in Canada, construction seasons are limited, and as result, a treatment plant takes much longer to build and access to safe drinking water is delayed. This points to the access issues that are faced across Canada by Indigenous communities. Whether it be access to infrastructure, or access to experts to assist with maintenance, Indigenous communities are not given the same rights and services as non-Indigenous communities who have well-developed expert services and faster construction times through their provincial governments.

As engaged promoters, prevention officers, and health care deliverers, health practitioners can be part of the solution to the realities experienced by Indigenous peoples across Canada. They could provide data to support local claims of health impacts; advice for coping with challenges; emotional, social, and practical support for both improved drinking water provision and for improved delivery of health care services targeted at water related health issues; and partnerships with other agencies who are tasked with promoting reconciliation and improved community conditions.

Next, we share specific results from our case study to inform health practitioners of the basis for movements in

Saskatchewan towards more equitable safe drinking water provision for health and wellbeing. We start with water quality and health impacts, then report on our results for water quantity and health impacts.

Theme 1: Water Quality – Direct and Indirect Health Impacts

Members from each of the eight communities spoke about the poor aesthetic quality of their drinking water and the associated health impacts they experienced as a result:

Our water was being treated for a while at [location]. We had a little treatment plant going on there and we started having problems with it. You know, it was just the colour of, it was like [brown]. Even worse than that…There's three houses there. Well, we didn't even dare, it was being treated so bad that there was so much chlorine in it, it was wrecking our clothes. Our black clothes were brown, purple. The elasticity in socks, your underwear, your bras, was cracking. It was eating away at it…All we were doing in it was showering and even that, our skin was getting so dry. Our eyes were burning, your nose would burn when you were showering because there was so much chlorine in it. The [chlorine] levels were just unreal (PFN 4, July 9, 2014, Interview)

The majority of participants told us that high chlorine levels in drinking water resulted in both direct (dry skin, irritation to eye, nose, and skin) and indirect health impacts (aesthetics, economic hardship, and risk perceptions). The participants feared the potential health effects of the water treatment processes and their statements reflected high levels of anxiety in communities. They reported not being aware of the types of treatments that were being instituted, nor feeling that they were culturally appropriate. They were frustrated that their source water needed so much treatment in the first place. The perception of water as being life-giving, pure, and medicinal was altered to a perception of it being toxic to physical, mental, and spiritual health. Participants described making efforts to safeguard their children from exposure.

The economic difficulty associated with poor drinking water quality was described by many community members:

I get my drinking water from [right here]. I drive all the way here to come and get it. And everybody else, like even these people that are on social assistance that have to pay for a cab to come and get their water over here because they won't drink [their tap] water (CHCN 5, May 28, 2014, Interview)

The clothes, something dark, you can't have very long. It fades [because of] the chlorine. Like, what I normally do for my dark clothes I wash them in cold water. I buy a cold water detergent. I've tried so many different things and none of them work. I tried hot water, warm water, cold water. It seems the only thing that lasts the longest is the whites. It costs a lot of money for parents to keep getting clothes … faded when they're not even a month old. Nobody even washes their vehicles with that water. Cuz it leaves a white residue all over the vehicle (LRRFN 2, June 2, 2014, Interview)

If we can get every nickel and dime off of Indian Affairs we'd have a lot more than what we have now, because the amount of money that they give us is very minimal. We can't pay our workers properly and even our chemicals are having, we're having difficulties because they need the chemical, but the dollars don't match the chemicals going out (SLFN 2, June 25 2015, Interview)

Participants' preferences not to drink the community tap water or use their household supplied water resulted in reports of ongoing stress, economic challenges, and social pressures. Reserve members continually sought alternative water sources (bottled, trucked from elsewhere, in-home purification systems) and this activity placed an economic burden on individuals, families and the community as a whole.

We don't trust [the tap water]. It doesn't taste right. I guess we're not used to the chlorine yet as a people. I refuse to drink the water. I won't drink it anymore. I've been buying water for the last ten years now (BOFN 1, August 8, 2012, Interview)

Deficiencies in source water quality, such as nearby lakes and groundwater, and the removal of values previously held for water extend from the individual to the community level. Rain dances and other ceremonies were cancelled because of the perceived toxicity of the water. Impacts of the perceived poor water quality burdened community members while they took part in daily activities and pursued cultural practices and traditional livelihoods.

Muskrats, beaver, we used to hunt those. But it seems like throughout the years it kind of changed … so we didn't bother

with them as much. Because, you know, the quality of the furs and meat, it wasn't good because of the—because of the water. (SLFN 3, January 12, 2015, Interview)

Many basic community needs such as ceremonial gatherings and food harvesting were not being met due to perceptions of risk held for local waters, and the inability to secure 'pure' water from the tap or from surrounding waterbodies for ceremonies and traditional practices.

Theme 2: Water Quantity – Interrupted Supply and Hygiene

Water distribution and supply varied in communities and was a second major focus of our work. Many communities were and are currently serviced by a truck-to-cistern system that delivers water at a charge from local treatment plants, or those nearby in non-Indigenous communities. Households are limited to a certain number of gallons per week without consideration of household size or special needs, such as hygiene practices for those with weakened immune systems, or for formula-fed babies. Here, a community member provided a picture of the impacts to health as a result of the realities of inadequate supply:

[I]n some communities they may not be getting all the water that they need. If you go visit somebody and spend some time with somebody whose house is connected to a cistern, you'll notice that they're conserving water, and the chances are they're not practicing the personal and environmental hygiene needed to prevent the spread of disease within the household. We've had outbreaks of Methicillin-resistant Staphylococcus aureus (MRSA) in communities and in one of the communities, it was a community with lots of cisterns, and lots of complaints about people running out of water because they weren't getting water delivery on a regular basis (SLFN 2, August 7, 2014, Interview)

Inadequate supply led to reduced ability to maintain personal hygiene, increased stress as a result of limited drinking water supplies, and the inability to meet basic household needs for water more generally. Poor source water, interference of water delivery (including the condition of roads, some impassible during floods or heavy rain), the availability and training of water hauling staff, and conditions of trucks and cisterns themselves are causes of drinking water poverty implied by the research participants. In addition, participants reported feeling frustrated with others on the same reserves who had better access, causing division and strife within the community.

The conclusions from this Saskatchewan-based work included the need for better drinking water quality *and* quantity for improvement of individual health and community wellbeing. Prejudicial treatment was experienced suggesting that widespread knowledge sharing and countering of myths was needed so that issues of equity brought forward by Indigenous groups could be approached using reason, and with justice as a driver.

Toward Resolution of Drinking Water Challenges

Good health, in the holistic sense, is only possible where resources are available to meet human social, cultural, spiritual, mental, and physical needs. Community members in eight reserves felt that their drinking water quantity and quality were detrimental to their health and community wellbeing. Insufficient data and case studies such as this one across the entire Indigenous reserve system makes informing government officials difficult. We do have hope, however, since more studies are emerging and new policy directions are being explored with greater emphasis on engagement with Indigenous people to solve problems in locally relevant ways.

Without piped, safe and sustainable drinking water, the daily activities and livelihoods of people on reserve are threatened. Economic burdens, inadequate water for practicing proper hygiene, and loss of cultural practices result from drinking water poverty. In the past, these issues were under-represented in federal government policy and action plans for drinking water on reserves. Our goal as a nation should be to remedy these inequities and reconcile our ways of knowing, valuing, and managing water. The goal of health practitioners should include better understanding the health

challenges related to poor drinking water provision so that we can advocate for improved health care promotion and prevention, as well as delivery.

Health practitioners have other important roles to play to reduce inequalities. There is the need for better and more holistic record keeping of health effects of drinking water on reserves so that trends can be established and enough data built up to support the arguments for change. Second, health practitioners could provide support for prioritizing use of water within households and across communities when supplies are limited, for example, by providing advice on hygiene practices and disease prevention. Mental health support is gravely needed for people struggling with drinking water challenges, health effects, and also those working to facilitate change. Health practitioners could provide valuable connections to other agencies that can assist communities with their barriers, for example, by helping to establish better guidelines for truck-to-cistern delivery systems to prevent contamination, or to educational institutes to help younger generations learn coping strategies when faced with water challenges.

In this chapter we have shared specific case study findings from Saskatchewan to help health practitioners gain understanding of how the health impacts of drinking water affect individuals and communities, and how inequities are perpetuated by a lack of knowledge of the wider issues interfering with safe, adequate drinking water provision on reserves. By doing so, we hope that health practitioners feel empowered to take up some of our recommendations for improving the situation and thereby contributing to reconciliation and holistic community wellbeing as a whole.

Additional Resources

Assembly of First Nations (AFN). (2010) AFN National Chief Calls for Real Action on Safe Drinking Water for First Nations: Need Action to Address the "Capacity Gap as well as the Regulatory Gap". AFN Press Release – Ottawa, May 27, 2010. http://www.afn.ca/article.asp?id=4920

Blackstock, M. (2001) Water: A First Nations' spiritual and ecological perspective. *Journal of Ecosystems and Management* 1(1): 2-14.

Castleden, H., Hart, C., Cunsolo, A., Harper, S., & Martin, D. (2017). Reconciliation and relationality in water research and management in Canada: Implementing Indigenous ontologies, epistemologies, and methodologies. In *Water Policy and Governance in Canada* (pp. 69-95). Springer, Cham.

Dhillon, C., & Young, M. G. (2010). Environmental racism and First Nations: a call for socially just public policy development. *Canadian Journal of Humanities and Social Sciences*, 1(1), 25-39.

Indian Northern Affairs Canada (INAC). (2006) Report of the Expert Panel on Safe Drinking Water for First Nations (Expert Panel), Vol. 1 Department of Indian Affairs and Northern Development, November 2006, p. 16.

Polaris Institute. (2008) Boiling Point: A synopsis prepared by the Polaris Institute in collaboration with the Assembly of First Nations and supported by the Canadian Labour Congress. Retrieved May 22, 2008 from www.polarisinstitute.org.

Neegan Burnside National Assessment of First Nations Water and Wastewater National Roll Out Report. Indigenous and Northern Affairs Canada (2011). Retrieved at: https://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/enr_wtr_nawws_rurnat_rurnat_1313761126676_eng.pdf

References

Adelson, N. (2005). The embodiment of inequity: Health disparities in Aboriginal Canada. *Canadian Journal of Public Health*, 996(Supp), 45-61.

Arquette, M., Cole, M., Cook, K., LaFrance, B., Peters, M., Ransom, J., Sargent, E., Smoke, V., and Stairs, A. (2002). Holistic risk-based environmental decision making: A Native perspective. *Environmental Health Perspectives* (Supplement 2: Community, Research, and Environmental Justice) 110, 259-264.

Bradford, LEA, Bharadwaj, L, Okpalauwaekwe, U., and Waldner, C. (2016). First Nations Water and Health: A Scoping Review. *International Journal of Circumpolar Health*, 75(1), 1-16. http://dx.doi.org/10.3402/ijch.v75.32336

Clark, M. (2002). Shigellosis and First Nations Communities. *Health Canada*: *Health Policy Research Bulletin*, 4, 15-18.

Commissioner of the Environment and Sustainable Development. (2005). *Report of the Commissioner of the Environment and Sustainable Development to the House of Commons: Chapter 5 – Drinking water in First Nations communities*. Ottawa: Office of the Auditor General of Canada.

David Suzuki Foundation. (2017). *Glass Half Empty? Year 1 Progress Toward Resolving Drinking Water Advisories in Nine First Nations in Ontario*. ISBN: 978-1-988424-03-3. Retrieved at: https://davidsuzuki.org/wp-content/uploads/2017/09/REPORT-progress-resolving-drinking-water-advisories-first-nations-ontario.pdf.

Environment and Climate Change Canada (2016) *Canadian Environmental Sustainability Indicators*: *First Nations Water and Wastewater System Risk*. Retrieved March 19, 2018. Available at: www.ec.gc.ca/indicateurs-indicators/default.asp?lang=en&n=EA902CF7-1

Health Council of Canada. (2005) The Health Status of Canada's First Nations, Metis, and Inuit Peoples. Toronto, ON. Retrieved March 19, 2018 from http://publications.gc.ca/collections/collection_2012/ccs-hcc/H174-37-2005-1-eng.pdf

Mascarenhas, M. (2007). Where the waters divide: First Nations, tainted water and environmental justice in Canada. *Local Environment*, 12(6), 565-577.

Mascarenhas, M. (2012). *Where the Waters Divide*: *Neoliberalism, White Privilege, and Environmental Racism in Canada*. Landham, Maryland: Lexington Books.

McCullough, J., & Farahbakhsh, K. (2012). Square peg, round hole: First Nations drinking water infrastructure and federal policies, programs, and processes. *International Indigenous Policy Journal*, 3(1).

O'Connor, D.R. (2002a) *Report of the Walkerton Inquiry*: *The events of May 2000 and related issues, part one*. Toronto: Queen's Printer for Ontario.

O'Connor, D.R. (2002b) *Report of the Walkerton Inquiry*: *The events of May 2000 and related issues, part two*. Toronto: Queen's Printer for Ontario.

Pavia, J. (2017, July 30) Ohsweken waits for funding to deliver clean water to more people. *CBC news*. Retrieved from http://www.cbc.ca/news/canada/kitchener-waterloo/indigenous-water-supply-1.4226347.

Plummer, R., de Grosbois, D., Armitage, D., and de Loë, R. C. (2013). An integrative assessment of water vulnerability in First Nation communities in Southern Ontario, Canada. *Global environmental change*, 23(4), 749-763.

Sanderson, C. D. (2004). *Nipiy Wasekimew / Clear Water*: *The meaning of water from the words of the Elders – The interconnections of health, education, law and the environment* Doctoral dissertation, Faculty of Education, Simon Fraser University, Burnaby, BC. Retrieved from http://www.collectionscanada.gc.ca/obj/thesescanada/vol2/002/NR58519.PDF

Waldram, J. B., Herring, D. A., and Young, T. K. (2006). *Aboriginal health in Canada*: *Historical, cultural, and epidemiological perspectives*. Toronto, ON: University of Toronto Press.

Vaismoradi, M., Turunen, H., & Bondas, T. (2013). Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. *Nursing & health sciences*, 15(3), 398-405.

5. Indigenous Birth

ANGELA BOWEN AND CARRIE PRATT

Children born into their home community are more likely to develop a clear sense of identity, which helps to promote resilience and build strong community bonds. However, most Indigenous women are forced to travel to urban centres to give birth in settings that may not feel culturally secure. Careproviders and administrators need to value and incorporate birth traditions, rituals, and ceremonies, provide different options for safe maternity care outside of major centres, and increase the number of Indigenous maternity careproviders (e.g., midwives, doulas, birth workers). This chapter briefly explores the state of Indigenous birth and the impact on the mother and community in Canada and increasing the cultural competence of careproviders.

Key Terms: birth, motherhood, Indigenous, traditional

Introduction

Childbirth can be a positive, empowering experience for a woman, which can promote kinship and strengthen community bonds; however, if the care a mother receives lacks cultural safety, she may experience confusion, anxiety, depression, and trauma that can stay with her throughout her life, which can affect how she parents her baby and in turn impact her child's growth and development (Bowen et al., 2014; Kornelsen, Kostaka, Waterfall, Willie & Wilson, 2011).

Until the 1970s, many Indigenous women gave birth in their home communities with some mothers birthing on the land; the centralization of health care has resulted in the loss of traditional birthing practices that had previously assured strong community roots for women and their families. Children born into their home community are more likely to develop a clear sense of identity, which helps to promote resilience and build strong community bonds (SOGC, 2017).

This chapter briefly explores the state of Indigenous birth in Canada, the impact on the maternal and infant health, and the importance of increasing culturally-safe care.

Support for Culturally Safe Indigenous Birth

Canada has fully endorsed the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which asserts that Indigenous people have the right to practice and revitalize their cultural traditions and customs (United Nations, 2008). The Canadian Government has endorsed the *Truth and Reconciliation Commission Report* (TRC) (2015) to increase healing and establish and maintain a mutually respectful relationship between Indigenous and non-Indigenous peoples. Amongst the TRC Calls to Action, two are particularly compelling for reclaiming traditional birth: 1) "We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients" (#22); and 2) "increasing the number of Aboriginal health care providers working in Aboriginal communities" (#23.1).

Impact on Health

The Society of Obstetricians and Gynecologists of Canada (SOGC) acknowledges that there are gaps between birth outcomes for Indigenous and non-Indigenous families and that the organization of maternity services contributes to a lack of access to care (SOGC, 2017). Indigenous people are more burdened by chronic diseases, such as cancer, cardiovascular disease, diabetes, and mental illness in comparison to non-Indigenous people (Wilk, Maltby & Cooke, 2017) and many of these conditions have their origins in early life, i.e., conception, pregnancy, birth, and early childhood (Barker, 1995). One study in Australia showed Indigenous mothers appear to experience higher rates of stress during pregnancy than non-Indigenous women (Parker, McKinnon, & Kruske, 2014). Stress in pregnancy is associated with adverse outcomes, resulting in expensive neonatal care and lifelong complications (Kornelson, Stoll, & Grzybowski, 2011; Tarlier, Johnson, Browne & Sheps, 2013).

Given the social and historical contexts of colonization in Canada, it is necessary to consider the impacts of intergenerational trauma, a phenomenon which impacts all Indigenous populations; but, due to the intersection of sexism and racism, especially hurts Indigenous women (Roy, 2014). Stresses of pregnancy can exacerbate existing symptoms of trauma in women, therefore pregnancy may be an especially important time to provide interventions as it can be a powerful time for mothers to choose a healing path and break cycles of intergenerational trauma (Roy, 2014).

Birthing Away from Community

Through a systematic review and semi-structured interviews with mothers who travelled out of community for birth, O'Driscoll and colleagues determined the loss of community birth is a cultural loss (O'Driscoll et al., 2014). By the late 1960s, births in community were deemed unsafe due to distance and isolation (Chamberlain, 1999) and policies arose to support medical evacuation to regional and tertiary care hospitals (Douglas, 2006) including moving women to urban centres at approximately 37 weeks gestation (Chamberlain, 1999). Though sometimes clinically warranted, medical evacuation is often associated with colonialization (O'Driscoll et al., 2014). In some cases where women don't want to leave their family and community, resistance to medical evacuation is evidenced by mothers not reporting their pregnancies, which allows them to birth in their community (Douglas, 2006), and stories of women remaining in community until it is too late to be transferred to urban hospitals to give birth or receive specialized care. Indigenous women often feel lonely and vulnerable when forced to leave their home communities and families, and find themselves in situations that do not incorporate traditional practices or ceremonies into their birth experiences or newborn care (Kornelsen et al., 2011; SOGC, 2017). A study with Indigenous women giving birth in a large tertiary care facility showed that lack of choice in place of birth, type of delivery, and other birth decisions caused them distress, enhanced by lack of support from staff and trauma associated with going through labour without support from their partner, family, or culture (Chamberlain & Barclay, 2000). In Northwestern Ontario, Indigenous mothers reported incurring monetary costs from medical evacuation including airfare, babysitters, long distance calls, along with the challenge of reintegrating into the family and community when they return home with their baby (O'Driscoll et al., 2014).

Birthing in Community

In contrast, mothers who were able to birth in their home community by midwives said they appreciated the care and follow-up provided (Chamberlain & Barclay, 2000; Chamberlain, Barclay, & Moyer, 2001). Most women, regardless of ethnicity, prefer to give birth within their own culture and close to family (Chamberlain & Barclay, 2000). An Indigenous midwifery clinic in Quebec showed a dramatic reduction in the number of women who leave the community for birth,

along with improved antenatal visit rates and fewer obstetrical interventions (Van Wagner, Osepchook, Harney, Crosbie & Tulugak, 2012).

The SOGC supports returning birth to women's home communities as one way to improve their health through the promotion of traditional and cultural practices. They stress that women birthing in their home community establishes roots for the mother, her infant, and the family, and that children born in their home community develop a clear sense of identity that helps them to become resilient and responsible (SOGC, 2017). Improving access to midwifery and culturally-safe maternity care in their home community is considered best practice for the health of the woman and Indigenous communities, and to support the regeneration of strong families (National Aboriginal Council of Midwives, 2016; SOGC, 2017).

While there is professional support for birthing in community, there must always be a balance between cultural and physical safety, which are most critical in remote areas due to delays in treatment if evacuation to a tertiary centre is necessary (Simonet et al., 2009). There is a lack of biomedical research on the safety of midwife led maternity care in remote settings, especially from the period before the introduction of southern medical services (Douglas, 1999). Furthermore, most studies utilize perinatal mortality as the primary outcome, which may not be adequate to understand the safety of community perinatal and obstetric health (Grzybowski, 1991).

Despite the lack of scientific data, there is evidence of positive outcomes of returning the birth experience to remote communities. According to O'Driscoll et al. (2014), "the return of the birthing experience to remote Inuit communities has been very successful since 1986, and excellent outcomes have been demonstrated in the 3-existing birthing centres [of that region] without the capability for cesarean delivery" (p.127). A de facto experiment in Nunavik compared two communities of geographical similarity, one had midwives and one had physicians as the primary birthing attendants. The risk of perinatal death in midwife compared to physician attended births was not significant. In Hudson Bay, Canada, 73% of births were attended by midwives and the perinatal death rate was 14.4 per 1000; in Ungava Bay, 95% of births were attended by western physicians, and the perinatal death rate was 10.0 per 1000 (Simonet et al., 2009). After accounting for preterm birth and evacuation rates (9.4% and 28% in in Hudson Bay and Ungava Bay, respectively), the difference in perinatal death rates were comparable. Regardless of type of birthing attendant, perinatal and infant mortality rates were 1.6 – 4.8 times higher for the Inuit speaking versus French speaking women (Simonet et al., 2009). This disparity indicates a need to "improve perinatal and infant health and address broader and more fundamental social and environmental determinants of health in [Indigenous] communities" (Simonet et al., p. 548).

It is important to consider that pregnancy risk assessments are often culturally biased, based on western health models that do not address differences in physiology and heath (Chamberlain, 2000). For example, one study found shoulder dystocia is rare for Inuit women, yet all primiparous women were sent out of community as they were deemed at risk for this potential complication along with other poor outcomes; furthermore, adolescent Inuit women had healthy babies compared to the risks identified for non-Inuit women of the same age (Chamberlain, 2000).

While midwife led maternity care may be preferable for cultural and medical reasons, not all women can give birth in their home community for accessibility or medical/obstetrical reasons, pointing to an urgent need to provide culturally-safe care not only in her community, but wherever the woman feels comfortable giving birth.

Culturally Safe Care

Care providers may be well-meaning in their intentions to care for the Indigenous mother and her infant based on their professional training, but this has also resulted in birth being medicalized in Western ways with subsequent loss of traditional birth practices, ceremonies, and rituals for Indigenous families (National Aboriginal Council of Midwives, 2016). To offer quality maternity care to Indigenous mothers and their families, providers should work towards practicing cultural safety. Cultural safety addresses inequities arising from sociocultural factors and power differentials between service providers and those they care for; clinical practice without cultural safety contributes to the continued oppression of Indigenous peoples (Roy, 2014). Learning about different peoples and cultures is a

key component of gaining cultural competence for careproviders (Kirmayer, 2012; Tervalon & Murray-García, 1998). Therefore, increasing careprovider understanding about traditional maternal and newborn Indigenous birthing practices and ceremonies is essential to promote cultural security for childbearing women.

Indigenous Ways

According to Douglas (2006), there is "significant cultural variation across the Canadian Arctic, but there is also cultural continuity (p. 119)". For example, although specific birth traditions vary between communities, Douglas (2006) reports Inuit births traditionally occurred within the family group, with assistance from either an experienced midwife (or the husband, when no one else was available), and was traditionally a communal responsibility. Douglas (2006) discusses the traditional attendant's role of cutting the umbilical cord, and how that person would have an important connection to the family thereafter. O'Driscoll and colleagues (2014) found most women knew about some form of umbilical and cradleboard teachings, but they also report that traditional knowledge was not usually received by young mothers (O'Driscoll, 2014). Roy also discusses the importance of holism in Indigenous healing practices (Roy, 2014).

Uniting Indigenous Ways with Western Biophysical Models

Roy (2014) reports the importance of complementing mainstream therapies with traditional healing practices that allow connection with Indigenous identity, and promote healing through balance, kinship nature, spirituality, along with rituals and traditions. Careproviders should understand the knowledge and emotional needs of Indigenous mothers and their families, and develop culturally appropriate responses (O'Driscoll et al., 2011). Providing culturally safe care may help bridge between gap in western medicine and Indigenous knowledge (Simonet et al., 2009).

Summary

There is an urgent need to find ways to support cultural birth experiences to increase comfort for women wherever they give birth, either in their home community, regional centre, or in an urban hospital. This requires that care providers and administrators honour the UNDRIP and the TRC by valuing birth traditions and by increasing the number of Indigenous maternity care providers.

Additional Resources

National Aboriginal Council of Midwives: www.aboriginalmidwives.ca

Strong Women, Strong Nations: Aboriginal Midwifery in British Columbia: https://www.ccnsa-nccah.ca/docs/health/FS-AboriginalMaternalHealth-Smylie-EN.pdf

References

Barker, D. J. P. (1995). The foetal origins of adult disease. *Biol Science, 262*, 37-43.

Bowen, A., Duncan, V., Peacock, S., Bowen, R., Campbell, D., Gawley, L., & Muhajarine, N. (2014). Mood and anxiety problems in perinatal Indigenous women in Australia, New Zealand, and North America (including Hawaii). *Transcultural Psychiatry, 51*(1), 93-111.

Chamberlain, M., & Barclay, K. (2000). Psychosocial costs of transferring Indigenous women from their community for birth. *Midwifery, 16*, 116-122.

Chamberlain, M., Barclay, K., & Moyer, A. (2001). Aboriginal birth psychosocial or physiological safety *Birth Issue, 10*(3), 81-85.

Douglas, V. K. (2006). Childbirth among the Canadian Inuit: a review of the clinical and cultural literature. *International Journal of Circumpolar Health, 65*(2), 117–132.

Grzybowski, S. C., Cadesky, A. S., & Hogg, W. E. (n.d.). Rural obstetrics: a 5-year prospective study of the outcomes of all pregnancies in a remote northern community. *Cmaj, 144*(8), 987–994.

Kirmayer, L. (2012). Rethinking cultural competence. *Transcultural Psychiatry, 49*(2), 149-164. doi:10.1177/1363461512444673

Kornelsen, J., Kostaka, A., Waterfall, P., Willie, L., & Wilson, D. (2011). Alienation and Resilience: The Dynamics of Birth Outside Their Community for Rural First Nations Women. *Journal of Aboriginal Health*, 55-64.

Kornelson, J., Stoll, K., & Grzybowski, S. (2011). Stress and anxiety associated with lack of access to maternity services for rural parturient women. *Australian Journal of Rural Health, 19*(9-14). doi:10.1111/j.1440-1584.2010.01170.x

National Aboriginal Council of Midwives. (2016). The Landscape of Midwifery Care for Aboriginal Communities in Canada. Retrieved from aboriginalmidwives.ca

O'Driscoll, T., Kelly, L., Payne, L., St Pierre-Hansen, N., Cromarty, H., Minty, B., & Linkewich, B. (2011). Delivering away from home: the perinatal experiences of First Nations women in northwestern Ontario. *Canadian Journal of Rural Medicine: The Official Journal of the Society of Rural Physicians of Canada = Journal Canadien De La Medecine Rurale : Le Journal Officiel De La Societe De Medecine Rurale Du Canada, 16*(4), 126–130.

Parker, S., McKinnon, L., & Kruske, S. (2014). Choice, culture, and confidence: Key findings from the 2012 having a baby in Queensland Aboriginal and Torres Strait Islander survey. *Health Services Research, 14*(1-12).

Roy, A. (2014). Intergenerational Trauma and Aboriginal Women: Implications for Mental Health during Pregnancy. *First Peoples Child & Family Review, 9*(1), 7–21

Simonet, F., Wilkins, R., Labranche, E., Smylie, J., Heaman, M., Martens, P., et al. (2009). Primary birthing attendants and birth outcomes in remote Inuit communities – A natural "experiment" in Nunavik, Canada. *Journal of Epidemiology and Community Health, 63*(7), 546–551.

SOGC. (October, 2017). Returning Birth to Aboriginal, Rural, and Remote Communities. *The Journal of Obstetrics and Gynaecology of Canada*, e395-397.

Tarlier, D. S., Johnson, J. L., Browne, A. J., & Sheps, S. (2013). Maternal infant health outcomes and nursing practice in a remote First Nations community in Northern Canada. *Canadian Journal of Nursing Research, 45*(2), 76-100.

Tervalon, M., & Murray-García, J. (1998). Cultural Humility Versus Cultural Competence: A Critical Distinction in Defining Physician Training Outcomes in Multicultural Education *Journal of Health Care for the Poor and Underserved, 9*(2), 117-125. doi:10.1353/hpu.2010.0233

United Nations. (2008). *United Nations Declaration on the rights of Indigenous Peoples*. Retrieved from Geneva: https://www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf

Van Wagner, V., Osepchook, C., Harney, E., Crosbie, C., & Tulugak, M. (2012). Remote midwifery in Nunavik, Québec, Canada: Outcomes of perinatal care for the Inuulitsivik health centre. *Issues in Perinatal Care, 39*(3), 230-237.

Wilk, P., Maltby, A., & Cooke, M. (2017). Residential schools and the effects on Indigenous health and well-being in Canada—a scoping review. *BMC Public Health, 38*(8). doi:https://doi.org/10.1186/s40985-017-0055-6

6. Working with Unbounded Communities: A Metis Case Study

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Recognizing the uniqueness of different Indigenous communities and groups is essential towards ensuring that research, policies, programming, and services truly meet relevant needs. While arbitrary, euro-centric parameters about selection criteria or cultural identity may be justified as a necessity for policy and programming, these can prove problematic when selection criteria are imposed by individuals and institutions who are not members of a given community. Equally problematic is when assumptions are made without consulting those individuals and communities affected by programming and policy decisions. Within Manitoba, Metis and First Nations people often live side-by-side, but have unequal access to health services and supports due to differences between federal and provincial fiduciary responsibilities. These different fiduciary responsibilities reproduce health inequities and challenges the uptake of research, policies, programming, and services. In this chapter, we explore some of the key challenges Metis research participants have raised and propose points for consideration when engaging with Metis communities.

Key Terms: Metis, Canada, Gatekeepers, community engagement

Introduction

When work is being conducted within Metis1 contexts, determining who constitutes as partners is imbedded within a historical context infused with tensions. There are tensions related to defining Metis identity, what the legal and political rights of Metis people are, who is responsible for ensuring rights are met, and what does it mean to be an Indigenous, Metis person within Canada. The answers to these questions differ depending on the stakeholders involved in the dialogue. In order for research to be effective, the right people must be consulted, and their (often competing) needs must be met. In this chapter, we will discuss three challenges that need to be taken into consideration when conducting community-based research with Metis communities. These include: 1) who are Metis citizens?; 2) do we need to work with gatekeepers?; and 3) what makes a community? We propose that through an ongoing consideration of these issues, it is possible to conduct work that has the potential to lead to meaningful change.

Challenge One: Who are Metis Citizens?

Within Canada, there are three identified groups of Indigenous peoples – First Nations, Inuit and Metis – each of which can be subdivided further by geographic and cultural experiences. While the recent Danials decision (Danials v. Canada, 2016) has provided some hope for people, the Metis communities with whom we have worked have expressed feelings that their interests and needs continue to be considered as lesser importance than First Nations and Inuit communities.

They explain that inequitable policies and procedures, such as limitations to hunting, fishing, land claims, and health services continue to place them within a lower position than other Indigenous cultural groups within the country.

Metis identity in many ways is the most rigid across the country, with a constitutional categorical link to the Métis Nation. To become a recognized Metis citizen in Manitoba, Canada, for example, must involve self-identification as Metis, being accepted by a contemporary Metis community, and a documented ancestral connection to the historic Metis Nation, all of which require extensive documentation. Citizenship must be renewed every five years (Manitoba Metis Federation, 2018). Membership within other jurisdictions is similar. While mixed Indigenous and non-Indigenous ancestry was a component of Metis identity in the eighteenth century, the community developed unique traditions, languages, and cultures. Blood quantum is not a cultural classification marker (Anderson, 2015). As understood by the Canadian constitution, of the ten provinces and three territories, the Métis Nation only spans three provinces in their entirety (Manitoba, Saskatchewan, and Alberta), and part of two provinces and one territory (Ontario, British Colombia, and the Northwest Territories). It is important to note that living within one of these provinces is not necessary for maintaining Metis identity; however, there must be a tangible familial link with the historic Métis Nation (Department of Justice, 1982; *R. v. Powley*, 2003).

Many people within Canada do not understand the political and cultural distinction of the Métis Nation, and will self-identify as Metis if they are have mixed ancestry that includes Indigenous heritage, but do not have First Nations or Metis status under other contexts (Anderson, 2016). As it is not possible to hold formal Metis and First Nations citizenship congruently, understanding who is Metis and who is part of Metis communities can be a challenge. We have found that access to healthcare is a driving factor for cultural identification, as First Nations citizens have access to non-insured health benefits, such as pharmaceutical prescriptions, dental care, vision care and medical transportation, while, with some exceptions (Manitoba Metis Federation, 2018), Metis citizens currently must secure private health insurance to receive such benefits (Health Canada, 2008). This may result in having people indicate on paper that they are First Nations, but may culturally affiliate as Metis. This may introduce potential bias into how Indigenous experiences in Canada are represented, as well as what programming, policies, and procedures are necessary to ensure health and wellbeing of Metis citizens.

Challenge Two: Do we need to care about Gatekeepers?

A key component of creating policies, procedures, and programming that is relevant to Metis citizens is involving Metis gatekeepers within consultation processes. There are different levels of gatekeepers who need to be consulted. Depending on the work, and the scope of programming, policies and/or procedures, the level of involvement of gatekeepers differs. Within our work in Manitoba, initial engagement with the Manitoba Metis Federation-Health and Wellness Department at the provincial level took place to help establish research priorities. The next step involves approaching the regional Vice-Presidents and/or local level Metis communities to understand what their interests are and if the research priorities previously identified were consistent at the provincial level. Subsequently, community members are consulted to further narrow down the scope of research interests. It is important that each group be consulted, although the ability to affect change by these different levels may be difficult because of limitations the Metis federation and community organizations have to affect change related to service delivery and economic sustainability.

Challenge Three: What Makes a Community?

In order to develop and implement effective programming, policies and procedures, it is important to understand where people who will benefit the most are situated. Metis citizens are dispersed across geographic areas. A community is constituted by people with a shared cultural identity, a shared political identity, a shared belief system, and/or a shared

sense of place. While many First Nations and Inuit communities are geographically bonded, Metis communities tend to encompass a larger geographic region and identify based on other markers of community, although some geographic districts may have larger Metis populations than others (Martins, Bartlett et al, 2010).

Many rural Metis communities are in close proximity to First Nations reserves. In the cases of Pine Creek and Camperville, Manitoba, the communities are only 800 meters apart, yet programming and policies within these two neighbouring locations are limited by policies and procedures in terms of access to services. For people who live in geographically bounded communities, the closest access to healthcare may be at a nursing station within a First Nations reserve community. For Metis citizens who live with First Nations family members, such as a spouse, this may also be the case; however, as participants in studies we've conducted have explained, these individuals may not be able to access services or supports that are within close geographic distance because of jurisdictional policy regulations. At times, a person or community may be able to request permission to access services, such as the ability to attend a public school within a reserve community or seek medical help from the closest healthcare practitioner, but these allowances must be made in advance and are not always approved.

It is important to understand the need for Metis individuals, cultures, and communities to remain separate from First Nations and Inuit categories, while still remaining cognizant of the potential for shared priorities, such as concerns over the impact of extraction activities (fracking, hydro etc.). By narrowing the scope of policies and procedures specific to Metis within these contexts may prove alienating for both Metis and non-Metis community members who see themselves as stakeholders in terms of the issues. In such instances, it may be worthwhile to involve the greater community in the conversation while being cognizant of Metis specific interests and the Metis voice.

Conclusion

Within community-based health research, there is a desire to conduct work that can lead to meaningful change. This often happens through partnership-based models, and is entrenched within historical, contemporary, and political relationships. There is still a long way to go before Metis rights are equitable to that of other Indigenous populations within Canada, and even further before health status of Metis citizens is on par with the general Canadian population. Working with Metis stakeholders to determine both who, what their priorities are, and how they fit within programming, policies, and procedures is an important step towards reaching this goal.

Notes

1. The Manitoba Metis Federation does not use the acute accent over the "e". The term "Métis", with the acute accent, historically symbolizes circumstances associated with French and Catholic influences, identifying people of mixed Cree and French decent. Historically the term "halfbreed" was used to refer to people of mixed-decent with Scottish and British ancestry, often affiliated with the Hudson's Bay Company. As many Metis people have other Indigenous historical affiliations beyond Cree, such as Anishinabe ancestry and other European/Euro-Canadian ancestry, the accent privileges both French and Cree above other historical lineages. The term Metis without the acute accent indicates unique traditions and heritage that encompasses all people who were part of the historic Metis Nation (spanning northern Ontario thorough Western British Columba and part of the Northwest Territories) (Macdougall, 2017). It is important that the acute accent is used within some documents written by the Manitoba Metis Federation, and it is used by other political organizations, scholars and individuals to denote people of Metis ancestry and their specific cultural traditions.

References

Anderson, C. (2016). The colonialism of Canada's Métis health population dynamics: Caught between bad data and no data at all. *Journal of Population Research*, 33, 67-82.

Anderson, C. (2015). Métis: Race, Recognition, and the Struggle for Indigenous Peoplehood. UBC Press.

Macdougall, B. (2017). *Land, family and identity: Contextualizing health and wellbeing.*

National Collaborating Centre for Aboriginal health. Accessed from: https://www.ccnsa-nccah.ca/495/Land,_Family_and_Identity__Contextualizing_Metis_health_and_well-being.nccah?id=197

Daniels v. Canada (Indian Affairs and Northern Development). (2016) SCC12.

Government of Canada. (1982). *The Constitution Acts, 1867 to 1982*. Ottawa: Queen's Printer. Retrieved from http://laws-lois.justice.gc.ca/PDF/CONST_E.pdf.

Health Canada (2008). *Fact Sheet First Nations and Inuit Health Branch*. Ottawa, ON:

Health Canada. Retrieved from: http://www.hc-sc.gc.ca/ahc-asc/branchdirgen/fnihb-dgspni/fact-fiche-eng.php.

Martens, P. J., Bartlett, J. G., Burland, E. M. J., Prior, H. J., Burchill, C. A., Huq, S., . . . Bailly. (2010). *Profile of Metis health status and healthcare utilization in Manitoba: a population-based study*. Winnipeg: Manitoba Centre for Health Policy.

Manitoba Metis Federation. (2018). *Membership Citizenship/Membership*. Retrieved from: www.mmf.mb.ca/membership.php

Manitoba Metis Federation. (2018). *Prescription Drug Program*. Retrieved from: http://www.mmf.mb.ca/pdp_health.php Supreme Court of Canada, R v. Powley. (2003). 2SCR 207 SCC 43

7. Everyday Life with Chronic Illness: Physical Health or Well-being?

TINE AAGAARD

The background of the study reported in this chapter was the growing number of chronically ill patients. The purpose was to explore patients' perspectives on life with chronic illness and how it relates to healthcare practice. The research was conducted as an ethnographic field study. A conclusion of the study is that the disease-oriented healthcare system is not geared to deal with rehabilitation because of a narrow focus on disease and treatment, and the exclusion of patients' knowledge. However, knowledge about patients' everyday life and perspectives hold potentials for rehabilitative and health promotional professional interventions.

Key Terms: Chronic illness, rehabilitation, health promotion, patient involvement, wellbeing, everyday life, Greenland

Introduction

A growing number of people worldwide are living with chronic illnesses which are responsible for 70% of all deaths. This presents huge challenges for the healthcare systems, concerning tasks, personnel, logistics, and economics (WHO, 2018a), and brings WHO's broad health concept from 1948[1] into a renewed focus. In Greenland, recent health strategies (DSI, 2013; DSI, 2014; DS, 2017) are trying to meet the challenges through an increased focus on health promotion and rehabilitation, in order to ease the pressure on medical treatment. The involvement of patients as active participants in healthcare contributions has been pointed out as an important precondition for the success of the contributions. Greenlandic health strategies are modeled after Danish strategies. According to research in Denmark, patient involvement is often put into practice in problematic ways in that patients are expected to participate in healthcare on the institutional terms (Norlyk & Harder, 2009; Holen & Ahrenkiel, 2011; Thuesen, 2013). Therefore, the aim of the study presented in this chapter (Aagaard, 2015; Aagaard, 2017) was to explore patients' perspectives on everyday life with illness and how it relates to healthcare professional efforts. Below, the methodology of the study is outlined, and some findings concerning the consequences of excluding patients' and relatives' perspectives from professional practice, and the significance of involving patients' and relatives' knowledge and perspectives for rehabilitation and health promotion are presented.

Theoretical Approach

The theoretical approach was social-psychological (Holzkamp, 1998, Dreier, 2008). A key concept is Conduct of Everyday Life, which emphasizes persons' agency. It draws attention to the fact that people on a daily basis strive to make their lives hang together, both time-wise, organizationally, and in relation to other participants in their lives. This is done

in interplay with their conditions. Thus, social practice is reproduced and changed through the participants' ongoing actions in interplay with each other and the conditions.

The theoretical approach builds on Critical Psychology which has its origin in Germany in the 1970's and since then has spread internationally (see e. g. Annual Review of Critical Psychology, 2006 and 2013). Critical Psychology is a theoretically founded conceptual frame of analysis for analyzing social practice (Dreier, 2008). The analytic concepts were developed through a historical and concrete analysis of human psychical development (Holzkamp, 1998). A basic ontological point is that human beings have potentials for changing and developing social practice for the common good. Survival is not up to 'the fittest', but is a question of cooperation. Part of the analysis of social practice is to deconstruct and criticize prevailing or merely common sense-concepts, for example western concepts of health and wellbeing, as a basis for reconstructing a specific social practice, e. g. a local healthcare practice, by including the perspectives of all participants and by elaborating the historical and cultural context of the practice2. The reconstruction can show opportunities for developing the practice in a common perspective. In this way, Critical Psychology is a culture-sensitive and anti-imperialistic theory.

Methods

The study was designed as an ethnographic fieldwork (Spradley 1979; Spradley, 1980). 13 patients with chronic illness were interviewed in the national hospital in Nuuk, the capital of Greenland. Subsequently, five of these patients were visited in their homes in towns and settlements up to three times over a period of 2.5 years. As part of patients' contexts in everyday life, the healthcare institutions in Nuuk and locally were studied. The methods were participant observations, qualitative interviews, and document analysis.

Findings

Patients' Invisible Everyday Lives

The insight in patients' lives and perspectives shows that patients are extremely active in order to manage their life with illness, both the physical disabilities derived from the disease and medical treatment, and the relational consequences of loss of occupation, conflicts in the family, meaninglessness, solitude, etc. Patients deal with these problems daily, but very often they don't succeed. They need healthcare professional support, not only to handle medication and other disease-related interventions, but also to discuss their opportunities to manage the everyday life with illness. In healthcare practice, this is not seen as an object, and professionals know little or nothing about patients' everyday life outside hospital. For example, a woman with a kidney disease and her husband, who lived in a settlement far from Nuuk, had ongoing discussions between them about whether to stay on in Greenland for the sake of familial obligations or move to Denmark, in order to live nearby a specialized hospital. Since the doctors and nurses did not know about the concerns of the couple; they carried out prolonged examinations and treatment in the national hospital in Nuuk. This meant long periods of separation for the spouses, and at a time the woman nearly died without her husband at her side. A dialogue with the professionals about the everyday life could have helped the couple to decide where to settle down and to take their measures in relation to that.

A Disease-Oriented Practice

Though the ethos of the nursing profession prescribes that nurses treat patients as human beings with a life and not as dysfunctional bodies, nurses are not given good opportunities to do so in practice because practice is dominated by disease-oriented procedures, such as clinical observations, treatment of wounds, administration of medicine, etc. This has consequences for patients and relatives. For example, the study shows that relatives are often overlooked or even regarded as a burden for the professional work if they pose questions or make demands, because it takes time from the disease-oriented procedures. Communication between nurses and patients is most often limited to information from nurses about disease and medical treatment. Nurses and other healthcare professionals mostly seek patients' knowledge about their lives in order to make disease-oriented arrangements, such as consultations with doctors.

The Valuation of Knowledge

In healthcare practice, patients' practical knowledge is regarded as subordinate to professional academic knowledge and, therefore, not sought out. However, the study indicates that well-intentioned professional efforts often fall to the ground due to the exclusion of patients' everyday knowledge and their own perspectives on a meaningful life. For example, stroke patients who are eager to regain lost functions risk being viewed as unrealistic about their future physical abilities and, therefore, not getting the necessary support for training. However, patients often exceed professional expectations because they have a strong motivation in their everyday life, such as the wish to get a new occupation or being able to take care of grandchildren. This motivation remains invisible if the professionals don't approve of patients' knowledge and seek it. Consequently, professional practice often misses important knowledge about patients' resources for managing the everyday life with chronic illness – in defiance of the well-documented significance of such resources for rehabilitation (Borg, 2002; SST, 2012, Thuesen, 2013, Arntzen, Hamran & Borg, 2015).

The Value of Patients' Knowledge and Perspectives for Professional Practice

The study shows that patients in the national hospital in Nuuk built up their own communities around joint activities. These self-appointed activities were meaningful for them and promoted their wellbeing. For example, many patients found support in mutual discussions about life with illness. They received inspiration about new ways to tackle problems, and developed new perspectives on future opportunities. Other meaningful activities were walks in the surrounding nature, attending social and cultural events in town, meeting around story-telling, singing and listening to music, and more. Patients in the study indicated that this kind of togetherness was encouraging and decisive for their abilities to endure the hospital stay and to manage the everyday life after discharge.

From the perspective of professionals who are working in a disease-oriented healthcare system, such activities among patients are regarded as irrelevant and only of private interest for the patients. However, the insight in patients' activities holds knowledge about possibilities for professional action in relation to health promotion and rehabilitation. The patients' joint activities during hospital stay show their needs and wishes and their resources. This knowledge is crucial for the arrangements for rehabilitation, where wellbeing, not treatment of disease, is at the center. The involvement of patients' needs and wishes in a life perspective and the involvement of their resources in everyday life in professional practice show ways for professional initiatives concerning health promotion and rehabilitation.

Conclusion

Patient involvement is a strategy for solving current problems in healthcare because of the growing prevalence of chronic illness. Still, patients and relatives do not feel much involved. Two main problems are pointed to in this chapter: the disease-orientation of healthcare practice and the unequal valuation of patients' and professional knowledge. In terms of the broad health definition of WHO, the character of support needed for people with chronic illness is about wellbeing just as much as physical health. This directs the attention to the contexts where people live their everyday lives and where their resources to overcome life with illness have to be found. The significance of this is recognized in health strategies. But in practice, healthcare still concentrates on physical disease and medical treatment from a one-sided professional perspective. This study shows the restrictions of this kind of practice in Greenland and the potentials for health promotion and rehabilitation by involving the patients' lives and perspectives in professional practice.

Notes

1. 'Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity' (WHO, 2018b).
2. This is an extensive and concrete work and the results are only hinted in this short text. For more knowledge about the meaning of the living conditions, the environment, the particular culture and the present development in Greenland I refer to my book 'Everyday life with illness – patients' cultural perspectives on healthcare practice in Greenland' (see the list of references).

Aagaard, T. & Borg, T. (2018). Patient Participation in Healthcare Practice in Greenland:

Local Challenges and Global Reflections. *Outlines – Critical Practice Studies*. 19(1).

Elsass, P., Christensen, H. P., Falhof, J., Hvolby, A. (1994). Greenlanders in hospital; lack of language understanding is not always a hindrance to intercultural communication. Comparison of interviews of Greenlandic patients and their Danish therapists with respect to concepts of communication, patient satisfaction, disease and health. *Arctic Medical Research* 53(2), 97-104.

Jensen, U. J. (2007). The Struggle for Clinical Authority: Shifting Ontologies and the Politics of Evidence. *BioSocieties*. 2(1), 101–114.

Jordan, Brigitte. (1997). Authoritative Knowledge and Its Construction. In: Davis-Floyd, R. E. & Sargent, C. F. (eds.): *Childbirth and Authoritative Knowledge*; *Cross-cultural Perspectives*. University of California Press, Berkeley and Los Angeles, California

Thorgaard, Keld. (2012). Critique of influential epistemological presuppositions in clinical reasoning. *European Journal for Person Centered Healthcare* 1(1), 124-128.

References

Aagaard, T. (2015). Hverdagsliv med sygdom—patienters kulturelle perspektiver på sundhedspraksis i Grønland (Everyday life with illness—Patients' cultural perspectives on healthcare practice in Greenland). *Inussuk—Arktisk forskningsjournal*, 1, 1–221. http://naalakkersuisut.gl/~/media/Nanoq/Files/Attached%20Files/Forskning/Inussuk/DK%20og%20ENG/Inussuk%201%202015.pdf.

Aagaard, T. (2017). Patient involvement in healthcare professional practice in hospital – A question about knowledge. *International Journal of Circumpolar Health*, 76(1), 1403258.

Arntzen, C., Hamran, T., Borg, T. (2015). Body, participation and self transformations during and after in-patient stroke rehabilitation. *Scandinavian Journal of Disability Research*, 17(4), 300-320.

Dreier, O. (2008). *Psychotherapy in Everyday Life*. New York: Cambridge University Press.

DS – Departementet for Sundhed. (2017). *Forslag til en National Rehabiliteringsstrategi 2017*. Nuuk: Naalakkersuisut/Grønlands Selvstyre (Ministry of Health. (2017). *Bill for a National Strategy for Rehabilitation 2017*. Nuuk: Naalakkersuisut/Government of Greenland).

DSI – Departementet for Sundhed og Infrastruktur. (2013). *Kræftplan for Grønland.* Nuuk: Naalakkersuisut/Grønlands selvstyre (Ministry of Health and Infrastructure. (2013). *Cancer Plan for Greenland.* Nuuk: Naalakkersuisut/Government of Greenland).

DSI – Departementet for Sundhed og Infrastruktur. (2014). *National Sundhedsstrategi 2014-2017*. Nuuk: Naalakkersuisut/Grønlands selvstyre (Ministry of Health and Infrastructure. (2014). *National Health Strategy 2014-17*. Nuuk: Naalakkersuisut/Government of Greenland).

Holen, M., & Ahrenkiel, A. (2011). 'After all, you should rather want to be at home'. Responsibility as a means to patient involvement in the Danish health system. *Journal of Social Work Practice*, 25(3), 297-310.

Holzkamp, K. (1998). Daglig Livsførelse som subjektvidenskabeligt grundkoncept. (Conduct Of Everyday Life as Founding Concept of a Science of the Subject). *Nordiske Udkast*, 26(2), 3–31.

Norlyk, A. & Harder, I. (2009). After colonic surgery: The lived experience of participating in a fast-track programme. *International Journal of Qualitative Studies on Health and Wellbeing*, 4(3), 170-180. https://doi.org/10.1080/17482620903027726

Spradley, J. P. (1979). *The ethnographic interview*. Belmont, CA: Wadsworth, Cengage Learning.

Spradley, J. P. (1980). *Participant observation*. Belmont, CA: Wadsworth, Cengage Learning. SST

Sundhedsstyrelsen. (2012). *Forløbsprogram for rehabilitering og palliation i forbindelse med kræft – del af samlet forløbsprogram for kræft*. København: Sundhedsstyrelsen (National Board of Health. (2012). *Course programme for rehabilitation and palliation in relation to cancer – part of a package programme for cancer*. Copenhagen: National Board of Health).

Thuesen, J. (2013). *Gammel og svækket i nye omgivelser – narrativt arbejde i brugerorienterede rehabiliteringsforløb* (Old and impaired in new surroundings – narrative work in user-oriented rehabilitation courses). Ph.d.-afhandling. Institut for Psykologi og Uddannelsesforskning, Roskilde Universitet. Retrieved from http://www.etf.dk/sites/default/files/uploads/public/phd_afhandling_jette_thuesen.pdf

WHO (World Health Organization). (2018a). *Noncommunicable diseases and their risk factors*. Retrieved from: http://www.who.int/ncds/en/.

WHO (World Health Organization). (2018b). *What is the WHO definition of health?* Retrieved from: http://www.who.int/suggestions/faq/en/. http://www.who.int/suggestions/faq/en/

8. The Role of Nurses in Preventing Tuberculosis in Russia's Remote Northern Territories of Residence

NIKOLAI DIACHKOVSKII AND ALEKSANDRA OBUTOVA

Tuberculosis (TB) continues to be a global healthcare problem and is the leading cause of death among infectious diseases. In 2014, a Global Report by the World Health Organization (WHO) declared its intention to eliminate TB worldwide by the year 2035. The Russian Federation is one of the countries with a high TB burden, with the worst incidence of TB observed in the regions of the Extreme North of Russia. Control measures against TB are influenced in complex ways by living conditions and lifestyle characteristics, which stem from extreme weather and climate conditions. For instance, residents of the Extreme North were observed to develop 'polar stress syndrome', leading to increased vulnerability to environmental factors. Simultaneously, traditional ways of life and interpersonal relations are changing due to an influx of migration and the extensive industrial land use of the traditional territories of Indigenous peoples. All of these factors have left a deep imprint on the lives of the Indigenous population. The only available medical care in Russia's Extreme North, with its sparse population and absence of all-season roads, is often provided solely by nurses, especially in remote villages, located far from administrative centers. Therefore, nurses are required to take on a more important role, as an autonomous actor within the rural TB control service. In this context, it is becoming increasingly important to explore social and health-related aspects of TB and its prevention in Indigenous populations, and which take into consideration the conditions of the Extreme North when determining strategies to achieve the WHO's goal of eliminating TB.

Key Terms: Tuberculosis, Extreme North of Russia, Northern Nursing, Infectious Diseases.

Introduction

For the past few decades, global tuberculosis (TB) incidence and mortality trends have been in decline. Nevertheless, as per testimony from the World Health Organization (WHO), TB is still the top cause of death from infectious diseases. The WHO Strategy to end TB between 2016 to 2035, approved by the World Health Assembly (WHA), urges a reduction by 950% in the number of deaths from TB by 2030, and by 980% in the incidence of TB, as compared to 2015 statistics (World Health Organization, 2014). According to the WHO (2014) strategy, for these tasks goals to be achieved, all health workers within the community must be ready to assume leadership and perform these duties. Too often, there is a single health worker tasked to work on improving the quality of care for TB patients in rural areas.

In conventional practice, a mid-level health personnel professional, such as a nurse or rural feldsher, would be assigned the role of physician's assistant and carry out the physician's prescriptions and recommendations. But, in remote sparsely populated areas, which are located at a considerable distance from central district hospitals and may entail the absence of year-round road transportation, physicians are often not on site to participate directly in anti-epidemic activities and deliver medical care to the rural population. In light of this reality, an increasingly important role in managing anti-epidemic measures against TB infection would be assigned to the nurse, as an autonomous health worker within the rural TB service.

Considering the stressful situation caused by the high TB incidence and high mortality rates, the problem of strengthening efforts to better prevent this infectious disease is one requiring an urgent response. During recent years, *M.tuberculosis* (MTB), the causative agent of TB, has been acquiring the features of a nosocomial infection, i.e. one acquired in a hospital, that is highly virulent and transmissible, and possessing multidrug resistance and resistance to disinfectants. The emergence of TB hotspots with HIV and hepatitis co-infection has been observed as well (Skachkova & Nechaeva, 2006).

We found few works in the current literature which address the role of mid-level personnel in organizing TB control measures (Obutova, 2017; Oshchepkova, 2013). To date, both draft and officially issued legal regulations do not provide any implementation mechanisms or guidelines for mid-level personnel on how to manage anti-TB measures (including targeted measures) in the settings of a feldsher-midwife station. The feldsher-midwife station is a structural division within a healthcare system, which delivers pre-hospital primary care in rural areas and is led by a mid-level health worker. In the situation of a feldsher-midwife, anti-TB measures are performed under the guidance of a district physician (or district TB physician), and it is quite often performed under distance supervision, especially when it comes to remote and isolated settlements.

In response to this reality, there has been a need to develop a unified algorithm of preventive and anti-epidemic measures against TB, to be used by health workers at feldsher-midwife stations and targeted primarily at reducing the infection pool and reducing TB disease incidence in northern and remote populations of the administrative territories. This chapter underscores a pilot project, "Village Free from TB", in the territory of Khomustakh village, Ust-Aldan district of the Sakha Republic (Yakutia), that undertook the development and implementation of this algorithm. We begin with a review of the literature. Next, we describe the *Village Free from TB* pilot project. Following, we describe the outcomes of that project on TB incidence, TB contact rates, and the rates of preventative behavior within the Khomustakh village, and conclude with some thoughts on the project.

Literature Review

During the years 2009 to 2014, a total of 360 patients with TB (at various periods and phases of chemotherapy) have been observed at feldsher-midwife stations of the Ministry of Health system of the Sakha Republic (Yakutia). Of those patients, 80% did not have permanent employment; 59.2% were newly diagnosed with TB; 5.8% had a relapse; 35% had chronic TB; and 50.3% were sputum and/or culture positive for TB. Smoking and alcohol abuse were adverse factors which had an aggravating effect on treatment and rehabilitation in rural settings.

A rural TB hotspot comprises the patient's place of residence, and public and administrative facilities visited by patient; therefore, if at least one active TB case has been detected, the entire village is considered a TB hotspot. In our study, TB hotspots were present in 23.1+1.7% feldsher-midwife stations. On average, 7.1+0.9% of all patients with TB resided in the serviced territory. On average, each household hotspot had at least 1 adult patient with TB and less than 1 normal child. The number of children residing per one household hotspot was less (p <0.001) than the number of adult TB patients (p <0.001). 40.2% of household hotspots were designated as class 1 hotspots, indicating the co-existence of the most unfavorable factors in those hotspots, and requiring special attention. A link was established between the presence of TB household-hotspots in an area serviced by feldsher-midwife station, and the probability of new hotspot emergence (r = 0.84, p <0.001).

To assess the effectiveness of preventive and anti-epidemic measures against TB performed by a rural feldsher-midwife station under scientific and methodical guidance from the Phthisiatry Research-Practice Center, we developed and implemented the project *Village Free from TB*.

Village Free From TB Project

Upon mutual agreement with the local administration and after receiving approval from the active villagers, a pilot project was implemented from 2009 to 2014, in the territory of Khomustakh village, Ust-Aldan district of the Sakha Republic (Yakutia). The project included systematic annual preventive house-to-house examination of the total population. Specifically, adults underwent x-ray examination and children were tested with the 2TU Mantoux test. Patients with TB became subject to regular medical check-ups and were referred for treatment to a district-level or republic-level TB Clinic. Individuals with prolonged cough (i.e. more than 2 weeks) were referred to sputum microscopy for AFB (acid fast bacilli). All individuals who skipped their obligatory x-ray examination were tested with *Diaskintest*, an intra-dermal test based on recombinant protein CFP10-ESAT6. Program efficiency was assessed based on occurrence of new cases of TB, skin test conversions1 in children, and population coverage percentage with preventive examinations.

The algorithm of procedures on anti-TB and anti-epidemic measures for a nurse working in feldsher-midwife station included 4 stages:

Stage I: Comprehensive plan of anti-TB measures:

– Compile comprehensive plan of TB control work in a village (prepared by a feldsher at a feldsher-midwife station; based on the district-level plan and cleared through the village administration).

Stage II: Organize preventive medical examinations for the population:

2.1. Perform census of households.

2.2. Perform immunological diagnosis in pediatric population.

2.3. Perform x-ray examination of adolescent and adult population.

2.4. Perform Diaskintest for those who failed to undergo x-ray examination in time.

2.5. Arrange collection of sputum samples for AFB test and transport to TB Clinic.

If positive results were obtained:

2.6. Consult with therapist.

2.7. Consult with TB physician.

Stage III: Conduct anti-TB activities at hotspots:

3.1. Arrange hospitalization of patients to in-patient facility.

3.2. Manage patient treatment:

· Manage directly observed administration of anti-TB drugs in treatment continuation phase.

· Refer to TB Clinic for planned (periodic) examination.

3.3. Conduct anti-epidemic measures at household-hotspots:

· Trace contacts;

· Train people to perform current disinfection;

· Organize terminal disinfection at household-hotspots;

· Have the veterinary service check the hotspots.

3.4. Work with contacts exposed to TB:

- Perform preventive medical check-up;

- Isolate children from household-hotspots;

- Manage specific preventive chemotherapy (after consultation with TB physician);

- Perform activities at patient's workplace.

3.5. Conduct anti-epidemic measures covering an entire village:

- Notify Village Administration on emergence of new infected households;

- Cooperate with active villagers to perform terminal disinfection depending on data of drug sensitivity of mycobacteria circulating in a village to disinfectants.

3.6. Manage out-patient observation of clinically cured patients:

- Timely refer patients to planned medical examination, prescribe and monitor anti-relapse therapy (by a TB physician, twice a year).

Stage IV: Monitor for TB, analyse the work done.

Discussion

At the beginning of the implementation of the project, *Village Free from TB* annually identified from 2 to 5 foci of tuberculosis infection. Sources of tuberculosis were persons released from penitentiary places. The number of contact persons of the adult population varied from 2 to 4 people, and the children's contingent of the population was up to 14 years old from 1 to 6 children (Table 1).

Year	Amount of adults	Amount children under 14 years	Amount foci of tuberculosis	Amount contact persons	Amount contact children under 14 years old
2007	175	77	2	2	1
2008	191	76	5	4	6
2009	184	76	5	3	4
2010	176	69	5	2	3
2011	181	73	3	2	1
2012	195	78	0	0	0
2013	182	84	0	0	0
2014	179	81	0	0	0

At the same time, it should be noted that since 2011, the second year of the project, there has been a clear decrease in the number of foci of tuberculosis and contact persons of adults and children in the population of the village Khomustakh. Specifically, during the study period, the baseline pediatric infection level in Khomustakh village has declined from 5 cases (6.5%) to 1 (1.2%) case within the entire pediatric population ($\chi2= 3.99$; $p < 0.05$); after 2013, no new cases of TB were registered. The pool of adult patients with TB reduced from 5 (2.7%) to 0 ($r=0.95$; $p<0.001$). The population coverage with preventive x-ray exams increased substantially, from 66.3% in 2007 to 91.3% in 2014 ($r=0.81$; $p<0.05$), due to examining

the so-called unreached sector. Meanwhile, every third case of TB among detected ones originated from the unreached sector (Please see Table 2).

Table 2. Trends in preventive medical check-ups and tuberculosis disease occurrence in Khomustakh village, years 2007 to 2014.

	2007	2008	2009	2010	2011	2012	2013	2014	Total
Mantoux skin test conversion	5	6	2	0	1	0	2	1	2.12+0.78*
Proportion of pediatric population infected with TB (%)	6.5	7.9	2.6	0	1.4	0	2.4	1.2	2.75+1.03
Number of patients with TB at feldsher-midwife station	2	4	5	5	4	1	1	0	2.75+0.70*
Proportion of adult population (%)	1.1	2.1	2.7	2.8	2.2	0.5	0.5	0	1.48+0.38
Number of cases among adults	2	2	2	1	1	1	0	0	1.12+0.29**
Number of cases among children	0	0	0	0	0	0	0	0	0
X-ray examination (%)	66.3*	71.6	71.8	86.6	87.5	89.5	89	91.3*	81.7+3.5**

Notes: *- p<0.05 (χ2=3.99)**–p<0.05 (r=0.950)*- p<0.05 (r=0.805).

Conclusion

Thus, in the remote settlements of the Far North, the nurse is the main organizer and direct implementer of antituberculous preventive and antiepidemic measures, whose quality correlates to the quality of TB care for the rural population. As demonstrated by the *Village Free from TB* pilot project, conducting continuous annual preventive examinations of the population are more effective in detecting tuberculosis in unorganized population groups. The algorithm of the feldsher-midwife station nurse's work on anti-tuberculosis and antiepidemic measures consisting of 4 stages is a simple, inexpensive and at the same time most effective method of preventing tuberculosis infection.

Notes

1. Tuberculin skin test conversion – change from negative to positive of a response to intradermal introduction of tuberculin, not associated with vaccination against TB, or else, 6 mm or more enlargement of reaction on top of postvaccinal allergy during 1.

References

Aksenova, V. A. (2013) *Federal'nye klinicheskie rekomendatsii po diagnostike i*
   lecheniyu latentnoy tuberkuleznoy infektsii u detey [Federal clinical guidelines on diagnosis and treatment of tuberculosis infection in children]. Retrieved from http://www.kuzdrav.ru/sites/default/files/normadoc/2015/lti.pdf.
   Fedorova, L. S. (2006). *Teoriya i praktika sovershenstvovaniya dezinfitsiruyushchikh*
   sredstv [Theory and practice in the improvement of disinfection agents]. Moscow: Meditsina publ.
   Obutova, A. I. (2017). *Rol' fel'dshera v organizatsii protivotuberkuleznykh meropriyatiy*
   v ochagakh tuberkuleznoy infektsii v sel'skoy mestnosti: dis. ... kand. med. nauk [Role of feldsher in managing anti-tuberculosis measures on sites of tuberculosis infection in rural area. (Master's Thesis). Moscow.

Oshchepkova, N. M. (2013). *Osobennosti organizatsii protivoepidemicheskikh*

meropriyatiy sredi detey v ochagakh tuberkuleza v sel'skoy mestnosti regiona Kraynego Severa: diss. ... kand. med.nauk
[*Specifics of organization of anti-epidemic measures among children in hotspots of tuberculosis infections in rural areas of the extreme north* (Master's Thesis). Moscow.

Skachkova, E. I., & Nechaeva, O. B. (2006). Protivotuberkuleznaya pomoshch'

naseleniyu: glavnye napravleniya, rol' medsestry [Population tuberculosis care: key areas, and role of the nurse]. *Meditsinskaya sestra*, 5, 21-23.

World Health Organization. (2014). Draft Global Strategy and Targets for Tuberculosis Prevention, Care, and Control after 2015. *Sixty-seventh World Health Assembly* A67/11. Retrieved from: http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_11-en.pdf.

9. Community Development in Canada's North

KERRY LYNN DURNFORD, CATHERINE BRADBURY, SUSAN STARKS, MARNIE BELL, AND PERTICE MOFFITT

> *Community development is an essential component of community health nursing. Community health nursing in Canada's North is unique due to the transient nature and diverse scopes of practice of health care providers. Expectations related to interprofessional and intersectoral collaboration heighten the complexity of northern nursing practice. The rural and remote location of many communities also increases the cost of professional development and continuing competence. Particularly important is the rich diversity of northern people, but also knowledge and recognition of the legacy of residential schools and colonial practices, which have created health disparities for Indigenous people. Community development approaches built upon collaborative, respectful and egalitarian relationships with both Indigenous people and the intersectoral team are essential to an effective health care system. The purpose of this chapter is to discuss community health nursing competencies necessary for the practice of community health nursing in the North.*
>
> **Key Terms:** Community development, competencies, Indigenous, pan-territorial

Introduction

Throughout Canada's North, northern health and human service practitioners work with communities who are often marginalized. A key concept needed within northern curricula is community development. Community-based and participatory approaches embedded in community development are at the core of community work whereby empowerment, social justice, cooperation, participation, and capacity-building come alive. This chapter will focus on four key competencies related to community development, as identified by a pan-territorial needs assessment. Other competencies, based on frequency of knowledge gaps, were selected for a community-development module, including those that address process-based skills, such as asset mapping and proposal writing. Resources to meet these additional competencies, including a link to the northern community development module, can be found at the end of the chapter.

Canada's Northern Context

The three territories (Yukon, Northwest Territories, Nunavut) are located above the 60th parallel and are each unique, in terms of culture, composition, and context. Indigenous peoples and settlers occupy the three territories. The term settler refers to the colonial practice and power dynamic intended to exert control over Indigenous people and their land (Battelll-Lowman & Barker, 2015). Many remote communities are scattered across the landscape. There is difficulty with recruitment and retention of healthcare practitioners in the territories and turnover compels attention to training and professional development (Kulig, Kilpatrick, Moffitt, & Zimmer, 2015). Service provider competency and understanding of people, communities, and the colonial legacy are essential to address the disparities documented in the Canadian North (McNally & Martin, 2017).

Community Development and Professional Development Challenges

Community development is the process of developing the strength and sustainability of a community. Community strength is evident in the essential skills and assets of the community, along with the collaborative action and problem solving in which community members engage (Bradbury, Starks, Durnford, & Moffitt, 2016; Frank & Smith, 1999; Vancouver Costal Health, 2009).

Barriers for health professionals in accessing continuing education (CE) are a reality in rural and remote settings. Nurses face particular constraints in pursuing CE, including the lack of time, finances, technology, and workplace supports (Santos, 2012). Penz, D'Arcy, Stewart, Kosteniuk, Morgan and Smith (2007) analyzed survey data from 3,933 Canadian nurses working in rural or remote settings and found that although many concerns about access to CE were aligned with those of urban counterparts, nurses in rural and remote settings added isolation/rural location, difficulty finding backfill in small staff pools, and distance to nurse educators and quality education.

Pavloff, Farthing and Duff (2017) concluded that, "the rural and remote nursing work environment, complexity and diversity of nursing care necessitates the need for educational opportunities that are designed specifically for rural and remote nurses." (p. 90) Northern health and human service practitioners surveyed in a pan-territorial needs assessment reported frequent engagement in community development activities; however less than half indicated that they had received any preparation for the role in their undergraduate education (Bradbury et al., 2016).

Community Development Competencies

Overview

In 2012, educators and public health representatives from the three Canadian territories began a collaborative project to explore the community development learning needs of the pan-territorial community health and human service workforce. Community capacity building competencies developed by the Public Health Association of British Columbia (2008) provided a template of competencies relevant to the territories. These 13 community development competencies identified the skills, knowledge, and attitudes required to work effectively with northern communities in this grassroots approach. Research led to identification of key competencies where education gaps exist, revision of language to meet the diverse needs of northern practitioners, and development of a competency-based self-directed learning module. This learning module addressed competencies rated as the greatest need by participants including: advocating for services and policies that influence the health and well-being of many people at the same time; helping communities work through issues using problem-solving and conflict resolution skills; understanding and applying participation action research, community asset mapping and participatory evaluation to gather information; advising on and influencing opportunities to help communities keep their efforts going; and developing strategic plans, grant proposals, project proposals, briefs, options papers and requests for proposals. The remoteness of many northern communities, the transient nature of professionals, and the large territorial Indigenous population, highlights the importance of four other competencies not discussed in the workbook: establishing effective relationships, utilizing a population and social determinants approach to health, encouraging and supporting community-based advocacy, and cultural competency. These competencies will be further explored in this chapter.

Table 1: Community Development Competencies for Northern Practitioners

1. Understand the concepts of working effectively in the community and able to build community capacity in my work.
2. Able to establish effective working relationships with all kinds of individuals, organizations and groups.
3. Able to influence others, foster leadership, mobilize a community to action and help others to successfully work through change.
4. Able to use a population and social determinants approach to explore factors that affect health (i.e. income, food, housing, etc.) in order to improve health and wellbeing of groups and communities.
5. Able to apply at least two of the following to develop capabilities of others: Group facilitation, Coaching, Consultation techniques, Community engagement processes.
6. Able to engage communities to advocate for services and policies that influence the health and wellbeing of many people at the same time.
7. Able to ensure information (both written and oral) is passed on and understood by others in a timely and effective way.
8. Able to help communities work through issues using problem-solving and conflict resolution skills.
9. Able to understand and apply at least one of the following to gather information: Participatory action research, Community asset mapping, Participatory evaluation.
10. Able to take into account diverse values, beliefs and cultural practices when working with communities.
11. Able to advise on and influence opportunities to help communities keep their efforts going.
12. Able to develop two or more of the following: Strategic plans, Grant proposals, Project proposals, Briefs, Options papers, Requests for proposals.
13. Able to encourage innovation and support new approaches.

Adapted from BC Core Competencies Project. (2010) by the Public Health Association of British Columbia. Adapted with permission.

Establishing Working Relationships (Competency 2)

The ability to establish effective working relationships with individuals, organizations, and groups is important in the diverse, autonomous, and often complex northern health care environment. In many remote northern communities, health care services are provided in health centres, which are usually staffed with a small number of nurses, who are often the primary care providers (Rahaman, Holmes, & Chartrand, 2017). Other essential members of the team may include one social worker and community health representatives (CHRs). CHRs are often Indigenous community members who play essential roles in health promotion (Cameron, Carmargo Plazas, Salas, Bourque Bearskin, & Hungler, 2014). Consultations are frequently completed via telephone with interprofessional team members in territorial and larger southern hospitals. Local elders, cultural healers, teachers, and police officers become colleagues (Leipert & Reutter, 1998). Building partnerships with these community members is essential to community development success.

Philip, a Registered Nurse (RN), has moved to a remote northern community of 500 people, after five years of working in a large busy hospital in southern Canada. Over 90 percent of the community members are Indigenous. The community health centre is staffed by three RNs, a community health representative, and a social worker. A general physician visits monthly. The only access to the community during the summer is by air, with ice road access during the winter months. Philip has learned about transcultural nursing in his undergraduate education, but has discovered in his practice, that culture is ever evolving and created through relationships. He recognizes that to develop effective working relationships, he must develop connections within the community and come to understand the culture. How can Philip develop these relationships?

Case Study Suggestions:

Philip must learn about the community, its history and culture, from the people. Philip could visit the local band office to introduce himself. He could form a relationship with the community health representative, who is typically a local community member with training in health promotion. Philip should seek advice from the community health representative, or the band office, on local protocol for speaking with elders and requesting to learn from them (for example, in some cultures it is appropriate to offer tobacco or other gift, before asking questions or requesting to learn from the wisdom of an elder). Philip should seek opportunities to attend local community events, such as feasts, or drum dances. Importantly, Philip could request a visit with local elders to introduce himself, and to learn more about the people and their culture. Philip should also complete the history of colonization course offered online by the government, as well as local cultural awareness modules.

Using a Population and Social Determinants Approach (Competency 4)

Practitioners must use a population and social determinants approach to explore factors that affect health in order to improve health and wellbeing of groups and communities. Heath is defined as the state of complete physical, mental and social well-being and not merely the absence of disease or infirmity (World Health Organization, 1948, p.1). Canada's territories are home to many Indigenous people. A history of colonization and racism spawned by Canadian government policies, resulting in intergenerational trauma from residential school experiences, has created great health disparities between Indigenous and non-Indigenous Canadians (McNally & Martin, 2017). The front-line care provider must be cognizant of the social determinants of health specific to Indigenous peoples. Nesdole, Voigts, Lepnurm, and Roberts (2014) state that to facilitate community programming relevant to Indigenous peoples, practitioners must address such determinants as basic physical needs, safety and security, community solidarity and social support, strong families, healthy child development, and critical learning opportunities.

Canada's Indigenous peoples remain a strong and resilient community. It is important for the practitioner to adopt a strength-based approach to community development. Community care is best when it is based upon the needs of the community, led by the community, and delivered in a culturally appropriate manner (Nesdole et al., 2014). The poor health of Indigenous peoples must be actioned rather than accepted as "status quo" (Rahaman et al., 2017, p. 194). Indigenous people deserve autonomy in health decisions and practitioners must demonstrate reciprocity through mutual respect, communication, and collaboration.

> **Learning from Mothers, Grandmothers and Great-Grandmothers about Breastfeeding in the Northwest Territories**
>
> An example of using a social determinants approach in community development can be seen in recent research to explore breastfeeding in the Northwest Territories. Dr. Pertice Moffitt, the lead in a project funded by the Northwest Territories Department of Health and Social Services, requested the guidance of respected elders to learn about breastfeeding. The Advisory Circle of Knowledge Keepers worked with the project lead in interviewing women, delivering community presentations and developing community resources. The project described the nature of breastfeeding, from a traditional and evidenced informed perspective, and highlights the strengths and resilience of women in the North. The knowledge created will inform practice, policy, and future research (Moffitt, 2018).

Engaging in Community Advocacy (Competency 6)

The ability to engage communities to advocate for services and policies that influence the health and wellbeing of many people is an important step in creating lasting change. Care providers should learn to work with community members to frame the issue, formulate a plan to address that issue and to engage and support community members in leading the way. Considering the diversity of the health and social service care team in remote communities, care providers are encouraged to explore the competing expectations around advocacy from communities, employers, licensing bodies, and their own ethical principles.

Demonstrating Cultural Competency (Competency 10)

Cultural competence in community health practice assumes respect for culturally diverse communities and is informed by cultural awareness, cultural knowledge, cultural skill, cultural encounters, and cultural desire on the part of motivated health care providers (Stamler, Yiu, & Dosani, A., 2016). The concept of cultural safety is defined as effective cross-cultural nursing practice, as determined by the clients receiving care (Stamler et al., 2016). Culture is more than a collection of common characteristics. It is a continual, relational process (Browne & Varcoe, 2006).

A cultural safety perspective reminds us that, to provide quality care for people across a range of ethnicities and cultures, we must offer care within the cultural values and norms of the client, which suggests a change in power structure and a focus on the outcomes of health care encounters from a client's perspective (Brascoupe & Waters, 2009). The provision of culturally safe care is considered an important competency for those working with northern people, as it incorporates an exploration of personal ways of being, privilege and power dynamics, and a recognition of historical and political factors that shape health and social care systems for Indigenous people (Ramsden, 2002).

Many northern employers utilize cultural safety modules and online resources to increase practitioner's knowledge of Indigenous people and to promote awareness of personal biases which may impede the ability to create an environment where people feel safe in receiving care. The Truth and Reconciliation Committee's calls to action identify changes to basic education. These actions include "Aboriginal health issues, the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights and Indigenous teachings

and practices" (The Truth and Reconciliation Committee, 2015, p. 323), as well as receiving skills-based training in intercultural competency.

Benefit to Practice

A commitment to utilizing the community development competencies has the potential to meet the community development learning needs of care providers who work in any community, particularly rural and remote settings. The transient nature of health care professionals in the north and use of temporary care providers raises many challenges, not the least of which is the ability to partner with community members to identify issues, collaborate on and champion for sustainable solutions. Knowledge and embodiment of the community development competencies can strengthen the knowledge, skills, and abilities of health care providers. A shift in the past decade in the three Northern territories to more community-based and participatory approaches to health and wellness necessitates that health care providers have the knowledge and skills to achieve strategic vision and support community-driven initiatives. The strength-based approach of the competencies can assist care providers to engage with community members and foster empowerment.

Communities of practice were informally created among some participants during the community development project, in 2012. The opportunity to dialogue and interact with colleagues about the learning was valuable in generating new knowledge and shared understanding, and extending the inquiry. As well, consulting and networking with peers is both socially and educationally attractive to health care providers who often work in isolation in rural and remote locations.

Conclusion

This chapter offered a brief exploration of the community development competencies of the health and human service practitioner in Canada's far North. An understanding of the challenges in accessing ongoing education to address learning needs and the importance of education to develop competencies in community development is critical to working effectively with northern communities. Community development is an empowerment strategy valued by both practitioners and community members, showing a commitment to community development. Initiative on behalf of the care provider to learn and embody these competencies is an important step in reducing health disparities and increasing collaboration with northern people.

Additional Resources

Community Development in Northern Canada: A Competency Approach -online module (Northern Institute of Social Justice)

Cultural safety module 1: Peoples' Experiences of Colonization (University of Victoria)

Cultural safety module 2: Peoples' Experiences of Oppression (University of Victoria)

Cultural safety module 3: Peoples' Experiences of Colonization in Relation to Health Care (University of Victoria_

From the Ground Up: An Organizing Handbook for Healthy Communities (Ontario Healthy Communities Coalition)

Strategies for Effective Proposal Writing (Ontario Healthy Communities Coalition)

Community Tool Box (The University of Kansas)

References

Battell-Lowman, E. & Barker, A.J. (2015). *Settler: Identity and colonialism in 21st century Canada.* Halifax, Canada: Fernwood Publishing.

Bradbury, C., Starks, S., Durnford, K.L., Moffitt, P. (2016). Nurse educators collaborate in a pan-territorial approach to develop a community development learning opportunity. *Northern Review, 43,* 117-128.

Brascoupe, S., & Waters, C. (2009). Cultural safety: Exploring the applicability of the concept of cultural safety to Aboriginal health and community wellness. *Journal of Aboriginal Health, 5*(2), 6-41. Retrieved from http://www.naho.ca/journal/2009/11/08/cultural-safety-exploring-the-applicability-of-the-concept-of-cultural-safety-to-aboriginal-health-and-community-wellness/

Browne, A.J., & Varcoe, C. (2006). Critical cultural perspectives and health care involving Aboriginal peoples. *Contemporary Nurse, 22*(2), 155-167.

Cameron, B., Camargo Plazas, M.D., Salas, A.S., Bourque Bearskin, L.R., & Hungler, K. (2014). Understanding inequities in access to health care services for Aboriginal people: A call for nursing action. *Advances in Nursing Science,* 37(3), E1-E16. doi:10.1097/ANS.0000000000000039

Frank, F. & Smith, A. (1999). *The community development handbook: A tool to build community capacity.* Prepared for Human Resources Development Canada. Retrieved from http://publications.gc.ca/site/eng/245322/publication.html.

Kulig, J.C., Kilpatrick, K., Moffitt, P., & Zimmer, L. (2015). Recruitment and retention in rural nursing: It's still an issue! *Nursing Leadership,* (28)2, 40-50.

Leipert, B., & Reutter, L. (1998). Women's health and community health nursing practice in geographically isolated settings: A Canadian perspective. *Health Care for Women International, 19,* 575-588.

McNally, M., & Martin, D. (2017). First Nation, Inuit and Metis health: Considerations for Canadian health leaders in the wake of the Truth and Reconciliation report. *Healthcare Management Forum, 30*(2), 117-122. doi: 10.1177/0840470416680445

Moffitt, P. (2018, June). Learning from mothers, grandmothers and great-grandmothers about breastfeeding in the Northwest Territories. Reported prepared for the Department of Health and Social Services, Government of the Northwest Territories, Yellowknife, Canada.

Nesdole, R., Voigts, D., Lepnurm, R., & Roberts, R. (2014). Reconceptualizing determinants of health: Barriers to improving the health status of First Nations peoples. *Canadian Journal of Public Health, 105*(3), 209-213.

Pavloff, M., Farthing, P., & Duff, E., (2017). Rural and remote continuing nursing education: An integrative literature review. *Online Journal of Rural Nursing and Health Care, 17*(2), 88-102. http://dx.doi.org/10.14574/ojrnhc.v17i2.450

Penz, K., D'Arcy, C., Stewart, N., Kosteniuk, J., Morgan, D., & Smith, B. (2007). Barriers to participation in continuing education activities among rural and remote nurses. *The Journal of Continuing Education in Nursing, 38*(2), 58-66.

Public Health Association of British Columbia. (2010). *Community Capacity Building Self-Assessment Employee Tool* [Measurement Instrument]. BC Core Competencies Project. Retrieved from https://phabc.org/competency/self-assessment-tools/.

Rahaman, Z., Holmes, D., & Chartrand, L. (2017). An opportunity for healing and holistic health care: Exploring the roles

of health care providers working within northern Canadian Aboriginal communities. *Journal of Holistic Nursing, 35*(2), 185-197. doi:1177/0898010116650773

Ramsden, I.M. (2002). Cultural safety and nursing education in Aotearoa and Te Waipounamu. (Doctoral thesis, Victoria University of Wellington). Retrieved from: https://www.nzno.org.nz/resources/library/theses#R.

Santos, M.C., (2012). Nurses' barriers to learning: An integrative review. *Journal for nurses in staff development 28*(4), 182-185. doi: 10.1097/NND.0b013e3182dfb60.

Stamler, L.L., Yiu, L., & Dosani, A. (2016). *Community health nursing.* A *Canadian perspective.* Toronto, Ontario: Pearson.

Truth and Reconciliation Committee of Canada. (2015). *Honouring the truth, reconciling for the future. Summary of the final report of the Truth and Reconciliation Commission of Canada.* Retrieved from http://www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf

Vancouver Coastal Health. (2009). *Community engagement framework.* Retrieved from http://www.vch.ca/Documents/CE-Framework.pdf

World Health Organization. (1948). Constitution of the World Health Organization. Retrieved from http://www.who.int/about/mission/en/

10. Theme 1 Review Questions

1. What are some of the consequences of poor oral health? What oral health interventions would you suggest in your role as a health professional?

2. What health strategies have emerged over the past 25 years or so to improve community health in northern and Indigenous communities?

3. What are some goals of a food security strategy in northern communities? What are the different physical and non-physical health aspects of food security?

4. What are some chronic illnesses that are more prevalent in northern and Indigenous communities than in the urban South? Why is the burden of disease in the North greater for these illnesses?

5. There are wide differences in the burden of disease between northern Canada, Alaska, Greenland and northern Russia on the one hand, and the Nordic Arctic regions on the other. Why might this be so?

THEME II – SOCIAL DETERMINANTS AND STRUCTURAL IMPACTS ON NORTHERN AND INDIGENOUS HEALTH

11. Introduction

LORNA BUTLER AND HEATHER EXNER-PIROT

Discussions on health and well-being often focus on health *care* – medical and pharmaceutical interventions to illness and trauma. Health budgets and policies, in the Circumpolar North as elsewhere, overwhelmingly focus on care provision – hospital and clinic infrastructure, medical supplies, drugs, emergency transportation, and the salaries of health professionals such as nurses and physicians.

Yet, we understand more than ever that health and well-being are rooted in an individual's

or community's social context. Educational attainment, economic prosperity and employment, and the food, housing, recreation and status it affords, are far greater predictors of health than the availability of health care. These are known as the *social determinants of health.*

Historical Perspectives

The concept of social determinants has evolved over the past fifty years with multiple writings on both the conceptualization and the influence on health and well-being of populations. The early writings of the 1980s presented a sociological analyses of structural determinants impacting working class conditions, such as the distribution of economic, social, and political resources; however, these findings were overshadowed by the traditional biomedical interpretations of health (Raphael, 2006). Recognition of a broader understanding of health was later acknowledged in 1984 when the World Health Organization (WHO) convened an international conference "Health for All by Year 2000" (WHO, 1984). Health was defined as "a positive concept emphasizing social and personal resources, as well as physical capacities...with agreed upon "fundamental conditions and resources for health." (WHO, 1984) Tarlov (1996) has been credited as introducing the term "social determinants of health" to describe how inequalities of living conditions had an effect on disease. Research conducted over the late 1990s and early 2000s provided evidence to support the inclusion of socio-political, economic, biomedical, and behavioural concepts as determinants of health (Health Canada, 1998; Bryant, Raphael, Schrecker & Labonte, 2011). Based on a synthesis of existing research evidence, Raphael (2006) identified eleven constructs as the key social determinants of health (See Table 1).

Table 1 Examples of the Evolution of Social Determinants of Health

1984	1998	2006	2011
Ottawa Charter	Health Canada	Rapheal	Cooke & Long
Peace	Income/social status	Aboriginal status	
Shelter Education* Food Income A Stable Eco-System Sustainable Resources Social Justice Equity	Social Support Network Education* Gender Culture Employment/Working conditions Environment: Physical & social Healthy child development Health Services	Early life Education* Employment/working conditions Food security Health care services Housing Income Social safety net Social exclusion Unemployment/ Employment security	Participation in traditional activities Balance Life Control Environmental Education* Material resources Social resources Environmental/cultural connections

The terminology of social determinants of health is understood within academic health sciences, but is less clear for policy makers and public audiences. When the Robert Wood Foundation restructured in 2003, they added a portfolio

of vulnerable populations. The challenge became finding ways to translate the meaning of determinants of health at the community level. In developing their messaging, it was identified that social determinants of health consisted of two components: context of health – where people lived, worked, played, and learned – and disparities of health, referring to class, race, and ethnicity (Woods Foundation, 2010). Lessons learned included the use of local language to relate to the people, reflecting the values of a community, and giving some sense of a shared responsibility to achieve a difference resonated with their audiences. Rather than talking about determinants of health, terminology became "Health begins where we live, learn and play." (p. 7) While some may dismiss this as a corporate example, the purpose is to demonstrate the complexity of layers involved in addressing social determinants of health. Decision making that spans from a company's mandate to support health-related programs to decisions by governments and policy makers requires an understanding of how social determinants may impact health and health service delivery.

Member countries within the United Nations have tried to determine action plans to address health inequalities (WHO, 2008) from an evidence-based perspective. There is strong evidence to demonstrate that, for countries within the OECD, health spending does not translate to improved health outcomes. To give a comparison, between Norway and Canada, health expenditures per capita include: $5,003 (US) and $ 4,078 (US) respectively, life expectancy is the same (80 years), yet infant mortality rates differ significantly with Canada falling to 12th while Norway ranks 6th. How health dollars are spent versus the amount spent is a pressing concern as tertiary care spending competes with the longer term investment in health promotion and disease prevention. Canada must come to grips with the health demands of an aging population that has poor lifestyle behaviours and rising chronic illnesses (CBoC, 2018). Based on an analysis of three core social determinants: income inequality, incidence of poverty, and housing, Canada has made little progress on reducing the health inequities for a country with a great history of universal health insurance (Bryant et al., 2011; Norwood, Ploeg, Markle-Reid & Sherifali, 2017).

Introduction of Indigenous Social Determinants

Simultaneous to the international debates on the social determinants of health, evidence began to emerge on causes associated with the inequities within various populations. Within the Canadian context, early writings by Reading and Wien (2009) considered social determinants of health within the context of Aboriginal people. They presented a model that depicts four dimensions of physical, spiritual, emotional, and mental health across the life span. The goal was to provide a way to consider various pathways of how social determinants influence health at different life stages, such as interventions aimed at the vulnerabilities experienced by Aboriginal children and youth may influence behaviours that could have a lasting impact on adulthood (refer to section on childhood oral health in this chapter). Reflective of the early work by Reading & Wein (2009), incorporating Indigenous values with published documents describing circumpolar values for health systems stewardship found several shared values aligned including: respect, teaching, kinship (family) and nourishment (land) (Chatwood, et, al. 2017).

Introduction to northern social determinants

Residents of the Circumpolar North, especially rural and Indigenous residents, face additional social impacts to their health compared to their southern or urban counterparts. Inequalities arise from boom and bust resource economies and a lack of economic diversification. Limited transportation infrastructure means that basic goods and services such as food and shelter are much more expensive – even unaffordable – for many families. Rural areas of the North have been further marginalized in the 21st century due to poor internet connectivity.

Amongst the greatest social determinant of northern health has been the history of colonization. Northern societies were self-sufficient and autonomous for centuries and millennia before Europeans moved West to North America,

East to Siberia and North to the European Arctic. Europeans appropriated vast northern territories and colonized Indigenous peoples in order to support economic activities from fishing to the fur trade to mining, or to conduct Christian missions. The effects of this phenomena include loss of culture and language, disruption of the subsistence economy, forced relocation and settlement, destruction of family and societal values and norms, dependency, and political powerlessness. Although the past four decades have seen a renaissance in northern and Indigenous self-determination and a move towards decolonization, the intergenerational impacts of colonization continue to negatively impact northern health and well-being.

This theme begins with the article *Social and Structural Determinants of Indigenous Health* from Cindy Jardine and Laurie-Ann Lines who elaborates on this introduction to the social determinants of health and examine how the proximal, intermediate, and distal determinants of health currently affect the health of Indigenous peoples in Canada. Addressing inequities resulting from shortfalls in the social determinants of health is an ongoing problem, and Jardine and Lines underscore the importance of strengths-based approaches and how positive, affirming and health promoting factors provide a positive way of dealing with health issues. This strengths-based approach focuses on celebrating, reinforcing and reaffirming determinants specific to Indigenous peoples' health, to promote community health in a more holistic way.

Amongst the many impacts of political and economic marginalization, the majority of chapters in this theme focus on one particularly deplorable consequence: family violence. Physical abuse and sexual violence rates are disproportionately high across the Circumpolar North, and are responses to the feelings of powerlessness and the cycles of violence incited by poverty and colonization. In many regions, Indigenous youth are particularly vulnerable. The impacts of violence on its victims are far-reaching, and include low self-esteem, depression, addiction, and vulnerability to physical illness. These, in turn, affect life outcomes, such as educational achievement, employability, healthy family relationships, and overall wellness.

Despite their terrible consequences, family violence and sexual abuse are often hidden or minimized due to shame and a culture of silence, leaving victims with few options to seek health and healing. The following chapters attempt to shed light on this fundamental health challenge.

Geoffrey Maina, in his chapter on *Sexual Violence and its Impact on Physical, Mental, and Psychological Health*, addresses the many impacts of sexual violence. Sexual violence can happen to both men and women of any age; however, in Canada victims tend to be women, young, Aboriginal, single, homosexual, or bisexual. Aboriginal women are more than three times more likely to be victims of sexual violence due to the objectification of Aboriginal women, which is engrained in racism, sexism, and colonialism. Community-focused solutions which involve men are more likely to be sustainable in the long term.

Siv Kvernmo looks at the Scandinavian comparative context in her chapter *Sexual Abuse in Indigenous and Arctic Children and Adolescents in Scandinavia*. While Arctic residents have higher rates of sexual abuse than non-Arctic ones, she finds little evidence to support the assumption that Sami, like other Indigenous groups across the North, have more experience with sexual violence than their non-Indigenous peers. The recent literature on the subject, in fact, finds similar rates among Sami and non-Sami youth in Norway. Kvernmo attributes the lower Sami rates of sexual abuse, as compared to other Arctic Indigenous groups, to lower incidence of substance use among parents, lack of parental involvement or broken families, as well as the strong socio-economic benefits enjoyed in the Nordic states.

Following on this theme, Sigrun Sigurdardottir and Sigridur Halldorsdottir examine sexual violence from an Icelandic perspective in their chapter *Childhood Sexual Abuse* (CSA): *Consequences and Holistic Intervention*. Comparing gender similarities and differences, they find that women have a greater tendency to *internalize* their emotional suffering, resulting in behavioral and emotional suppression; whereas men have a greater tendency to *externalize* their emotional suffering, making them more prone to rage, aggressiveness, antisocial behavior, and other behavioral problems. All survivors demonstrated poor health and lack of well-being, both in childhood and adulthood, as well as difficulties in relationships and in relating to their children. A holistic intervention of a Wellness Program, which provided person-centered, holistic, traditional and complementary therapy for female CSA survivors, proved effective in addressing trauma.

Pertice Moffitt and Heather Fikowski look at two sides of the same issue in two separate but complementary

chapters. In *Addressing Intimate Partner Violence in the Northwest Territories, Canada: Findings and Implications from a Study on Northern Community Response*, they find that in the Canadian territories, intimate partner violence (IPV) rates are seven times the national average. Factors that keep IPV rates at crisis levels include the normalization of violence, depleted resources, a revolving frontline service, and historical trauma. The Northwest Territories government has made addressing family violence a top priority, with an action plan that consists of seven strategies: knowledge mobilization, education and awareness, stable and adequate funding, a coordinated response strategy, assessment and screening, social supports, and community healing.

In their second chapter, *A Culture of Violence and Silence in Remote Canada: Impacts on Service Delivery to Address Intimate Partner Violence*, Fikowski and Moffitt describe the Canadian North's social construct of violence and silence based on powerful anecdotes from over fifty interviews with frontline service providers, including police officers, shelter workers, victim services workers, nurses, counsellors and social workers. Contributors to the high incidence of violence include historical trauma, normalization, gossip as a tool for silence, community retribution, family and community values, and self-preservation. This "culture of violence and silence" imposes barriers to service provision in northern areas of Canada requiring new and innovative strategies. Front line workers must also guard against vicarious trauma and compassion fatigue.

Gert Mulvad examines *Family Health and Local Capacity Building in a Developing Community in Greenland, Seen from a Health Promotion Perspective*. Mulvad makes the case that family values, and the health of children and youth must be prioritized to address the effects of disparities between settlements and cities, and their impact on family values and social norms, and ensure the healthy development of future generations. Increased investment in children's education; social services; resources and increased training for new families; language; public health; and social research on mental health can help to achieve this goal.

Together these chapters provide a compelling narrative on the widespread impacts of colonization and poor social determinants of health. Health care professionals must be mindful of these contexts in order to effectively promote community and individual health and well-being.

12. Social and Structural Determinants of Indigenous Health

CINDY JARDINE AND LAURIE-ANN LINES

Social determinants of health reflect the circumstances, conditions, and contexts of peoples' lives, and the effect these have on health and wellbeing. Indigenous peoples are consistently ranked lower in almost every determinant of health, resulting in profound health impacts and inequities. Social determinants of health in an Indigenous context include unique structural determinants such as the continuing impact of colonialism. Addressing Indigenous health inequities requires focusing on changing underlying structural determinants rather than just addressing symptomatic effects, and needs to be done using a strength-based perspective that celebrates positive determinants such as connection to the land, relationships and communities.

Key Terms: Indigenous Peoples; social determinants of health; structural determinants of health; inequities; strength-based approach

Determinants of Indigenous Health

Health is being increasingly recognized as much more than an individualistic, biomedical concept; rather, it is also determined by social circumstances and contexts. These *social determinants of health* involve the conditions under which people live and work, and include diverse factors, such as income, education, stress, social marginalization, and food security (Wilkinson & Marmot, 2003). Deficits in the social determinants of health are considered the major underlying reasons for health inequities and inequalities between populations (WHO Commission on Social Determinants of Health, 2008).

In the 'Western' world, using a social determinants lens is considered a relatively new and innovative approach to health and wellbeing. However, Indigenous peoples throughout the world have always known that health is a holistic concept that extends beyond individual behaviours and genetics (de Leeuw, Lindsay, & Greenwood, 2015). Social determinants of health in an Indigenous context also include unique *structural determinants*, such as history, political climate, economics, and social contexts. These determinants are premised on the importance of relationships, interconnectivity, and community (Reading, 2015).

So it is very ironic that simply being Indigenous has been suggested to be a significant social determinant of health (Mikkonen & Raphael, 2010). For example, in Canada, Indigenous people[1] are ranked lower in almost every direct, or *proximal* (Krieger, 2008), determinant of health than non-Indigenous Canadians. Approximately 33% of Indigenous adults aged 25 to 54 reported having less than a high school education compared to nearly 13% of the non-Indigenous population. The median total income of the Indigenous population for the same age cohort was reported to be just over $22,000, compared to over $33,000 for the non-Indigenous population (Statistics Canada, 2015). Indigenous Canadians are described as being three times more like to experience food insecurity (Health Canada, 2017). These deficits are facilitated by *intermediate* determinants of health, such as government programs and policies on health care, education, and justice (Krieger, 2008). Multiple adverse health outcomes resulting from these deficits include, but are not limited to, elevated rates of: infant and young child mortality, infectious diseases, malnutrition, tobacco use,

accidents, interpersonal violence, homicide, suicide, obesity, cardiovascular disease, diabetes, and diseases caused by environmental contamination (Gracey & King, 2009). For example, the age-standardized rate for diabetes is 17.2% for First Nations individuals living on-reserve, compared to 5.0% for other Canadians (Public Health Agency of Canada, 2012). The prognosis for those who suffer ill-health is also worse; First Nations people with cancer have a significantly poorer 5-year survival than their non-Indigenous peers (Withrow, Pole, Nishri, Tjepkema, & Marrett, 2017). However, it is important to remember that these statistics, while important for identifying inequitable population circumstances, capture only a symptom-heavy aspect of Indigenous health. Determinants of Indigenous health also include positive, affirming and health promoting factors, as described below.

Underlying these proximal and intermediate determinants of health are the continued effects of colonialism, often considered to be the most important foundational or *distal* determinant of health for Indigenous Peoples (Krieger, 2008; Richmond & Ross, 2009). In Canada, the symptoms of colonialism largely stem from the devastating Indian Residential School system, occurring from 1892 to the mid 1990's, that aimed to eliminate the 'Indian' in Indigenous populations by destroying families, culture, and language (Beavon & Cooke, 2003). Health issues faced by Indigenous Peoples are a multiplicative product, rather than additive sum, of cultural wounds resulting from colonialism; beyond individual impact, such wounds impact the entire community and ways of life (Chandler & Dunlop, 2015). These historical contexts are a structural determinant of health that is considered to be a key etiologic factor underlying high rates of illness, disease, and mortality in Indigenous populations (King, Smith & Gracey, 2009).

Addressing Inequities – Moving Forward

Addressing inequities resulting from shortfalls in the social determinants of health is an ongoing problem, particularly for Indigenous populations. However, Indigenous scholars and researchers have identified several areas for positive change. First, health policy-makers need to adopt a structural approach to addressing health inequities concerning Indigenous Peoples rather than continuing to myopically focus on proximal determinants and effects, despite the obvious lack of impact. Failing to address the underlying root causes of disparities (such as a lack of resources for healthy child development, fair and equitable employment opportunities, and differential exposures to harmful environments), perpetuates the structural inequities that are impacting future generations (Reading, 2015).

Second, we need to change the focus to individual and community strengths (what Indigenous Peoples need to succeed), as opposed to the more traditional focus on problems (where and why they have failed) (Anderson, Pakula, Smye, Peters, & Schroeder, 2011). Strength-based approaches are premised on empowering Indigenous Peoples to create social change (Kana'iaupuni, 2005). This is consistent with viewing social determinants of health as 'health promoting' (as opposed to 'health demoting') factors that are influenced by political ideologies, public policies, societal recognition and outrage, and the ability of individuals and communities to effect change (World Health Organization, 2011). Using a health promotion lens shifts the focus from a pathogenic approach that emphasizes factors related to disease and illness to a salutogenic model that stresses positive, salutary factors that support people's health and well-being (Antonovsky, 1994; Becker, Glascoff, & Felts, 2010).

Finally, in the spirit of a strength-based approach, we need to promote, encourage, and enable people to experience positive determinants of health in a culturally appropriate way, and accept these as legitimate health determinants. In an Indigenous context, these include activities on the land, language, traditional means of sharing and passing down knowledge, and connectivity to people and communities (Loppie Reading & Wien, 2009). Providing opportunities for Indigenous-led research and recognizing Indigenous traditional knowledge as valid encourages deeper investigation into these important structural determinants of health. Research we have conducted with northern Indigenous youth has demonstrated the inextricable link they make between connection to the land and health, and the value they attach to relationships honed through traditional activities (Lines & Jardine, 2018).

In summary, reframing our approach to addressing the most profound social determinants of Indigenous health through a structural rather than symptom perspective is necessary if we are to realize the elimination of inequities

for the founding inhabitants of the Circumpolar North. Doing so from a strength-based perspective that focuses on celebrating, reinforcing and reaffirming determinants specific to Indigenous peoples' health holds the most promise for achieving this goal.\

Notes

1. In Canada, Indigenous peoples refers to First Nations, Métis and Inuit peoples.

Additional Resources

Greenwood, M., de Leeuw, S., Lindsay, N.M and Reading C. (Eds.). (2015) *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social.* Toronto: Canadian Scholars' Press Inc.

Loppie Reading, C. & Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health.* Prince George: National Collaborating Centre for Aboriginal Health. *https://www.ccnsa-nccah.ca/docs/ determinants/RPT-HealthInequalities-Reading-Wien-EN.pdf*.

References

Anderson, J.F., Pakula, B., Smye, V., Peters, V. & Schroeder, L. (2011). Strengthening
Aboriginal health through a place-based learning community. *Journal of Aboriginal Health March*, 42-53.
Antonovsky, A. The salutogenic model as a theory to guide health promotion. *Health Promotion International* 11(1), 11–18.
Beavon, D. & Cooke, M. (2003). An application of the United Nations human development index to registered Indians in Canada. In J.P. White, P. Maxim & D. Beavon (Eds), *Aboriginal Conditions.* Vancouver: UBC Press
Becker, C.M., Glascoff, M.A. & Felts, W.M. (2010). Salutogenesis 30 years later: Where do we go from here? *International Electronic Journal of Health Education* 13, 25–32.
Chandler, M. J. & Dunlop, W. L. (2015). Cultural wounds demand cultural medicines. In Greenwood, S. de Leeuw, N.M Lindsay, and C. Reading (Eds.), *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social.* Toronto: Canadian Scholars' Press Inc.
de Leeuw, S., Lindsay, N.M., & Greenwood, M. (2015). Introduction: Rethinking determinants of Indigenous People's health in Canada. In M. Greenwood, S. de Leeuw, N.M Lindsay, and C. Reading (Eds.), *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social.* Toronto: Canadian Scholars' Press Inc.
Gracey, M. & King, M. (2009). Indigenous health part 1: Determinants and disease patterns. *Lancet* 374, 65-75.
Health Canada. (2017). Household Food Insecurity in Canada Statistics and Graphics (2011 to 2012). Retrieved from *https://www.canada.ca/en/health-canada/services/nutrition-science-research/food-security/household-food-security-statistics-2011-2012.html?wbdisable=true*.

Kana'iaupuni, S.M. (2005). Ka'akālai Kū Kanaka: A call for strengths-based approaches from a Native Hawaiian perspective. *Education Research* 34(5), 32-38.

King, M., Smith, A. & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *Lancet* 374, 76-85.

Krieger, K. (2008). Proximal, distal and the politics of causation: What's level got to do with it? *American Journal of Public Health* 98, 221-230.

Lines, L.-A. & Jardine, C.G. 2018. Connection to the land as a youth-identified social determinant of Indigenous Peoples' Health. Revised and resubmitted to *BMC Public Health.*

Loppie Reading, C. & Wien, F. (2009). *Health Inequalities and Social Determinants of Aboriginal Peoples' Health.* Prince George: National Collaborating Centre for Aboriginal Health. *https://www.ccnsa-nccah.ca/docs/determinants/RPT-HealthInequalities-Reading-Wien-EN.pdf*

Mikkonen, J. & Raphael, D. (2010) *Social Determinants of Health: The Canadian Facts*; York Toronto: University School of Health Policy and Management. Retrieved from *http://www.thecanadianfacts.org/The_Canadian_Facts.pdf*.

Public Health Agency of Canada. (2012) Diabetes in Canada: Facts and Figures from a

Public Health Perspective. Retrieved from https://www.canada.ca/en/public-health/services/chronic-diseases/reports-publications/diabetes/diabetes-canada-facts-figures-a-public-health-perspective.html

Reading, C. (2015). Chapter 1: Structural determinants of Aboriginal People's health. In Greenwood, S. de Leeuw, N.M Lindsay, and C. Reading (Eds.), *Determinants of Indigenous Peoples' Health in Canada: Beyond the Social*;; Toronto: Canadian Scholars' Press Inc.

Richmond, C.A.M. & Ross, N.A. (2009). The determinants of First Nation and Inuit health. *Health Place* 15, 403-411.

Statistics Canada. (2015). *Aboriginal Statistics at a Glance.* Retrieved from https://www.statcan.gc.ca/pub/89-645-x/89-645-x2010001-eng.htm.

WHO Commission on Social Determinants of Health. (2008). *Closing the Gap in a*

Generation: Health Equity through Action on the Social Determinants of Health. Geneva, Switzerland: World Health Organization. Retrieved from *http://apps.who.int/iris/bitstream/10665/43943/1/9789241563703_eng.pdf* .

Wilkinson, R. & Marmot, M. (Eds.). 2003. *The Social Determinants of Health: The Solid*

Facts 2nd ed. Geneva, Switzerland: World Health Organization. Retrieved from *http://www.thecanadianfacts.org/The_Canadian_Facts.pdf* .

Withrow, D.R., Pole, J.D., Nishri, E.D., Tjepkema, M. & Marrett, D. (2017). Cancer survival disparities between First Nation and non-Aboriginal adults in Canada: Follow-up of the 1991 census mortality cohort. *Cancer Epidemiology Biomarkers Prevention*, 26(1), 145-151.

World Health Organization. (2100). World Conference on Social Determinants of Health. Rio Political Declaration on Social Determinants of Health, Rio de Janeiro, Brazil, 21 October 2011. World Health Organization: Geneva, Switzerland, 2011.

13. Sexual Violence and its Impact on Physical, Mental, and Psychological Health

GEOFFREY MAINA

Sexual abuse is any unwanted sexual contact or activity in which the perpetrator uses force, threats or takes advantage of victims without consent. Sexual violence includes attempted rape, unwanted sexual touch, forcing a victim to perform sexual acts, and rape. Sexual abuse can happen to both men and women of any age and, in most instances, the perpetrator is known to the victim. Sexual abuse has devastating consequences to the victim. These include risk for sexually transmitted infections, injuries, depression, flashback and post-traumatic stress disorders, guilt, blame, and shame. Victims often manifest with low self-esteem, have difficulty forming and sustaining relationships, and struggle with addictions. This chapter focusses on the demographics of the victims of sexual violence in the Canadian context and the adverse health impact of sexual violence. Sexual violence is rooted in a rape culture that encourages male sexual aggression and supports violence against women. Following, to address sexual violence, a multiperspectival approach is needed. This includes bystander education, male involvement in prevention education, and risk reduction approaches.

Key Terms: Sexual, abuse, violence; effects of sexual violence

Sexual violence

Sexual violence is defined as, "any sexual act, attempt to obtain a sexual act, unwanted sexual comments, or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work" (Krug, Dahlberg, Mercy, Zwi, & Lozano, 2002, p. 149). Women are seven times likely to be victims of sexual violence compared to men (Statistics Canada, 2017). This chapter is devoted to a discussion related to sexual violence against women, its effects and ways to address it.

Sexual violence manifests as rape within marriage or dating relationships or by strangers, or during armed conflict, homicide, unwanted sexual advances, or sexual harassment. Sexual abuse of mentally or physically disabled people or children; forced marriage or cohabitation; denial of the right to use contraception; or to adopt other measures to protect against sexually transmitted diseases, as well as forced abortion also constitute sexual violence (Krug et al., 2002). Coercion entails the use of physical force and may involve psychological intimidation, blackmail, or other threats (Krahé, 2013). It can also occur when a person is unable to give consent, e.g., while drunk, drugged, asleep, or mentally incapable of understanding the situation (Krug et al., 2002). Online and social media platforms can be used to perpetrate sexual violence, such as threats and harassments and revenge pornography, etc. (Benoit, Shumka, Phillips, Kennedy, & Belle-Isle, 2015).

Sexual violence in Canada is a major problem. The provinces of Manitoba and Saskatchewan have the highest rates of sexual violence reported to the police (Benoit, et al., 2015). According to Conroy and Cotter (2017), 2.2% of Canadians have experienced a form of sexual violence in their lives. In 2012, there were 21,900 incidences of sexual assaults reported to police in Canada. Most of the victims tend to be women, young, Aboriginal, single, homosexual, or bisexual

(Conroy & Cotter (2017). Most often, the sexual offender is a friend, acquaintance, or a neighbor (Benoit et al., 2015; Conroy & Cotter, 2017). Women in the sex trade have a higher risk of physical and sexual violence, especially from clients, which compromises their ability to negotiate for safe sex or provide service in a safe environment (Decker, Pearson, Illangasekare, Clark, & Sherman, 2013).

The rates of sexual violence among Aboriginal women are higher than non-Aboriginal women in Canada (Scrim, 2017). Aboriginal women are three times more likely to be victims that non-Aboriginal women (Jodi-Anne, Taylor-Butts, & Johnson, 2006). This violence is rooted in the objectification of Aboriginal women, which is engrained in racism, sexism, and colonialism (Bourassa, McKay-McNabb, & Hampton, 2004). Unresolved trauma, drugs, and alcohol are thought to contribute to high rates of sexual assault in First Nations reserves (Chansonneuve, 2007). Criminogenic factors that are thought to increase Aboriginal women's risk of victimization include unemployment, low education attainment, being raised in a single family home, alcohol, and drugs (Scrim, 2017).

Sexual violence is often grossly underreported to police (Scrim, 2017). Often, the victims do not perceive sexual violence to be severe enough to warrant reporting. Others do not know what constitutes sexual violence. Fear, shame, the embarrassment of being judged, blamed, and not believed, and fear of the perpetrator may keep some victims from reporting to police (Benoit et al., 2015; Lindsay, 2015). Among Aboriginal peoples, the proximity of First Nations people living on reserves makes the victims of sexual violence reluctant to report sexual assault or child sexual assault to the police (Sexualassault.ca. n.d.) Moreover, a lack of confidence in police makes Aboriginal women less likely to report incidences of violence against them compared to non-Aboriginal women (Boyce, 2016).

Addressing sexual violence

Sexual violence has devastating physical, mental, emotional, and psychological consequences to the victims. Victims of sexual violence are three times more likely to experience a disruption in life and seven times more likely to fear for their lives (Sinha, 2013). Victims of sexual violence may have a diminished sense of self and self-esteem; may experience dissociation and powerlessness; show signs and symptoms of post-traumatic stress disorders, such as nightmares and flashbacks; and may relive the traumatic experience long after the event happened (Jina & Thomas, 2013). Depression and suicidal ideation are common mental health consequences of sexual violence. Victims may attempt to regain control of life by abusing drugs and alcohol. (Jina & Thomas, 2013). The physical consequences of sexual violence include pain, fatigue, muscle problems and gynecological problems (Jina & Thomas, 2013; Sinha, 2013; Lonsway & Archambault, 2017).

Feminist scholars have articulated sexual violence within the context of rape culture and as a form of social controls that is motivated by violence, power, or control (Lee, Guy, Perry, Sniffen & Mixson, 2007; McPhail, 2016). Therefore, to confront this culture, community-focused solutions are required (Banyard, Moynihan, & Plante, 2007). Prevention of sexual violence must, therefore, comprise of confronting rape culture through bystander intervention, male involvement in prevention education, and risk reduction approaches (American college health association (n.d.).

First, bystander education, based on a community of responsibility model, teaches men and women to safely and effectively intervene in situations involving sexual violence is often regarded as a primary prevention intervention (Banyard, Moynihan, & Plante, 2007). Such an intervention increases the likelihood of community receptivity to prevention messages and may increase the possibility of community members taking an active role in prevention and intervention (Banyard, Plante, & Moynihan, 2004).

Second, involving men in sexual violence prevention does not frame them as potential perpetuators; rather, this approach acknowledges that those sexual violence behaviors are related to norms of masculinity (American College Health Association, n.d.). Men can thus be involved in this endeavor by intentionally taking responsibility for playing a role in ending sexual and relationship violence as a men's issue, intentionally modeling respect for women and refusing to participate in events that denigrate women (American college health association (n.d.).

Finally, risk reduction approaches entail the development of skills to reduce an individual's risk of experiencing sexual violence. These include recognizing signs of unhealthy relationships, situational awareness, communication skills, and

self-defense (American college health association, n.d.). Involving men in addressing sexual violence against women can help a community find long-term solution to this issue (Lamontagne, 2011).

In addition, developing organization-specific initiatives to address sexual violence is paramount to mitigating the effects of violence, and to champion proactive and prevention initiatives. In Canada, several Indigenous organizations and initiatives are responding to violence especially against women. These include, National Native Women's Association in Canada (NWAC), Sisters in Spirit campaign, Ontario Federation of Indian Friendship Centres, Strategic Framework to End Violence Against Aboriginal women, National Strategy for Abuse Prevention in Inuit Communities, Ontario Native Women's Association, and Mothers of the Red Nation, Manitoba (Lamontagne, 2011).

Health care providers have a significant role to play in supporting victims of sexual violence. As the first professionals to encounter clients facing sexual and other forms of violence, health care providers are best positioned to respond to and assist these victims as they seek healthcare (World Health Organization, 2013). Women who are victims of sexual violence are likely to seek care more than non-abused women (World Health Organization, 2013). By diagnosing sexual violence promptly, they can offer treatment, counseling, document injuries and refer clients to receive legal and social assistance.

Additional Resources

Black, M. C., Basile, K. C., Breiding, M. J., Smith, S. G., Walters, M. L., Merrick, M. T., & Stevens, M. R. (2011). The national intimate partner and sexual violence survey: 2010 summary report. *Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention, 19*, 39-40.

Kraanen, F. L., & Emmelkamp, P. M. (2016). *The Oxford Handbook of Sex Offences and Sex Offenders*. Oxford University Press.

Krahé, B. (2013). Sexual Agression. In B.Krane. *The social psychology of aggression*. Psychology Press.

Quinlan, E., Fogel, C., Quinlan, A., & Taylor, G. (2017). *Sexual Violence at Canadian Universities: Activism, Institutional Responses, and Strategies for Change*. Waterloo, Ontario, Canada: Wilfrid Laurier University Press.

Sexual Violence. (2014). N. Berlatsky (Ed.), *Global Viewpoints*. Farmington Hills, MI: Greenhaven Press.

References

American college health association (n.d). Addressing sexual and relationship violence: a trauma-informed approach. Accessed at https://www.acha.org/documents/resources/ Addressing_Sexual_and_Relationship_Violence_A_Trauma_Informed_Approach.pdf.

Benoit, C., Shumka, L., Phillips, R., Kennedy, M. C., & Belle-Isle, L. M. (2015). *Issue brief: Sexual violence against women in Canada*. Status of Women Canada. Retrieved from www.swc-cfc.gc.ca/svawc-vcsfc/issue-brief-en.pdf.

Bourassa, C., McKay-McNabb, K., & Hampton, M. (2004). Racism, sexism and colonialism: The impact on the health of Aboriginal women in Canada. *Canadian Woman Studies*, 24(1), 23-30.

Boyce, G. (2016). *Victimization of Aboriginal people in Canada*, 2014. Retrieved from http://www.statcan.gc.ca/pub/ 85-002-x/2016001/article/14631-eng.pdf.

Banyard, V. L., Plante, E. G., & Moynihan, M. M. (2004). Bystander education: Bringing a broader community perspective to sexual violence prevention. Journal of community psychology, 32(1), 61-79.

Banyard, V. L., Moynihan, M. M., & Plante, E. G. (2007). Sexual violence prevention through bystander education: An experimental evaluation. Journal of Community Psychology, 35(4), 463-481.

Chansonneuve, D. (2007). *Addictive behaviors among aboriginal people in Canada*. Aboriginal Healing Foundation. Retrieved from www.ahf.ca/downloads/addictive-behaviours.pdf

Conroy, S., & Cotter, A. (2017). *Self-reported sexual assault in Canada, 2014*. Juristat: Canadian Centre for Justice Statistics. Retrieved from http://www.statcan.gc.ca/pub/85-002-x/2017001/article/14842-eng.htm

Decker, M. R., Pearson, E., Illangasekare, S. L., Clark, E., & Sherman, S. G. (2013). Violence against women in sex work and HIV risk implications differ qualitatively by perpetrator. *BMC Public Health*, 13(1), 876.

Jodi-Anne., B, Taylor-Butts, A., & Johnson. S., (2006). Victimization and offending among the Aboriginal population in Canada. Ottawa: Canadian Centre for Justice Statistics

Krahé, B. (2013). *The social psychology of aggression*. Psychology Press. London and New York.

Krug, E., Dahlberg, L., Mercy, J., Zwi, A. & Lozano, R. (2002). World report on violence and health. *World Health Organization*. Geneva. Retrieved from http://apps.who.int/iris/bitstream/10665/42495/1/9241545615_eng.pdf.

Lamontagne, M. (2011). Violence Against Aboriginal Women. Scan and Report. Canadian Women's Foundation. Accessed at https://www.canadianwomen.org/wp-content/uploads/2017/09/PDF-VP-Resources-Lamontagne_CWF_Aboriginal-Women_Final_2011.pdf

Lee, D. S., Guy, L., Perry, B., Sniffen, C. K., & Mixson, S. A. (2007). Sexual violence prevention. *The Prevention Researcher*, 14(2), 15-20.

Lindsay, M. (2015). A *survey of survivors of sexual violence in three Canadian cities. Department of Justice Canada, Research and Statistics Division*. Retrieved from http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rr13_19/index.html.

Lonsway, K and Archambault, J. (2017). *Victim impact: how victims are affected by sexual assault and how law enforcement can respond. end violence against women international (EVAWI)*. Retrieved from http://www.evawintl.org/library/DocumentLibraryHandler.ashx?id=656.

McPhail, B. A. (2016). Feminist framework plus: Knitting feminist theories of rape etiology into a comprehensive model. *Trauma, Violence, & Abuse*, 17(3), 314-329.

Scrim, K. (2017). *Aboriginal Victimization in Canada: A Summary of the Literature: Victims of Crime: Research Digest No. 3*. Retrieved from http://www.justice.gc.ca/eng/rp-pr/cj-jp/victim/rd3-rr3/p3.html

Sexualassault.ca. (n.d). *Aboriginal Sexual Assault in Canada. Sexual Abuse on Native Indian reserve*. Retrieved from https://www.sexassault.ca/aboriginal.htm.

Sinha, M. (2013). *Measuring violence against women: Statistical trends. Canadian Centre for Justice Statistics*. http://www.statcan.gc.ca/pub/85-002-x/2013001/article/11766-eng.pdf

Statistics Canada. (2017). Self-reported sexual assault in Canada, 2014. Accessed at https://www150.statcan.gc.ca/n1/pub/85-002-x/2017001/article/14842-eng.htm

World Health Organization. (2013). Responding to intimate partner violence and sexual violence against women: WHO clinical and policy guidelines. World Health Organization.

14. Sexual Abuse in Indigenous and Arctic Children and Adolescents in Scandinavia

SIV KVERNMO

Sexual and physical violence in childhood are acknowledged as major risk factors for mental and physical health in children, as well as adults. As sexual abuse is associated with silence and shame, it is often underreported. Some Indigenous peoples are shown to be at higher risks for several adversities, such as racism, violence and childhood sexual abuse, compared to non-Indigenous populations. The knowledge of sexual abuse in Arctic Indigenous children and adolescents, however, is sparse and, in particular, among the Sami. This chapter will draw a picture of childhood sexual abuse in Arctic and Indigenous Sami children and adolescents and the impact on their mental health.

Key Terms: Child sexual abuse, Sami, Indigenous, Arctic, adolescents

Introduction

Adolescence and early childhood are vulnerable periods for adverse life events such as sexual abuse with regard to psychological, social and cognitive development (Geoffroy, Boivin, Arseneault et al, 2018). Childhood sexual abuse (CSA) which refers to sexual abuse or harassment experienced in the childhood or adolescence, differs in many ways from sexual abuse among adults. Children and adolescents rarely disclose sexual abuse immediately after the assault (Braithwaith, 2018). The disclosure also tends to be a process over time (Ruggiero, Smith, Hanson, Resnick, Saunders, Kilpatrick & Best, 2004; Wyatt & Newcomb, 1990). Physical complaints or behavioral changes often initiate the disclosure. Early life stress and serious adverse life experiences can have long-term physiological and genetic influence on brain development and cognition in children and adolescents, and cause enduring negative psychological, social, educational, and physical health outcome through the lifespan (Anda et al., 2006; Weaver, 2014). The impact of longstanding abuse affects the child's health and development trajectories more severely than single abusive events (Finkelhor, Omrodd & Turner, 2007). Sexual abuse, as a serious childhood trauma, is therefore a public health problem, as it affects many childreńs development, particularly when the survivors do not have access to effective treatment and nurturing care.

In spite of sparsely scientific knowledge of CSA in Arctic Indigenous people, stories of sexual abuse and harassment in Norwegian Indigenous and religious communities have flared up in the media over the past few years (Minde & Weber, 2017). The #metoo campaign has also contributed to greater openness on this topic. In this chapter, the present knowledge of rates and determinants of childhood sexual abuse in Arctic and Indigenous communities will be presented, as well as the implications of sexual abuse on mental health.

Prevalence rates and determinants

International and Scandinavian rates of CSA

The rates of sexual abuse appear to vary across studies, according to the age of the respondents, study design, response rate, definition of sexual abuse, and awareness of sexual abuse in the community. In a systematic review of CSA under the age of 18 in 24 countries, the rate was found to vary between 8-31% for females and 3-17 % for males, depending on type of CSA (Barth, Bermetz, Heim, Trelle, & Tonia, 2013). Across the Nordic countries, the prevalence of sexual abuse in children and young people varies substantially as well (Kloppen, Haugland, Svedin, Mæhle, & Breivik, 2016). CSA (broadly defined) varies between 3–23% for males and 11–36% for females. Contact abuse occurred among 1–12% of the males and among 6–30% of the females, while penetrating abuse was reported by 0.3–6.8% and 1.1–13.5% of males and females, respectively.

Adolescence is a vulnerable time, as there is an increased risk of abuse from early adolescence and, due to the fact, that adolescent peers seem to constitute the largest group of victims (Kloppen et al , 2016). Ystgaard et al. found that, among 15-16 years olds in Norway, the rate of lifetime sexual abuse was 2.5% for boys and 10.7% for girls (Ystgaard, Reinholdt, Husby, & Mehlum, 2003).

Arctic and Indigenous Groups

The numbers of CSA in the Arctic areas have been described as higher than for non-Arctic areas. Among adolescents in Arctic Norway (the three northernmost counties) and Greenland, the prevalence of sexual abuse is higher than the national rates (Curtis, Larsen, Helweg-Larsen & Bjerregaard, 2002; Schou, Dyb, & Graff-Iversen, 2007). In a report of sexual abuse among 15-16 years old junior high school students in six different counties in Norway, the rates for adolescents in the Arctic areas were the highest. In the northernmost county, Finnmark, 9.2 % of females and 3.1 % of males reported sexual abuse, compared to an average of 6.1 % for females and 1.6 % for males across all counties (Schou et al, 2007).

Indigenous children and adolescents in the Arctic area seem to be more vulnerable to sexual abuse and violence than non-Indigenous peers (Curtis et al, 2002; Karsberg, Lasgaard & Elklit, 2012; Payne, Olsson & Parish, 2013; Eggertson, 2013). The effects of colonialism are assumed to contribute to the high rates of disrupted families, assaults, and negative health outcomes, but are not well documented (Bailey, Powell, & Brubacher, 2017; Du Mont, Kosa, Macdonald, Benoit, & Forte, 2017; Funston, 2013; Ross, Dion, Cantinotti, Collin-Vézina, & Paquette, 2015). Colonial structures, such as removal from traditional land, residential school settings, discrimination and racism, severe socioeconomic deprivation, forced assimilation, and marginalization were experienced by many Indigenous peoples. The consequences of colonialism however, showed great diversity and are not generalizable (Nelson & Wilson, 2017). Sami adolescents, for instance, have experienced more life adversities, but their mental health is in general not worse off compared to non-Indigenous counterparts (Reigstad & Kvernmo, 2017; Turi, Bals, Skre & Kvernmo, 2011).

In Greenland, 13% of female and 4% of male young people between 18-24 years of age reported CSA occurring before the age of 13 (Curtis et al., 2002). In approximately 50% of those cases, the abuse occurred within the family. For every fifth female, the perpetrator was the father and substance abuse in the family was more frequent. Furthermore, sexual abuse was significantly related to later health problems in adulthood (Curtis et al., 2002).

The prevalence of CSA in younger Greenlandic adolescents between 15 and 18 years, showed somewhat higher rates; 14.6 % among females and 4.4 % among males had experienced direct sexual abuse and indirect sexual abuse by 23.2 % of the females and 9.6 % of the males, respectively. Alcohol abuse in the family, rural living, physical violence from parents, and alcohol use debut before the age of 13 were all related to more frequent sexual abuse (Karsberg et al., 2012).

Sexual abuse among the Indigenous Sami are sparsely investigated. As far as known there are only two studies on this topic; one on the adult population (Eriksen, Hansen, Javo, & Schei, 2015) and one on adolescents (Kvernmo, n.d.). A recent study revealed that both adult Sami females and males in the Arctic part of Norway were more likely to report any lifetime emotional and physical violence than non-Sami counterparts were. For CSA, the prevalence for Sami women exceeded those for non-Sami counterparts with a prevalence of 16.8% for Sami versus 11.5 % for non-Sami females, respectively. No ethnic differences occurred for males with a rate of approximately 4%. Living in rural and Sami majority contexts, having a Laestadian religious affiliation, and Sami ethnicity all predicted more sexual violence in both genders (Eriksen et al, 2015).

In contrast to Sami adults in the Arctic area of Norway, the rate of sexual abuse in Sami adolescents did not exceed that of non-Sami peers significantly, although it was somewhat higher (Kvernmo, n.d.). For both ethnic groups, sexual abuse was associated with more emotional problems and for females with more suicide attempts (Reigstad & Kvernmo, 2017). In Sami adolescents, more parental control protected against sexual abuse. In the non-Sami group, substantially more risk factors were associated with sexual abuse than among the Sami, including less parental support, mental health problems in parents, and externalizing problems. Compared to other Indigenous groups, risk factors for CSA, such as substance use among parents, lack of parental involvement, and broken families are less frequent. These conditions can possibly explain the lower rates of CSA in Sami compared to Indigenous peers (Reigstad & Kvernmo, 2017).

More research is needed to explore the present incidence of sexual abuse in Sami children and adolescents, as well as adults, but also in other ethnic groups such as national minorities and majority Norwegian population in Arctic areas.

Prevention programs of CSA are usually universal educational programs delivered in school settings. Evaluation of these programs has revealed increased knowledge of CSA in children, but have not shown a decrease in numbers of CSA (MacMillan et al., 2009; Mikton & Butchart, 2009; Wurtele, 2009). Wurtle (2009) and Collin-Vézina et al. (2013) argue that there is a need for redirecting prevention programs from a unilateral child approach towards targeting families and parents, and professionals working with children but also the general population to effectively prevent CSA, also in future generations.

Conclusion

Child sexual abuse is a form of maltreatment that provokes reactions in all societies and cultures and is a considerable public health problem. It continues to inflict detrimental impacts on a substantial part of the population in their important and vulnerable development. The consequences of CSA are broad with respect to impaired social, cognitive, and psychological development in children and adolescents, and a broad specter of mental and physical health problems across the life span. A broad range of risk factors are related to sexual abuse, including fragmentation of families and communities, socioeconomic disadvantage, dysfunctional families, parental mental health problems, and substance abuse to peer relations. Meanwhile, limited knowledge exists regarding protective factors and effective prevention programs.

Arctic and Indigenous groups worldwide are known to be in a disadvantage position of childhood sexual abuse. The long history of oppression, marginalization, and stigmatization of Indigenous peoples is claimed to contribute to violence against women and children, but little research exist to support this. In contrast to other Arctic Indigenous groups, the Sami have been in close and adaptable contact with the majority populations over hundreds of years, and occupied a less oppressed position. Cultural exchange has been a bi-directional process over time.

Sami youngsters do not differ in rates of sexual abuse from their non-Sami peers. The Sami population has during the last decades gone through a strong political and cultural revitalization, which has strengthen the Sami culture and political rights on group and individual level, and heightened the position of Sami in the dominant society. In addition, the Sami have experienced the same benefit of socioeconomically advantages taking place in Norway and other Nordic countries generally the last decades with regard to educational possibilities, social welfare, and access to health care, also including Indigenous-focused health care. In certain Sami areas, for instance, the educational level among Sami

females is among the highest in Norway and the general socioeconomic status not in disadvantage compared to the non-Sami population. Compared to many other Indigenous groups, the Sami are in a unique position which may explain the lower rates of CSA among Sami adolescents.

Overall, the prevalence of CSA is still too high and more preventive efforts are needed. Without a greater focus on CSA in communities and adults working with children, and a broader understanding of the complex nature of sexual abuse, which includes the cultural and social aspects of Indigenous peoples, the prevention of sexual abuse may not target the risk groups and offer good enough efforts. In addition, more knowledge of the effects of CSA is needed. Recent studies in adolescent groups also highlight the need for preventive efforts also targeting peer abuse. Stronger attention should also be put on more research on resilient factors preventing CSA and success factors in reducing rates of CSA.

Additional Resources

Sexual abuse in a rural Norwegian community. https://edition.cnn.com/2017/11/29/europe/norway-sexual-assault/index.html

Indian residential school truth and reconciliation commission of Canada. https://www.culturalsurvival.org/publications/cultural-survival-quarterly/indian-residential-school-truth-and-reconciliation

Sexual Abuse in Australia and New Zealand. https://www.gifrinc.com/wp-content/uploads/2017/02/SAANZ-issue-7-1-full.pdf

References

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., … Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood. A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience*, 256(3), 174–186. https://doi.org/10.1007/s00406-005-0624-4

Anderson L.A., Whiston S.C. (2005). Sexual assault education programs: A meta-analytic examination of their effectiveness. *Psychol Women*, 29, 374–388.

Bailey, C., Powell, M., & Brubacher, S. (2017). Reporting rates of child sexual abuse in Indigenous communities in two Australian jurisdictions. *Child Abuse & Neglect*, 68, 74–80. https://doi.org/10.1016/j.chiabu.2017.03.019

Barth, J., Bermetz, L., Heim, E., Trelle, S., & Tonia, T. (2013). The current prevalence of child sexual abuse worldwide: a systematic review and meta-analysis. *International Journal of Public Health*, 58(3), 469–483. https://doi.org/10.1007/s00038-012-0426-1

Collin-Vézina,D.,Daigneault, I., & Hébert, M. (2013). *Child and Adolescent Psychiatry and Mental Health*, 7 (22). http://www.capmh.com/content/7/1/22

Curtis, T., Larsen, F. B., Helweg-Larsen, K., & Bjerregaard, P. (2002). Violence, sexual abuse and health in Greenland. *International Journal of Circumpolar Health*, 61(2), 110–122. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/12078958

Du Mont, J., Kosa, D., Macdonald, S., Benoit, A., & Forte, T. (2017). A comparison of Indigenous and non-Indigenous survivors of sexual assault and their receipt of and satisfaction with specialized health care services. *PLoS ONE*, 12(11), 1–15. https://doi.org/10.1371/journal.pone.0188253

Eriksen, A. M. A., Hansen, K. L., Javo, C., & Schei, B. (2015). Emotional, physical and sexual violence among Sami and non-Sami populations in Norway: The SAMINOR 2 questionnaire study. *Scandinavian Journal of Public Health*, 43(6), 588–596. https://doi.org/10.1177/1403494815585936

Finkelhor, D., Ormrod, R., Turner, H. (2007). Poly-victimization: A neglected component in child victimization. *Child Abuse and Neglect*, 31, (1), 7-26

Funston, L. (2013). Aboriginal and Torres Strait Islander worldviews and cultural safety transforming sexual assault service provision for children and young people. *International Journal of Environmental Research and Public Health*, 10(9), 3818–3833. https://doi.org/10.3390/ijerph10093818

Karsberg, S. H., Lasgaard, M., & Elklit, A. (2012). Victimisation and PTSD in a Greenlandic youth sample. *International Journal of Circumpolar Health*, 71. https://doi.org/10.3402/ijch.v71i0.18378

Kloppen, K., Haugland, S., Svedin, C. G., Mæhle, M., & Breivik, K. (2016). Prevalence of Child Sexual Abuse in the Nordic Countries: A Literature Review. *Journal of Child Sexual Abuse*, 25(1), 37–55. https://doi.org/10.1080/10538712.2015.1108944

Kvernmo S, R. B. (n.d.). Sexual abuse and violence in Sami and non-Sami adolescents; The NAAHS study

MacMillan, H. L., Wathen, C. N., Barlow, J., Fergusson, D. M., Leventhal, J. M., & Taussig, H. N. (2009). Interventions to prevent child maltreatment and associated impairment. *The Lancet*, 373, 250-66.

Mikton, C. & Butchart, A. (2009). Child maltreatment prevention: A systematic review of reviews. *Bulletin of the World Health Organization*, 87, 353 – 61.

Minde, G.-T., & Weber, A. (2017). Hvordan reagerer små samiske lokalmiljøer når kvinner forteller om seksuelle overgrep? *Tidsskrift for Psykisk Helsearbeid*, 13(03), 265–274. https://doi.org/10.18261/issn.1504-3010-2017-03-07

Nelson, S., Wilson, K. (2017).The mental health of Indigenous peoples in Canada: A critical review of research. *Social Science & Medicine*, 176, 93-112

Reigstad, B., & Kvernmo, S. (2017). Concurrent adversities and suicide attempts among Sami and non-Sami adolescents: the Norwegian Arctic Adolescent Study (NAAHS). *Nordic J of Psychiatry*, 71 (6), 425-432.

Ross, A., Dion, J., Cantinotti, M., Collin-Vézina, D., & Paquette, L. (2015). Impact of residential schooling and of child abuse on substance use problem in Indigenous Peoples. *Addictive Behaviors*, 51, 184–192. https://doi.org/10.1016/j.addbeh.2015.07.014

Schou, L., Dyb, G., & Graff-Iversen, S. (2007). Voldsutsatt ungdom i Norge -resultater fra helseundersøkelser i seks fylker. *Norsk Folkehelseinstitutt*, 8. Retrieved from https://www.fhi.no/globalassets/dokumenterfiler/moba/pdf/voldsutsatt-ungdom-i-norge.pdf

Ystgaard, M., Reinholdt, N. P., Husby, J., & Mehlum, L. (2003). [Deliberate self harm in adolescents]. *Tidsskrift for Den Norske Laegeforening: Tidsskrift for Praktisk Medicin, Ny Raekke*, 123(16), 2241–2245. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/14508543

Wurtele, S. K. (2009). Preventing sexual abuse of children in the twenty-first century: Preparing for challenges and opportunities. *Journal of Child Sexual Abuse*, 18, 1-18.

Wyatt, G.E., & Newcomb, M. (1990). Internal and external mediators of women's sexual abuse in childhood. *Journal of Consulting and Clinical Psychology*, 58, 758–767.

15. Childhood Sexual Abuse (CSA): Consequences and Holistic Intervention

SIGRÚN SIGURÐARDÓTTIR AND SIGRIDUR HALLDORSDOTTIR

In order to develop a holistic program for Icelandic Childhood Sexual Abuse (CSA) survivors, we found it important to base such a program on an in-depth knowledge and understanding of the consequences of CSA for Icelandic survivors. The main results of our six studies presented in this chapter were that the consequences of CSA, for both men and women, were serious for their health and well-being. Their suffering was deep and almost unbearable. CSA survivors felt they had not received adequate support and understanding from healthcare professionals, but participation in the multidisciplinary 'Wellness-Program' improved the subjective health and wellbeing of those female CSA survivors attending. Similar program needs to be developed for male CSA survivors.

Key Terms: Childhood Sexual Abuse, Holistic Intervention, CSA survivors, resilience

Introduction

According to the World Health Organization, Child Sexual Abuse (CSA) is a worldwide health problem and it has become increasingly common to view violence from a public health perspective (WHO, 2002). The WHO defines CSA as:

The involvement of a child in sexual activity that he or she does not fully comprehend, is unable to give informed consent to, or for which the child is not developmentally prepared and cannot give consent, or that violates the laws or social taboos of society. Child sexual abuse is evidenced by this activity between a child and an adult or another child who by age or development is in a relationship of responsibility, trust or power, the activity being intended to gratify or satisfy the needs of the other person. This may include but is not limited to: the inducement or coercion of a child to engage in any unlawful sexual activity; the exploitative use of a child in prostitution or other unlawful sexual practices; the exploitative use of children in a pornographic performance and materials" (WHO, 2003, p. 75).

Violence places a heavy strain on the healthcare systems, social and welfare services (WHO, 2014) because

Unity of Mind and Body

There is no real distinction between the mind and the body because of the communications between the brain, the nervous system, endocrine, and immune systems (Brower, 2006) and psychological trauma, such as after childhood sexual abuse (CSA), has long-term physical health consequences, as research has found that stressful early life experiences can cause immune dysregulation across the lifespan (Fagundes, Glaser & Kiecolt-Glaser, 2013). This means that individuals with CSA experience are at a greater risk for serious illnesses than those without such experience and have increased need for healthcare. This goes hand-in-hand with significantly higher healthcare use such as a greater

number of visits to the emergency department, hospital outpatient department, pharmacy, primary care, and specialty care than those without a CSA experience (Bonomi et al., 2008).

Despite the fact that studies have identified childhood sexual abuse (CSA) survivors as a particularly vulnerable group, only a few attempts have been made to study their lived-experience of the health consequences of CSA. Research results indicate that approximately *one in every four women* and *one in every six men* have experienced CSA (Sigurdardottir, 2017). This suggests that health care providers, especially in high volume practices, encounter every day multiple women and men who are CSA survivors (Sigurdardottir & Halldorsdottir, 2018).

In this chapter, we will compare and discuss the health consequences of CSA for men and women. When comparing gender similarities and differences, we will use a study on the consequences of CSA for men's health and well-being from the perspective of male CSA survivors (Sigurdardottir, Halldorsdottir & Bender, 2012) and a study on the consequences of CSA for women's health and well-being from the perspective of female CSA survivors (Sigurdardottir & Halldorsdottir, 2013). We will also use a case study with a female CSA survivor (Sigurdardottir & Halldorsdottir, 2018). Then we will present the Wellness-Program, designed for female CSA survivors (see Sigurdardottir, Halldorsdottir, Bender & Agnarsdottir, 2016). We will describe this unique multidisciplinary program1 and the professionals working within it, provide certain details of the program, such as the daily schedule, as well as how it was initiated and funded. Finally, we will discuss how it affected the participants.

Trauma and Human Resilience

Not everyone develops PTSD following trauma, which makes the study of resilience interesting (Agaibi & Wilson, 2005). In some individuals, exposure to repeated trauma may increase resilience; in others it can degrade resiliency (Wilson & Drozdek, 2004). What we know of posttraumatic resilience is that it characterizes psycho-biologically healthy survivors; it can be learned and is critical to successful treatment; and, finally, it can be implemented through training programs to reduce the effects of traumatic exposure (Agaibi & Wilson, 2005). What we also know is that parenting influences resilience in adulthood. In a study by Lind et al (2018), the effect of parenting on the association between severe CSA and resilience in adulthood was examined in a large female twin sample (n= 1423). Severe CSA was associated with lower resilience to recent stressors in adulthood. Subscales of the Parental Bonding Instrument were significantly associated with resilience. Specifically, parental warmth was associated with increased resilience while parental protectiveness was associated with decreased resilience. Results suggest that CSA assessment remains important for therapeutic work in adulthood and that addressing parenting may be useful for interventions in children with a CSA history.

Comparing Men's and Women's Health Consequences of CSA

Because there is no real distinction between the mind and the body because of the communications between the brain, the nervous system, endocrine, and immune systems the list of the consequences of CSA for both men and women is very long. Psychological trauma, such as after childhood sexual abuse (CSA), has long-term consequences because stressful early life experience cause immune dysregulation across the lifespan (Fagundes, Glaser & Kiecolt-Glaser, 2013). This means that individuals with CSA experience are at a greater risk for serious illnesses than those without such experience. Some of the known consequences for health and well-being that some people are suffering from after CSA include psychological, social and physical consequences shown in Table 1.

Table 1 – Common Health Consequences of CSA

HEALTH CONSEQUENCES OF CSA	EXAMPLES OF HEALTH PROBLEMS
Psychological consequences	Depression, anxiety, phobia, self-destructive behavior, addiction, post-traumatic stress disorder (PTSD), suicidal thoughts and attempts, personal disorders, eating disorders and obesity (Sigurdardottir, 2017).
Physical health consequences	Widespread and chronic pain, sleeping problems, adult onset arthritis, fibromyalgia, long-term fatigue, diabetes, and circulatory-, digestive-, respiratory-, and musculoskeletal problems, as well as neurological and reproductive ones, such as increased problems during pregnancy as well as risk of difficulties during the postpartum period (Sigurdardottir, 2017; Sigurdardottir and Halldorsdottir, 2018).
Social consequences	Re-victimization, antisocial and criminal behavior, difficulties in sex life and in connection with spouse, difficulty trusting mates, marriage problems, anxiety and stress as parents, sexual risk behaviors; having many sexual partners, sexual problems and aggression and more likely to marry an alcoholic (Sigurdardottir, 2017).

When we studied men's experience of CSA, we found that their experience was characterized by anger and fear, as well as physical and psychological disconnection. In youth, the men were bullied, had learning difficulties, had been hyperactive, displayed criminal behavior, misused alcohol and drugs, and had numerous complex health problems. Their self-identity and self-image was broken. As adults, they had difficulty relating to their spouses and children, had gone through divorce, and were all divorced non-custodial fathers. They lived in silent and painful suffering because of prejudice and did not seek help or talk about the CSA until they were adults (Sigurdardottir et al., 2012).

In a case study with a female CSA survivor, we found that a long trauma history can have serious and destructive effects on physical health. The research participant was still a young child (two to three years old) when her father started to rape her. Since her childhood, she has experienced complex and widespread physical health consequences, such as repeated vaginal and abdominal infections, widespread and chronic pain, sleeping problems, digestive problems, chronic back problems, fibromyalgia, musculoskeletal problems, repeated urinary tract infections, cervical dysplasia, inflammation of the Fallopian tubes, menorrhagia, endometrial hyperplasia, chlamydia, ovarian cysts, ectopic pregnancies, uterus problems, severe adhesions, and ovarian cancer. She disclosed her CSA experience to several health care providers, but they were silent and failed to provide trauma-informed care. She felt she had not been met with adequate understanding and support in the health care system (Sigurdardottir and Halldorsdottir, 2018).

In comparing gender similarities and differences, we found that women had a greater tendency to *internalize* their emotional suffering, resulting in behavioral and emotional suppression that was later observed in complex physical health problems. The men, however, had a greater tendency to *externalize* their emotional suffering, which made them more prone to rage, aggressiveness, antisocial behavior, and other behavioral problems. Gender similarities were also found (see Table 2), in that participants all demonstrated poor childhood health and lack of well-being, poor adult health, and lack of well-being, as well as difficulties in relationships and in relating to their children.

Table 2 – Gender similarities regarding the consequences of CSA

Difficulties through the lifespan	Examples of consequences
Poor childhood health and lack of well-being	Emotional pain, dissociation, fear, self-blame, bullying, social isolation and dysfunction, self-harm, insecurity, and physical problems.
Poor adult health and a lack of well-being	Complex health problems, sleeping difficulties, myalgia and muscle pain, self-harm, rejection, sense of being impure, phobias and isolation, emotional numbness and despair, anxiety and depression, as well as deep emotional problems.
Difficulties in relationships and in relating to their children	Trust issues, relationship and touch issues, sexual pleasure issues, postpartum depression, issues regarding touching their children and distrusting others regarding their children

The results of these studies demonstrate that childhood violence, such as CSA, may have extensive and serious consequences for mind and body, and have long-term consequences for both men and women. This means that health professionals, and other professionals working with people, such as in schools and social services, need to be aware that a person presenting a certain health, social, or educational problem may possibly have another story hidden underneath – a story of serious childhood trauma never having reached the surface.

Holistic Intervention: The Wellness-Program

The Wellness-Program (in Icelandic 'Gæfusporin') was based on our own research on multifaceted needs of female CSA survivors (Sigurdardottir & Halldorsdottir, 2013). It was also based on the use of some body/mind therapies research findings have indicated were effective when dealing with some of the problems female CSA survivors are faced with. Finally, it was based on the program in Betania Malvik Norway for CSA survivors (Betania Malvik, n.d.; Haugen, 2007). Unfortunately, information about the Betania Malvik program is no longer available on the internet. In the Wellness-Program, the unity of body and mind was recognized, and the program aimed at increasing the women's health and well-being. The purpose was to develop a person-centered, holistic, traditional and complementary therapy for female CSA survivors, geared to women with complex mental, physical and social health problems that they had not been able to get the help they felt they needed within the healthcare system. The first Wellness-Program was conducted in Akureyri (the "capital of the North" in Iceland) in co-operation with *The Vocational Rehabilitation of the North* (Starfsendurhæfing Norðurlands) and funded by *VIRK – Vocational Rehabilitation Fund* in Iceland, whose goal is to systematically decrease the probability that employees lose their jobs due to incapacity and sickness, by increasing their activities and promoting vocational rehabilitation. Table 3 and table 4 provide an overview of the *Wellness-Program* and the professionals working within the program.

Table 3 – The daily schedule of the *Wellness-Program* (in all 20 hours per week)

Time	Monday	Tuesday	Wednesday	Thursday	Friday
10:00–12:00	Nursing group therapy, sharing of experiences and empowerment	Yoga group	Psychologist: mindfulness –group sessions	Basic body awareness	Group teaching about CSA, consequences and health and well-being
	Lunch	*Lunch*	*Lunch*		*Lunch*
12:00–13:00	Group meeting for planning the week	Diet and nutritional counselling	Getting together and talking	*Lunch*	Group meeting for closure of the week
13:00–14:00	Psychological therapy: mindfulness –individual sessions	Relaxation/ Hypnosis	Physical exercise group (fibromyalgia exercises, walking with walking sticks, water exercises)	Psychosomatic therapy (cranio- sacral therapy, reflexology therapy or body orientation therapy with massage)	Physical exercise group (fibromyalgia exercises, walking with walking sticks, water exercises)

(Sigurdardottir et al., 2016, p. 177)

Table 4 – An overview of the professionals, their education and their role in the Wellness-Program

PROFESSION	EDUCATION	ROLE/TYPE OF THERAPY
Nurse	B.Sc. in Nursing. MSc. in Health Sciences, Ph.D. student	Supervision, group teaching, relaxation, creation and communication group, getting together group
Family therapist. Manager	M.A. in Family Therapy	Education and personal consultation
Psychologist	M.A. in Psychology	Group therapy and personal consultation with mindfulness
Social worker (Educational and vocational guide)	B.A. in Social Work	Counselling
Physiotherapist	B.Sc. in Physiotherapy. Diploma in Basic Body Awareness	Basic body awareness
Physiotherapist	B.Sc. in Physiotherapy. MSc in Health Sciences	Psycho-somatic therapy, cranio-sacral therapy
Physiotherapist	B.Sc. in Physiotherapy	Psycho- somatic therapy, cranio-sacral therapy, integrative and therapeutic Yoga practice, exercises in water
Nurse	B.Sc. in Nursing. Diploma in Psychiatric Nursing, Hypnosis Therapist	Hypnosis
Health consultation therapist	Health and Life Coach. Institute for Integrative Nutrition	Diet and nutritional consultation
Physiotherapist	B.Sc. in Physiotherapy	Exercises for fibromyalgia, walking exercises with walking sticks
Nurse. Reflexology therapist	B.Sc. in Nursing. MSc in Health Sciences. Diploma in Reflexology Therapy	Reflexology, body-oriented therapy with massage
Occupational therapist	B.Sc. in Occupational Therapy	Personal consultation
Reflexology therapist. Alternative and complementary therapist	Diploma in Reflexology and Alternative – and Complementary Therapy	Reflexology

(Sigurdardottir et al., 2016, p. 178)

The Wellness-Program lasted for 10 weeks with organized schedule 20 hours per week (Table 3). A team of health professionals (Table 4) used a holistic approach and provided traditional and complementary individual and group therapy focusing on both mind and body. In-depth phenomenological interviews with the participants were conducted 1 week before and 1 week after the program as well as 12-15 months later. The female survivors who participated in the Wellness-Program were in the beginning of the program socially isolated and had complicated health problems. Their self-esteem was low, they could not work or study and their lack of well-being significantly affected their families and their own quality of life. Positive results were found regarding all these aspects in the participating women 12 to 15 months after the program — all, but one, were active in work, study, or in further rehabilitation. Furthermore, the in-depth interviews showed that their health and well-being, personal life and relationship with partners, family and friends had improved. They felt empowered, more in control, and had developed increased trust towards others. Thus, the Wellness-Program contributed considerably to improved subjective health and well-being of the women (Sigurdardottir et al., 2016).

Participating in the Wellness-program was a challenge for all the women and stressful at times. They had to work with their personal space and boundaries; learn to be "at home" in their own body; learn to go through flashbacks; learn to face "the monster"; and to get rid of self-accusations and self-blame. They sensed positive changes in their relationships with children and mates and some slowly learned to enjoy sex life. They also shared the feeling of being less fearful regarding relationships after the program as well as realizing better their own limits. All the women had been afflicted by some health related problems such as pain, lack of sleep, as well as digestive and uterine problems. In the program the women learned to live with the pain and experienced positive changes regarding sleep and rest, like one participant said:

I'm a completely different person after the Wellness-Program. I still get pain, but not as much as before. I recover much more quickly and the acid reflux is nearly gone. I sleep from dawn till dusk whereas I used to wake up 3-4 times every single night. Now, I just sleep. I can sleep 10 hours straight, which is something I don't ever remember being able to do.

They also learned to live with fibromyalgia. They all reported a big difference between before and after the program. All the women shared the power of being understood by the group and the therapists and "not being alone" in their suffering. One of them lost 70 kilos; another went back to work after five years of unemployment. They shared that they had more inner peace than ever before and one said the effects of the program was like a "physical, psychological and spiritual resurrection." (Sigurdardottir et al., 2016) Some of the participants in the Wellness-Program have reached post-traumatic growth since they experienced that their inner change was characterized by improved and deeper relationships with others, increased personal development, positive living, increased self-knowledge, and improved self-esteem which have been found to be the characteristics of post-traumatic growth (Sigurdardottir and Halldorsdottir, 2018). More than one hundred Icelandic women have now been through the Wellness-Program.

Conclusion

CSA can have serious and far-reaching consequences for the health and well-being of both men and women and their suffering can be deep and in fact almost unbearable. It is important for all professionals to be aware of and recognize the symptoms regarding the health consequences of CSA to be better able to provide support and gender-specific care. It is important to continue to develop a holistic program for CSA survivors, for both women and men. Through an organized holistic program, much can be gained for the CSA survivor, the survivor's family and society as a whole. Finally, yet importantly, public health measures have to be taken in order to prevent children from experiencing such serious trauma as CSA.

Notes

1. A multidisciplinary team is a group of healthcare workers who are members of different professions e.g. nurses, physiotherapists, occupational therapists, psychologists, social workers, each providing specific services to the client.

References

Agaibi, C. E. & Wilson, J. P. (2005). Trauma, PTSD, and resilience: A review of the literature. *Trauma, Violence, & Abuse*, 6(3), 195-216.

Betania Malvik (n.d.). *Behandlingstilbud til personer med traumer etter gjentatte seksuelle overgrep* [Treatment options for people who have been traumatized by repeated sexual abuse and violence].

Bonomi, A. E., Anderson, M. L., Rivara, F. P., Cannon, E. A., Fishman, P. A., Carrell, D., Reid, R. J. & Thompson, R. S. (2008). Healthcare utilization and costs associated with childhood abuse. *Journal of General and Internal Medicine*, 23, 294–299. doi: 10.1007/s11606-008-0516-1.

Brower, V. (2006). Mind-body research moves towards the mainstream. *EMBO Reports*, 7, 358–361. doi: 10.1038/sj.embor.7400671

Chartier, M. J., Walker, J. R., Naimark, B. (2009). Health risk behavior and mental health problems as mediators of the

relationship between childhood abuse and adult health. *American Journal of Public Health*, 99, 847–854. doi: 10.2105/AJPH.2007.122408

Fagundes, C. P., Glaser, R., Kiecolt-Glaser, J. K. (2013). Stressful early life experiences and immune dysregulation across the lifespan. *Brain, Behaviour and Immunity*, 27C, 8–12. doi: 10.1016/j.bbi.2012.06.014

Haugen T. (2007). *Voksne som ble utsatt for vedvarende seksuelle overgrep i barndommen-problemomrader, behandling og endring. Hovedoppgave i psychology.* Norges Teknisk Naturvitenskapelige Universitet. Trondheim, Norway. Open access: http://betaniamalvik.no/traume_enhet/fagstoff/content_1/text_25b99a55-ff4b-4d93-8154-f9677073e5b4/1337669975514/hovedoppgaven_siste_versjon_518190.pdf

Lind, M. J., Brown, R. C., Cheerin, C. M., York, T. P., Myers, J, M., Kendler, K. S., & Amstadter A. B. (2018). Does parenting influence the enduring impact of severe childhood sexual abuse on psychiatric resilience in adulthood? *Child Psychiatry & Human Development*, 49(1), 33-41.

Sigurdardottir, S. (2017). *Childhood sexual abuse: Consequences and holistic intervention* (Doctoral dissertation). The School of Health Sciences, Faculty of Nursing, University of Iceland. Open access: https://opinvisindi.is/handle/20.500.11815/317

Sigurdardottir, S., Halldorsdottir, S. & Bender, S. S. (2012). Deep and almost unbearable suffering: Consequences of childhood sexual abuse for men's health and well-being. *Scandinavian Journal of Caring Sciences*, 26(4), 688-697. doi: 10.1111/j.1471-6712.2012.00981.x

Sigurdardottir, S., Halldorsdottir, S. & Bender, S. S. (2014). Consequences of childhood sexual abuse for health and well-being: Gender similarities and differences. *Scandinavian Journal of Public Health*, 42(3), 278-286. doi: 10.1177/1403494813514645.

Sigurdardottir, S., Halldorsdottir, S., Bender S. S. & Agnarsdottir, G. (2016). Personal resurrection: Female childhood sexual abuse survivors' experience of the Wellness-Program. *Scandinavian Journal of Caring Sciences*, 30, 175–186. doi: 10.1111/scs.12238.

Sigurdardottir, S. & Halldorsdottir, S. (2013). Repressed and silent suffering: Consequences of childhood sexual abuse for women's health and well-being. *Scandinavian Journal of Caring Sciences*, 27(2), 422-432. doi: 10.1111/j.1471-6712.2012.01049.x.

Sigurdardottir, S. & Halldorsdottir, S. (2018). Screaming body and silent healthcare providers. *International Journal of Environmental Research and Public Health*, 15(1), 94-111. doi:10.3390/ijerph15010094.

Wilson, J. P., & Drozdek, B. (Eds.). (2004). *Broken spirits: The treatment of traumatized asylum seekers, refugees and war and torture victims.* New York: Brunner/Routledge.

World Health Organisation (WHO) (2002). *World report on violence and health.* Retrieved from: http://www.who.int/violence_injury_prevention/violence/world_report/en/full_en.pdf

World Health Organisation (WHO) (2003). *Guidelines for medico-legal care for victims of sexual violence.* Retrieved from: http://apps.who.int/iris/bitstream/10665/42788/1/924154628X.pdf

World Health Organisation (WHO) (2014). *Global status report on violence prevention 2014.* Retrieved from: file:///C:/Users/Lenovo/Downloads/9789241564793_eng.pdf.

16. A Culture of Violence and Silence in Remote Canada: Impacts on Service Delivery to Address Intimate Partner Violence

HEATHER FIKOWSKI AND PERTICE MOFFITT

Intimate partner violence (IPV) in Northern Canada is a major public health issue that continues to impact women, families and communities and consistently demonstrates the highest rates in the country. A five-year mixed-methods study conducted between 2011 and 2017 investigated the community and frontline response to IPV in the Northwest Territories. Several dominant themes emerged that facilitated frontline worker's sense of having their "hands tied" when trying to support women who are experiencing violence in their intimate relationships. The culture of violence and silence was identified as a theme pivotal in maintaining the social process of women "shutting up about the violence". This chapter will explore the culture of violence and silence by considering how this increases women's vulnerability and susceptibility to IPV as well as the negative impacts to effective frontline service delivery. Factors that will be specifically explored include: historical trauma, violence normalized, gossip as a tool for silence, community retribution, family and community values and self-preservation.

Key Terms: Aboriginal, Indigenous, intimate partner violence, abuse, northern, remote, Canada

Introduction

Violence rates are demonstratively higher amongst Indigenous women, as compared to non-Indigenous women in Canada (Brownridge, 2008). Researchers have also acknowledged that impacts of colonization and oppression contribute to Indigenous people's understanding of violence and its higher prevalence rates within these communities (Brownridge, 2003; Daoud, Smylie, Urquia, Allan & O'Campo, 2013; Wendt & Hornosty, 2010). Canada's long history of colonial policies, such as residential schooling, has resulted in intergenerational impacts of historical trauma for Indigenous peoples (Daoud et al., 2013). These structural experiences of oppression continue to demonstrate themselves in social issues, such as substance use, poverty, housing and the over-representation of Indigenous children in the child welfare system (Blackstock & Tromé, 2005). The impacts of this leads to Indigenous people's increased risk for poorer health and social problems, including intimate partner violence (IPV) (Bombay, Matheson, & Anisman, 2014). This chapter will focus on a particular construct that contributes to sustained higher rates of IPV in northern Canada, as well as hinders efforts of frontline service workers to support women who are surviving it.

Literature Review

A socially constructed culture of violence and silence has been acknowledged as a factor that shapes women's

experiences of violence in rural, remote and/or Indigenous communities (Campbell, 2007; Kuokkanen, 2015; McGillivray & Commaskey, 1999; Shepherd, 2001). This culture has been informally sanctioned belief around violence creates a community context in which children are socialized and women's susceptibility and vulnerability to violence is heightened. For example, McGillivray and Comaskey (1999) described the experiences of IPV with Indigenous women in rural Canada and found the normalization of violence to be widely reported across the lifespan. They noted this belief as a barrier to women trying to leave the relationship and as a barrier for those responding to violence, suggesting it exists relationally and at a community level.

Challenging this culturally constructed belief can possibly lead to community shaming or disapproval, banishment or repercussions from the perpetrator and his family and community allies (McGillivray & Comaskey, 1999; Wendt & Horonsty, 2010). In addition to this, women who experience violence also report societal pressure and values of maintaining the family. Additionally, the perpetrator's social status within the community (Wendt & Hornosty, 2010); a lack of privacy or anonymity as well as perceived lack of confidentiality has also been found to keep women silent in coming forward or seeking help to leave a violent relationship (Hughes, 2010; Shephard, 2001; Wendt & Hornosty, 2010; Wuerch, Zorn, Juschka, & Hampton, 2016). All of these factors pose unique and additional challenges to those already in existence for women who survive controlling, abusive intimate relationships.

A recent mixed-methods study conducted in northern Canada revealed IPV occurrences in every community, many of which are void of or sparsely supported by formal services to help women experiencing violence (Moffitt & Fikowski, 2017). Additionally, the geographic region of this study identified multiple communities with little to no road access. These remotely located communities were described as predominantly Indigenous with support provided by the larger regional centers which had greater populations of non-Indigenous residents. Findings indicated that frontline workers' hands were tied in efforts to support women and families as well as moving communities towards nonviolence. Three social processes described the context of this central problem: women are putting up with violence, shutting up about the violence and getting on with life. Details of the overall findings are listed in Table 1.

Table 1 – Thematic Description of NWT Community Response to IPV: "Hands Are Tied"

Putting Up with Violence
- Social determinants of health
- Remoteness
- Depleted resources

Shutting Up About the Violence
- Culture of violence and silence

Getting On with Life
- Actuality of services
- Alcohol use
- Resilience

This chapter will describe the culture of violence and silence as a contributing factor that uniquely intersects with remoteness, high rates of alcohol use, depleted resources, compromised social determinants of health, the actuality of frontline service provision, and resilience to sustain violence within communities across the Northwest Territories (NWT).

Methods

Data for this chapter was obtained from research conducted between 2010-1016 in the NWT of Canada. This was one of four jurisdictions seeking to understand the community response to IPV in rural and northern regions of Canada. The larger project team met annually to share findings and collaborate in moving forward with the next phases of data collection. These meetings and the project itself was continuously under the guidance of an Indigenous Elder who oversaw the larger project spanning all four jurisdictions Annually, ethics approval was provided by the University of Regina and scientific license awarded from the Aurora Research Institute.

In the first year of the study, data was gathered from the RCMP national database and an environmental scan of family violence resources across the NWT. This data was used with Geographic Information Systems techniques to produce several GIS maps that more tangibly visualize the resources available and IPV incidents across the NWT. These GIS maps helped indicate where data collection would occur in the second year of the project. In the second and third year of the study, 56 semi-structured interviews were completed face-to-face or over the telephone as well as a focus group in each of two communities; participants were frontline service providers working in the field of family violence. Participants were recruited by purposeful sampling and represented 12 NWT communities (35% of communities); the sample included police officers (RCMP members), shelter workers, victim services workers, nurses and other health care professionals, counsellors and social workers. Geographic Information Systems (GIS) maps, grounded theory and constant comparative method were used within a feminist philosophy to analyze the data which occurred concurrently with data collection. Interview transcripts were analyzed individually using line by line coding, and then would meet to share the analyses, collaborating to produce a preliminary model after the second year. Similar processes were used in the third year of data collection, presenting the preliminary model to participants for validation. The final years of the study comprised largely of the development of an action plan and knowledge translation.

Findings

Within the broad theme of a culture of violence and silence, six sub-themes were identified in the analysis: historical trauma, violence normalized, gossip as a tool for silence, community retribution, family and community values, and self-preservation. As one participant described a remote community of the NWT, "I call it the community of secrets, they really never talk about anything." (Community Health Nurse 13). Though each of these sub-themes will be discussed separately, they quite often were presented as a unique and complex web of intersecting variables that support each other in a way that maintains the social construct of violence and silence, and in turn the ongoing presence of IPV. None are more significant than others, but are uniquely multidimensional in the way women experience violence within their relationship and community. One participant demonstrated the nature of this intersectionality:

I think it's more normalized than I would like it to be. Yeah, I think with the heritage with residential schools and people suffering traumatic injury there and that pain being handed down generationally. I think there's been generations of people putting up with a lot and a lot of acting out. And I think that goes to the blaming I was talking about before. If a woman gets hit and files a police report, the people around her might be blaming her because as far as they're concerned, 'you don't do that. You don't go calling the police.' It's more normalized. (Shelter Worker 30)

This notion of intersectionality and unique web of intersecting factors was confirmed by participants throughout our study as we presented this concept to them for validation and as well, in our community presentations across the NWT.

Historical Trauma

Participants acknowledged IPV as an issue arising from historical trauma. They also discussed it reflected in the experience of violence as one that occurs across the lifespan. One participant explained:

I really think that in the north, it goes way beyond partner violence. It's like a family kind of violence. You know, when we do sharing circles with women in communities, the violence is not just from partners. It's from uncles, brothers, community members. Like the violence comes from all sides…A lot of the stories of violence with the women start when they're very small. It's not just partner violence. It starts when they're little. So, it could be a family member, it could be a community member. The violence starts sometimes as early as age two or three. (Community Development Worker 21)

Participants were aware of the country's colonial history, including residential schooling. They described the impacts historical trauma has and the effects upon an Indigenous person's functioning and overall well-being:

It's almost DNA implanted through the generations. Right through the alcohol abuse, the drug abuse, the residential school process. We have lost generations of parenting skills. And I'm an Aboriginal person…I've lived it. It's been in my family. I've witnessed it and that's why I'm a police officer today 'cause they were always at my door helping my mother when she was abused. And you know what, I can honest to God say that it's almost like DNA implanted in our people. I'm not saying all our people, but you know what, as Aboriginal people, we suffer a high volume of domestic violence. We can't hide the numbers. You can't sit there and say 'well, you know, we're spiritual'. Well, yeah, but at the end of the day we suffer a high percentage of it in our families and communities as a whole. And we suffer as a whole as a people because of that. Because that's not the traditional way, where our people come from, or the culture and protocols that are attached to our different societies. (RCMP Member 23)

This was confirmed by another participant who suggested a community member's struggle to regulate his emotions, even with helpful strategies to manage them:

I had a young guy come in who was actually quite a violent young fella and I was trying to do some counselling and, for some reason, he connected with me. He was saying how his father was incredibly abusive to him. His father tried to choke him, and so of course he had been putting this onto his wife, what was primarily emotional violence against his wife and children. But he was saying he didn't understand. He was saying, 'I work out, I eat well.' He said, "I work hard. I try to do things. And still inside I always feel anxious and revved up.' (Community Health Nurse 10).

Another impact of historical trauma comes from people's understanding of frontline service workers, such as RCMP and social workers. They described resistance or hesitation from community people to access their help as well as a general lack of trust with formal service providers. One participant noted:

I think that the process of understanding and healing the legacy of colonization from residential schools is really important in our community as part of healing lateral violence. I mean, it's a major, major divider and a cause of a really prevalent lack of trust that permeates our culture which makes any type of programming very difficult to get a positive outcome when there is that kind of foundation of a lack of trust. (Victim Services Worker 09).

Community healing is an important component to a shift towards nonviolence. They also noted ways in which this can be supported by frontline workers when working directly with people who might be experiencing the impacts of historical trauma. One participant suggested:

I really think looking at why does social suffering still continue and how past trauma and residential schools play into that. And I think that's a dialogue that is started a little but I think for a lot of people, it's the attitude of 'oh my goodness, it happened so long ago, and why are they still complaining about that? Move on and get over it.' But it's like, these are things you can't get over, this is something you take with you to the grave, and giving people that space, the people who went into those schools and experience that trauma to say 'this is why you're feeling like this and this is why it's hard for you to parent', and having that understanding. I think doing that at a community level would be really good. (Victim Services Worker 20).

Violence Normalized

Violence as an accepted reality amongst women, children, families, and communities was noted by most participants. They emphasized that this significantly contributes to the difficulties in providing services for women experiencing violence. One participant explained:

I think the message that women are getting is this is normalized; 'this is my life, at least it's not as bad as my neighbours'. You know, this is the normalization of violence. So I think it's a really lonely journey for women...There's a lot of shame, you know. Victims feel embarrassment and shame in having to get service providers involved...So you've done nothing wrong, you don't deserve the violence but you're being violated, and then we have this understanding; it's so normalized that people don't even feel like they deserve full services. It's kind of like, you made your bed now lie in it, and this is the way it is. (Victim Services Worker 20)

One way to help shift this acceptance is to gently heighten women's awareness to that sense of normal when they are intervening in a violent crisis using a supportive, nonjudgmental relationship. The importance of early education about healthy relationships was suggested by most participants as another means of creating change in the normalized position of violence:

Because for so long, it's just been kind of accepted and swept under the rug, and I think now we're at a pivotal time where, with the education and prevention, and young populations in a lot of our communities, it's a good time to focus on it. (Social Worker 25)

Other participants highlighted successful change when respected community members role model nonviolence:

Every community has one or two people, if not more [who don't use violence]. I think if the norm became nonviolence, then I think over time, that maybe more of a common goal, and the violence and abuse would become more the abnormal. Because right now, the norm is violence. (RCMP Member 29).

The notion that rates and severity of violence has become a normal concept across northern communities is two-fold. Participants described the normalization within communities but additionally acknowledged their own desensitization and acceptance of violence rates as frontline service workers. One participant described a notable change in her own understanding about violence and how it occurred with time worked in the north. She purported this changed view towards violence is not conducive to effective support:

We are almost, as service providers and as women, it's accepted. We've become desensitized to it. The victims have become desensitized, so to the service providers...I have extensive victim service experience in [southern Canada] and it is vastly different here [in the north]. There isn't acceptance [but] that this is a normal occurrence...there's something wrong with thinking that way. (Victim Services Worker C07)

While frontline workers are acknowledging this more normalized view to the frequency and severity of violence, it remained striking to hear the degree to which they continually emphasized a passion to support women, facilitate change across the north and locate effective responses to create safety for those experiencing violence. Though the desensitization to violence may be a reflection of the impact of the work, it reminds frontline service providers that this dialogue helps to remain conscientious of its abnormality as a way in which to help shift the culture of violence within communities.

Gossip as a Tool for Silence

Gossip within communities was noted by most participants as a powerful tool that keeps women from reaching out to family, friends or service providers. They described how this can stay with a woman and her children for years and that it continues to negatively impact a woman by bringing shame and blame upon her for having spoken out against her violent partner. Gossip, or the threat of gossip, comes from her family, the partner's family, friends or other community people. From this, she might feel isolated in her experience and without options to reach out for help.

Participants also explained that women might feel threatened by the possibilities of gossip if local people are in frontline positions, such as a community social worker. Regardless of the ethical obligation to maintain a woman's confidence, participants explained that there is a lack of trust this would be provided:

I'd say people do not want someone [who is in a frontline position] from their own community because there's this fear that it will be all over town...People just generally feel better, I think, talking to someone not from their own community. (RCMP Member 23)

Other participants explained the benefits of having a mixed staff that includes local people to provide the community perspective, as well as people from out of town so that they can feel safe from their perceptions about the threats of gossip or lack of confidentiality in receiving services from local people. This indicates the importance of acknowledging the possible hesitations, concerns and lack of trust and developing that within the helping relationship when women are accessing services.

Community Retribution

Women who access formal supports when experiencing violence can experience backlash from their family or community members. This retribution can also extend to women's children and might continue to be experienced for years. Retribution includes such things as harassment, isolation, restricted access to housing or limited employment opportunities within the community. A participant described the experience of retribution like this:

Because in a small community, especially when there is only a couple of main families in the community, she's basically gonna be banished from the community for going to the police about her husband who beats her up. So she has to move out of the community, or if she stays, then she's gonna be harassed. It's never gonna end for her. And then when the victims finally put a stand to it, they can't handle the pressure from the family members and the community to stay in the relationship. They have no where else to go. So basically, there's no way out for the victims who are chronically abused. (RCMP Member 06).

These threats of retribution from community people maintaining the silence of women when experiencing violence. To combat this fear, it is important to facilitate supportive relationships amongst community people. One participant suggested:

I think a lot of people in the smallest communities in the NWT, the women are living in isolation and they don't necessarily have a personal safety network. I think personal safety networks are really important. So that means working with women to learn to feel safe with each other and to trust each other...The best way we found was to get women together on the land, away from their partners and away from all the different stressors of the community. So, on the land was a good way to get women to sort of feel more comfortable, share and talk. (Community Development Worker 28)

Family and Community Values

Another factor that influences women's decisions to seek help or speak about the violence comes from the value of maintaining the family unit. This may be her own belief, messages delivered directly from others or embedded in covert ways. For example, during our study in one community, Elders insisted a married couple that died in a murder/suicide be buried side by side. One participant described the influential pressure like this:

A lot of the times there's a couple things that kind of make it difficult for [women]. So, one thing if they're from [the community], they get a lot of family pressure to return home, because there's that whole idea of, you know, 'you're married and you need to stay in this and you need to work it out'. So they get a lot of that pressure. (Community Health Nurse 13)

Aspects of Indigenous culture also facilitate the (lack of) response women and community people have to men who use violence in their intimate relationships. A participant explained:

But what I would say in general terms is that in some circles within the northern culture, it's appropriate and expected that the male is gonna be dominant in the family unit and if getting beat up occurred, then it's part of normal life. Now there's lots and lots of families that I can think of that don't buy into that and will not put up with that. But there's still a significant amount of people that still function in that way of thinking. (RCMP Member 07)

Self-preservation

Women who remain silent in an abusive relationship may be working from a position of self-preservation. They might realize the lack of services available in their community which increases their risks to successfully leave. The severity of abuse experienced by women and thought of leaving under such violent threats might be enough pressure to remain in the relationship. Women are also managing within the experience of a trauma, which might diminish their ability to function or make decisions about leaving. There exists the possible impact of historic trauma, the normalization of violence, threats of gossip and community retribution as well as pressures coming from family to stay in the relationship. In addition, some women experience a lack of understanding from frontline workers when they are resisting violence within their relationship. They can feel judged or blamed from the service providers as well, which also inhibit their willingness to come forward for help. One participant explained:

From my perspective, it looks to me as though family violence or IPV is still perceived largely as a private or domestic matter and not a public concern, not an issue of breaking the law in certain cases and types of violence. I'd say that there is still a lot of stigma attached to accessing services when a woman is experiencing violence. I see women experiencing, not only IPV, but then also a lot of pressure from either the partner's family or community members, just to kind of keep quiet about what's going on. And [she's] seen as a trouble maker if she won't keep quiet. I see women who resist IPV in the whole spectrum of ways that women resist, from being violent themselves, using verbal attacks, coping through substance abuse, as often being very misunderstood and being perceived by community members, including service providers, as being equally as abusive as opposed to resisting oppressing and trying to preserve their dignity. I'd say that there's a lot of blaming victims of IPV which I think can also contribute to women staying silent. (Shelter Worker 14)

The other factor that maintains a culture of violence and silence within a community and a woman's experience when surviving IPV is her willingness to shield the community from adding more indicators of violence that is present amongst the people. She might hesitate in coming forward with charges, seeking help from formal service providers, or reaching out for support from family or friends in an effort to avoid more trauma and violence to what is already occurring or what has been experienced by the community in the past. One participant reported:

I just find that when [women] are at home here and they're around family, they're around friends, it's a small isolated community. Eventually, a true victim will feel as though they're wronging the rest of the community by going ahead with [the charges]. (RCMP Member 17)

Summary and Implications

These findings describe the frontline experience offering IPV-related services to women in a northern, remote context and under the influence of an embedded culture of violence and silence. Consistently across interviews, participants noted the normalization of violence and the barriers this creates for them to deliver effective services. Participants suggested this possibly surfaces as an effect of historical trauma or as mechanism to manage the current traumas brought on by higher rates of violence in the north. Given this, it is imperative to create educational opportunities that will begin creating a shift in this way of knowing as well as trauma-informed practice approaches when working with

women and their families. A majority of participants recommended early educational interventions that focus on healthy relationships as a precursor to that effort. What was also highlighted as a significant action to reach nonviolence in communities was honoring the uniqueness of communities across the north and supporting their own goals and efforts in working towards change.

Several frontline service providers in the study reflected on their understanding about IPV and a noticeable shift where they become desensitized to its frequency and severity. Though only one participant acknowledged the impacts of compassion fatigue (CF) and vicarious trauma (VT), many recounted detailed accounts of traumas they were directly involved in and explained how these have stuck with them. It is important for service providers to ensure they are aware of these risks as a consequence of the work and be able to recognize the signs that it is impacting their professional and/or personal well-being (Mathieu, 2011; McCann & Pearlman, 1990). Both recurring memories and desensitized, normalized attitude towards IPV might be indicators that frontline workers are experiencing the effects of both CF and VT.

Not coming forward was, in part, described as an act of self-preservation; it is an effort to not add any additional challenges to their current life circumstances in the community. The threats and realities of gossip and retribution from community members intimidate women to reach out to service providers as well as family or friends. Frontline workers were also aware of family pressures to remain in the committed relationship, regardless of the violence. These factors also sustain a culture of violence and silence within communities across the NWT. Participants explained it as one way in which their hands are tied in efforts to support women and families. Though there may not be a quick fix to these barriers, there are tangible solutions that frontline workers have found effective. They noted the importance of developing trust within the relationship and a safe space for women to be free from the judgements of either surviving a violent relationship or making efforts to leave it. One participant suggested:

I think we have to provide a lot of education and awareness, a lot of healing programs, a lot of outreach services with people letting them know what resources are available. This model I like to use is 'there's never a wrong door'. So when you work with other agencies and support people, there's always people to help. There's never a wrong door [because as frontline workers], we'll direct you or help you and take you to where you should be…We would facilitate that and help them get the resources that they need. (Victim Services Worker 09)

Conclusion

The culture of violence and silence has been found to increase women's vulnerability to ongoing experiences of IPV and act as a barrier to service provision in northern areas of Canada. The notion of "culture" as described in this chapter relates to a social construction that appears at a personal level and community level. The ongoing violence in communities across the NWT is, in part, sustained by a silenced response from those experiencing it, perpetrating it or aware of its occurrence within the community. What frontline workers described was a somewhat ineffective and disabled response to IPV. That this culture continues to exist and make services more difficult to roll out effectively remains a frustration for workers. However, barriers were met with creative and hopeful directions offered up as a way to continue shifting the current culture towards one that stands up to violence with support.

Additional Resources

Family Violence Initiative: https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/initiative.html

Organized and led by the Public Health Agency of Canada, this initiative serves as a collaboration with multiple government departments and agencies to address family violence. The website includes information about family violence, trauma-informed approaches to policy and practice resources, ways in which professionals can promote healthy, safe relationships, tools for professionals working with people and communities affected by family violence, and links to possible funding opportunities.

National Aboriginal Circle Against Family Violence: http://nacafv.ca/

This organization focuses on supporting shelters in their efforts to promote safe environments for Indigenous Canadian families. It offers program initiatives for shelter and transition houses that are culturally appropriate as well as networking opportunities for frontline workers, especially those who are in remote locations. It also works to improve public awareness about family violence in Indigenous communities as well as strengthening the relationship and securing funds between all levels of governments, non-governmental organizations and Indigenous partners.

National Collaborating Centre for Aboriginal Health: https://www.ccnsa-nccah.ca/en/

This Canadian national organization supports Indigenous health through research, policy and practice initiatives. Information includes such things as family health across the lifespan and social determinants that impact Indigenous family health. It also includes a two-part series report on historic trauma, explaining Indigenous peoples' experiences of trauma and oppression as cumulative and intergenerational.

Rural and Northern Response to Intimate Partner Violence: http://www2.uregina.ca/ipv/index.html

This offers a localized space to obtain the details of the research project from which this chapter was based. It provides information about the project's background, final reports from all four jurisdictions in Canada (Alberta, Saskatchewan, Manitoba and the Northwest Territories) as well as knowledge translation activities in the last several years.

Status of Women Canada: http://www.swc-cfc.gc.ca/index-en.html

The Status of Women Canada aims to promote women's full participation in Canadian society. Part of their efforts work to end violence against women and girls. It does this by providing policy directives, supporting women's programs and promoting women's rights. Their website offers information and strategies to prevent and address gender-based violence as well as other links and resources related to family violence in Canada.

References

Blackstock, C., & Tromé, N. (2005). Community-based child welfare for Aboriginal children: Supporting resilience through structural change. In M. Ungar (Ed.), *Handbook for working with children and youth: Pathways to resilience across cultures and contexts* (pp. 105-120). Thousand Oaks, CA: Sage.

Bombay, A., Matheson, K., & Anisman, H. (2014). The intergenerational effects of Indian Residential Schools: Implications for the concept of historic trauma. *Transcultural Psychiatry*, 51, 320-338.

Brownridge, D. A. (2003). Male partner violence against Aboriginal women in Canada: An empirical analysis. *Journal of Interpersonal Violence*, 18, 65-83. doi: 10.1177/08862605022385421

Brownridge, D. A. (2008). Understanding the elevated risk of partner violence against Aboriginal women: A comparison of two nationally representative surveys in Canada. *Journal of Family Violence*, 23, 353-367.

Campbell, K. M. (2007). What was it they lost? *Journal of Ethnicity in Criminal Justice*, 5, 57 80. doi: 10.1300/J222v05n01_4

Daoud, N., Smylie, J., Urquia, M. Allan, B, & O'Campo, P. (2013). The contribution of   socioeconomic position to the excesses of violence and intimate partner violence among   Aboriginal versus non-Aboriginal women in Canada. *Canadian Journal of Public Health*, 104, 278-283.

Hughes, J. (2010). Putting the pieces together: How public health nurses in rural and remote   Canadian communities respond to intimate partner violence. *Journal of Rural Nursing   and Health Care*, 10, 34-47.

Kuokkanen, R. (2015). Gendered violence and politics in Indigenous communities. *International   Feminist Journal of Politics*, 17, 271-288. doi: 10.1080/14616742.2014.901816

Mathieu, F. (2011). *The compassion fatigue workbook: Creative tools for transforming   compassion fatigue and vicarious traumatization*. New York, NY: Routledge.

McCann, I. L., & Pearlman, L. A. (1990). Vicarious traumatization: A framework for   understanding the psychological effects of working with victims. *Journal of Traumatic Stress*, 3, 131-149.

McGillivray, A., & Comaskey, B. (1999). *Black eyes all of the time: Intimate violence,   Aboriginal women and the justice system.* Toronto, Canada: University of Toronto Press.

Moffitt, P., & Fikowski, H. (2017). Northwest Territories research project report for territorial   stakeholders: Rural and northern community response to intimate partner violence. Yellowknife: Faculties of Nursing and Social Work, Aurora College.

Shepherd, J. (2001). Where do you go when it's 40 below? Domestic violence among rural Alaska native women. *Affilia*, 14, 488-510.

Wendt, S., & Hornosty, J. (2010). Understanding contexts of family violence in rural, farming   communities: Implications for rural women's health. *Rural Society*, 20, 51-63.

Wuerch, M. A., Zorn, K. G., Juschka, D., & Hampton, M. (2016). Responding to intimate   partner violence: Challenges faced among service providers in northern communities.   *Journal of Interpersonal Violence*, 1-21. doi: 10.1177/0886260516645573

Acknowledgements

17. Addressing Intimate Partner Violence in the Northwest Territories, Canada: Findings and Implications from a Study on Northern Community Response (2011-2017)

PERTICE MOFFITT AND HEATHER FIKOWSKI

Death, posttraumatic stress, depression and other chronic physical conditions are reported outcomes of intimate partner violence (IPV) that contribute to the personal suffering of victims' wellbeing and mental health and that of their families, and their communities. The Northwest Territories experiences IPV at a rate seven times higher than the national Canadian average. As well, homicides occurred every year of a recent study and were linked to domestic violence. It is apparent that IPV is problematic for individuals, families, and communities, and has a negative impact on the health of territorial residents. The purpose of this chapter is to share research findings from a five-year Social Sciences and Humanities Research Council-funded project about northern community response to IPV. From the grounded theory model, this chapter highlights the central phenomenon "our hands are tied" – frustration, and the normalization of violence has occurred. The implications are outlined in an action plan to guide future education, research and advocacy efforts.

Key Terms: Intimate partner violence, domestic violence, northern research, rural and remote, Northwest Territories, Canada

Introduction

The three territories of Canada have the highest rates of intimate partner violence (IPV) in the country (Statistics Canada, 2016). As well, the current Government of Northwest Territories (GNWT) 18th Legislative Assembly (2016) identified family violence as a key priority, which further establishes the weight of the problem in the lives of residents. Compounding the problem of family violence is the fact that of the 33 communities in the territory, 25 communities have populations of 1000 or less people. Remote communities, such as these, have few to no resources for women experiencing IPV. IPV is defined as a range of physically, sexually, and psychologically coercive and controlling acts used against an adult woman by a current or former male or female intimate partner (Elseberg & Heise, 2005). The purpose of this chapter is to share an overview of the research methodology, findings, and action plan from a Social Science and Humanities Research Council funded project about northern community response to IPV in the Northwest Territories (NWT). The findings establish that frontline workers' "hands are tied" related to the intersection of many factors (for example, normalization of violence, depleted resources, a revolving frontline service, and historical trauma) which results in a crisis response to keep women safe. These are significant findings resulting in the creation of an action plan to move forward towards healing, healthy relationships and non-violent communities. This chapter will provide an overview of the findings as they relate specifically to the NWT.

Background

There is a dearth of research on IPV in Canada's North. Mostly, what is known comes from incidents reported in local media and statistical reports related to criminal activity that is occurring. However, there is a beginning body of literature on IPV occurring in Canadian northern and remote areas (Faller et al., 2018; Moffitt & Fikowski, 2017; Moffitt, 2012; Wuerch, Zorn, Juschka & Hampton, 2016; Zorn et al., 2017), accounts of suicide at high rates in the Arctic (Kral, 2012; Isaacs, Keogh, Menard, & Hockin, 1998; Redvers et al., 2015), and unique contextual factors influencing the health and wellbeing of northerners (Bjerregarrd & Young, 2000). The effects of IPV are felt and interact at multiple levels, spanning the person, family, community, and territory. As reported by the Chief Coroner at a Domestic Homicide Prevention conference in London, Ontario, domestic violence is the causative factor in the majority of homicides in the NWT (Menard, 2017). A review of homicides in the NWT demonstrates that patterns of repeated incidents of violence are predictable indicators of homicidal risk and can provide frontline workers with opportunities to intercede (Rendall, 2016).

Methodology

This research spanned five years (2011 to 2016) and involved a multidisciplinary team from four jurisdictions (Alberta, Saskatchewan, Manitoba and the NWT.) In each jurisdiction, the research team consisted of community partners, academic researchers, and graduate and undergraduate students. In the NWT, our formal partner was the YWCA and we informally partnered with the Coalition Against Family Violence and the Royal Canadian Mounted Police (RCMP) Domestic Violence Team. In all five years of the project, there was an annual meeting in Saskatchewan, led by Dr. Mary Hampton, the Principal Investigator; Joanne Dursel, the community partner; and Betty Mackenna, an Indigenous elder with academic and community representation from all four jurisdictions. A web-page was created and reports from all the research activity and knowledge mobilization are recorded (located at www2.uregina.ca/IPV/research).

The underpinning philosophical premises of this project were based on feminist perspectives of social justice (George & Stith, 2014; Moradi & Grzanka, 2017; van Wormer, 2009), inclusiveness, and equity in the research processes. Grounded theory and constant comparison process (Glaser & Strauss, 1967; Strauss & Corbin, 1998) was used throughout the project.

There were 56 participants in total over the five years of this project. Participants were frontline workers currently employed in the NWT as RCMP, shelter workers, victim service workers, nurses, social workers, or counsellors. This mixed-methods study included an environmental scan of IPV resources, synthesis of media reports, gathering RCMP reported incidents, and Geographical Information Systems (GIS) mapping. Semi-structured interviews (n=31) were completed in the third year, which helped to formulate a preliminary model to describe the community response to IPV. In the fourth year, narrative inquiry of two northern communities using focus groups (n=2) and semi-structured interviews (n=11) further developed and confirmed the model. Finally, an action plan was developed and an extensive knowledge mobilization plan was implemented whereby we returned to seven communities in the NWT as well as Whitehorse, Yukon and Iqaluit Nunavut to report the findings
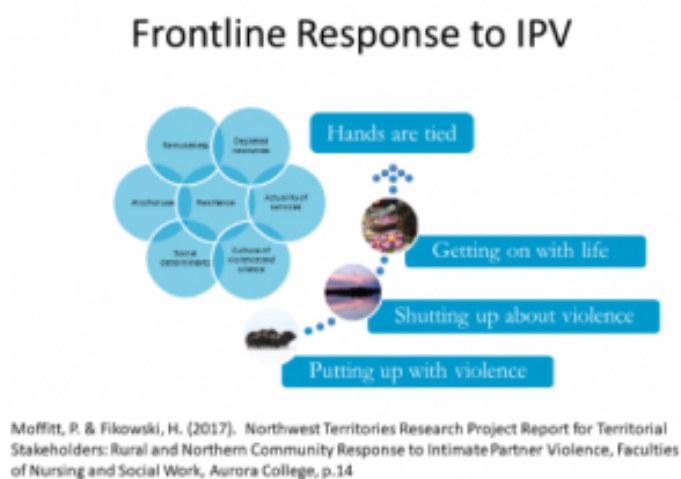
Findings

The findings from this five-year study include three tools to help navigate IPV in the territory. First of all, we completed five GIS maps from an environmental scan and statistics of reported IPV incidents, homicides, Emergency Protection Orders (EPOs), as well as the effects of summer and winter seasons on travel distances to the major center of NWT if

one were escaping violence. These GIS maps provide foundational pictures of the needs and gaps in resources and the extent of the IPV occurrence across the NWT. Secondly, we created a grounded theory with the central problem of "our hands are tied" that explains the community response to IPV through three social processes: shutting up about violence, putting up with violence, and getting on with life. The model helps to understand the challenges and barriers for women experiencing IPV and for frontline workers who are trying to meet the needs of women. Thirdly, we developed an action plan that identifies strategies and directions for decision makers and policy planners in the NWT to transform the community response to IPV from a crisis management response to a coordinated effort that produces a reduction in the rates of violence and leads to healthy outcomes.

The central phenomenon within community response to IPV is the frustration by frontline service providers managing a multitude of factors, including limited resources; turnover of frontline workers; no institutional memory; repeated offenders of violence; increased homicides and suicides related to violence; a history of colonization; silence and secrecy; and blame and shame, that has been stated as "our hands are tied." The following social processes are embedded in the community response model, "our hands are tied" (see Figure 1).

Figure 1 – Our Hands are Tied Model

Moffitt, P. & Fikowski, H. (2017). Northwest Territories Research Project Report for Territorial Stakeholders: Rural and Northern Community Response to Intimate Partner Violence, Faculties of Nursing and Social Work, Aurora College, p.14

Putting Up with Violence

Indigenous communities are experiencing higher rates of IPV (Statistics Canada, 2016) and most of the remote communities in the NWT are Indigenous. As a victim service worker shared, "...a lot of women do not come forward. They just live in fear and they will not leave their partner because of the threat [reprisal, retribution] it is too dangerous." One police officer said "they [the victims] can't handle the pressure from the family members and the community to stay in that relationship. They have nowhere else to go. So basically there is no way out for victims who are chronically abused." This suggests an attitude of acceptance that comes perhaps from shame and blame leading to a sense of futility in pursuing justice for the victim and an acceptance that violence is a "*way of life.*"

There is shaming of victim- it is her fault. The biggest take home is that there is no way   out and they are criticized by children and families. They lose everything if they leave.   The man is controlling the house. She can't afford to go. One woman left for a couple of   years and everyone talks and criticizes. Women lose their children and they feel this is   too steep a price to pay. It is a very untenable solution for many women (Shelter Worker).

The social determinants of health and, in particular, housing, are an issue for women fleeing violence. One participant said "housing and homelessness are a big barrier. It's so expensive and difficult to live up here...even if it is traumatic and violent, chances are you will stay because housing is so precarious and expensive" (Police Officer). The remoteness of many communities in the NWT contributes to putting up with violence.

Shutting Up About Violence

There is a culture of violence and silence in the territory that makes acts of IPV insular, protected, and private. The factors related to shutting up about violence are historical trauma, normalized violence, gossip, community retribution, family and community values, and women's self-preservation. As one participant shared, "I think that the impact of residential school is a major divider and a cause of a really prevalent lack of trust that permeates our culture." (Shelter Worker). Another participant said, "I think with the heritage with residential schools and people suffering traumatic injury there and that pain being handed down generationally, I think there's been generations of people putting up with a lot..." This culture of violence and silence contributes to sustaining turmoil that surrounds victims of violence and, in turn, influences frontline workers' efforts to help by creating a barrier of disengagement with the formal support system.

Getting On With Life

Frontline workers describe the context and multiple barriers faced in their efforts but they also described women as strong and resilient. Survivors of IPV demonstrate creative solutions in keeping their children and themselves safe through personal safety planning and ways of being with the perpetrator to help diminish an escalating situation. They are resisting acts of violence and taking measures to keep their children safe by protecting them in situations that are traumatic and sometimes life-threatening. As a victim service worker noted "some women are such strong fighters, they're like okay I am going to figure this out [in regards to getting help]". Another frontline worker said in their positions it is important to recognize

They've lived here for tens of thousands of years, and if we can support the healthy in

that network, I think that's what's going to make the change cause it's not us from the outside coming in, it's recognizing and valuing and supporting the strength that is already there.

A nurse described the sense of empowerment she has heard women describe when they are finally able to leave an abusive relationship:

I've met with some women who were in really bad way who did finally make it. They're so proud of themselves that they actually managed to get out of the relationship and they're happy, they feel good not having been beaten up. Some of them, I find, some of the Aboriginal ladies really find the Healing Drum very useful and they go there... They say it's the spirituality and they say it's other people understand because they've been through the same thing. So it's the support group from people who they said 'they help you stay strong and not to go back'.

The sense of hope and optimism participants shared about women surviving abuse in the NWT also described women's strength and perseverance. This perspective carries weight in providing counter-measures to the impacts of their frontline work in the remote northern setting of the NWT which allows them to get on with life as well.

Implications and Action Plan

The model, "our hands are tied", describes a northern community response to IPV. The model explicates struggle and pain that within the timeframe of this study included several homicides in the NWT. Yet, the resiliency of women experiencing IPV is also embedded in the model speaking to hope for a future where nonviolence and harmony can exist in communities. Many factors contribute to violence and were considered as we developed an action plan for the territory. The plan is derived from participants in the study responding to the question "how do we create and sustain nonviolent communities?", as well as considering and integrating published literature of best practices relevant for the territorial context. The NWT action plan consists of the following seven strategies: knowledge mobilization, education and awareness, stable and adequate funding, a coordinated response strategy, assessment and screening, social supports, and community healing. In this section, we will briefly address each strategy.

Knowledge Mobilization

Through a process of community meetings across the territory in 2017, the research and action plan were communicated to local service providers along with government planners and policy makers. At one meeting a frontline worker shared "we are a like a canoe that's running in the wrong direction of the river, getting nowhere, no matter how hard we are paddling." By targeting the actions in this plan, propelling the plan will take us upriver with solutions to create places less violent.

Education and Awareness

Recruitment and retention of service providers is an ongoing concern and because of the reality of frequent turnover, a frontline worker said there is *no institutional memory* of incidents, responses, policies and procedures in the NWT across agencies. This means that orientation, professional development, and training must be regularly implemented to maintain effective responses locally. Ideally, local people should drive the strategy so that it is created at home and is culturally and contextually intuitive. The legacy of a history of colonization, with its impact on territorial peoples and unique knowledges of communities, needs to be shared with the frontline service so that cultural safety and reconciliation is inherent in each action.

Many participants in this study expressed the necessity of emergency safety planning for women and children. A police officer shared that conflict occurs everywhere and when it happens, service providers need to be prepared to deal with the immediate situation of violence to keep women and children safe:

...I think the issue is having proper supports and education of people on the ground, on the scene so they can give the person who's making the report or having the issue sort of the immediate intervention, because if they're going to accept any kind of help or intervention, it's going to be in the immediate time after something happens...

Similarly, women who experience violence need to know how to develop a personal safety plan and how to access an emergency protection order when needed. These plans should be tailored to women's choice, staying strategies or leaving strategies, all of which must consider the risks in fleeing, realities of staying, and barriers women experience with either choice.

Stable and Adequate Funding

The complexity of issues related to IPV and barriers that women face (isolation, housing, financial uncertainties, loss of children, and more) shape their decisions to stay or leave a violent relationship. Because of this, women living in northern and remote areas use a variety of strategies when faced with IPV based on their context (Riddell, Ford-Gilboe & Leipert, 2008). Long-term funding targeting social determinants of health (such as housing, employment, education) will improve the livelihood of women experiencing IPV.

Coordinated Response to Violence

Coordinated community response has been defined as a unified response to domestic violence with the creation of a council or agency consisting of community services, such as police, government workers, shelter workers, social services workers, and other stakeholders to respond in a coordinated way to violence in communities (Shorey, Tiron & Stuart, 2014). In the NWT, interagency meetings happen sporadically but if they were stabilized with local people and regular meetings they may foster more coordinated responses. Enhanced advocacy, collaboration and coordination required to meet the needs of victims experiencing IPV may be realized. Using a case management and interprofessional approach could become a reality and may improve the response to IPV in remote areas and streamline access to supports.

Assessment and Screening

Screening tools for intimate partner violence (Arkins, Begley & Higgins, 2016) are needed to assess risk and provide interventions. An assessment question such as (does he hit you, does he hurt you?) could be used in the Well Women programs in remote communities. Practitioners will require education in how to respond to affirmative answers to these questions and how to refer or counsel women. Already, there is an assessment section on the prenatal tool but it is inconsistently used because of turnover, discomfort with asking this sensitive question and lack of knowledge of resources available.

Death reviews are recommended as a way of studying the circumstances leading up to homicides, identifying key predictors of risk for victims, creating decision making tools for risk assessment and safety planning, and developing preventative actions for service providers counselling victims of violence. There is not a formal death review committee in the territory.

Social Supports

Almost all participants spoke about the importance of early education with children and teens, recognizing the number of children being exposed to IPV in their family homes. Recommendations were made to include formal and informal education strategies, and promotional materials, and highlighting community champions living violence-free lives. The focus of education, be it formal or when engaged with frontline providers in a preventative service, would

help children and youth to develop healthy relationships and effective coping strategies to manage an overall sense of healthy wellbeing.

Some RCMP suggested "dry communities" (where alcohol use is banned) as an intervention. The regulation of alcohol in such a manner is a community-driven initiative in the NWT (Davison et al., 2011). In addition, there is a need to intervene with bootleggers who are bringing in vast quantities of alcohol, distributing it without censorship. One suggestion to combat the bootlegging problem was to make it more difficult for people to purchase large orders of alcohol through policy changes at the liquor store outlets.

Community Healing

"Reclaiming our Spirits", a health promotion intervention, holds promise for Indigenous women experiencing intimate partner violence (Varcoe et al., 2017). Although this is an urban intervention, it may be adapted and used with women living in northern and remote areas.

Land-based healing (Redvers, 2016) is gaining attention as a means to enhance wellness in the territory. An Arctic Indigenous Wellness Project (CBC, 2018) is currently being implemented with Indigenous Elders in Yellowknife, recipients of the Arctic Inspiration Award. Participants suggest that alcohol is a factor in IPV and addictions are a major problem requiring local healing. Land and place hold special meaning and relationship to Indigenous northerners' well-being and are now being accessed with hopes of sustained wellness.

Conclusion

IPV is on the radar of frontline service providers, government officials, community advocates and researchers alike. This study generates new knowledge about the experiences of service providers working with women who are faced with violence in the NWT and action plan to address ways to move towards nonviolence. We are building a research agenda to further these findings. Research is already being conducted specifically in relation to "keeping families safe: emergency protection orders" to better understand the nature of EPOs accessed by women in violent emergencies, the outcomes to those IPV emergencies and the utility for its applicants (the women). We are also collaborators in a national study on domestic homicide prevention (CDHPI, n.d.) and partners on a national observatory for femicide (CFOJA, 2018). With a proactive approach and collaboration with our communities, researchers, and decision makers, we hope to untie the multiplicity of factors that feed into the prevalence, severity and frequency of IPV across the NWT.

Additional Resources

Rural and Northern Response to Intimate Partner Violence

http://www2.uregina.ca/ipv/index.html

This offers a localized space to obtain the details of the research project from which this chapter was based. It provides information about the project's background, final reports from all four jurisdictions in Canada (Alberta, Saskatchewan, Manitoba and the Northwest Territories), as well as knowledge translation activities in the last several years.

Aurora Research Institute/Aurora College

http://nwtresearch.com/research-projects/health/intimate-partner-violence

This site offers a copy of the report by Moffitt and Fikowski (2017) on "Rural and Northern Community Response to Intimate Partner Violence."

Family Violence Initiative

https://www.canada.ca/en/public-health/services/health-promotion/stop-family-violence/initiative.html

Organized and led by the Public Health Agency of Canada, this initiative serves as a collaboration with multiple government departments and agencies to address family violence. The website includes information about family violence, trauma-informed approaches to policy and practice resources, ways in which professionals can promote healthy, safe relationships, tools for professionals working with people and communities affected by family violence, and links to possible funding opportunities.

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http://nacafv.ca/

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National Collaborating Centre for Aboriginal Health

https://www.ccnsa-nccah.ca/en/

This Canadian national organization supports Indigenous health through research, policy, and practice initiatives. Information includes family health across the lifespan and social determinants that impact Indigenous family health. It also includes a two-part series report on historic trauma, explaining Indigenous peoples' experiences of trauma and oppression as cumulative and intergenerational.

Status of Women Canada

http://www.swc-cfc.gc.ca/index-en.html

The Status of Women Canada aims to promote women's full participation in Canadian society. Part of their efforts work to end violence against women and girls. It does this by providing policy directives, supporting women's programs, and promoting women's rights.

Books

DeRiviere, L. (2014). The healing journey: intimate partner abuse and its implications in the labour marker. Winnipeg, CA: Fernwood Publishing.

References

Arkins, B., Begley, C., & Higgins, a. (2016). Measures for screening for intimate partner violence: a systematic review. *Journal of Psychiatric and Mental Health Nursing*, 23(3/4), 217-235.

Canadian Broadcasting Corporation (CBC). (2018). What will the Arctic Indigenous Wellness Project do with $1M. Arctic Inspiration prize? Retrieved from https://www.cbc.ca/news/canada/north/2018-arctic-inspiration-prize-1.4513445

Canadian Domestic Homicide Prevention Initiative (n.d.). Retrieved from http://cdhpi.ca/

Canadian Femocide Observatory for Justice and Accountability. (2018). Retrieved from https://femicideincanada.ca/home/contact

Davison, C.M., Ford, C.S., Peters, P.A., & Hawe, P. (2011). Community –driven alcohol policy in Canada's northern territories 1970-2008. *Health Policy*, 102, 34-40.

Elseberg, M., & Heise, L. (2005). *Researching violence against women: practical guidelines for researchers and activists.* Geneva: World Health Organization.

Faller, N., Wuerch, M.A., Hampton, M.R., Barton, S., Fraelich, C., Juscka, D., Milford, K., Moffitt, P., Ursel, J., & Zederayka, A. (2018). A web of disenheartenment wuth hope on the horizon: intimate partner violence in rural and northern communities. *Journal of Interpersonal Violence.* doi:10.1177/0886260518789141

Glaser, B.G., & Strauss, A. (1967). Discovery of grounded theory: strategies for qualitative research. Chicago: Aldine.

Isaacs, S., Keogh, S., Menard, C., & Hockin, J. (1998). Suicide in the Northwest Territories: A descriptive review. *Chronic Diseases in Canada, Ottawa*, 19(4), 152-156.

Kral, M.J. (2012). Postcolonial suicide among Inuit in Arctic Canada. *Cultural Medical Psychiatry*, 36, 306-325.

Moffitt, P., Fikowski, H., Mauricio, M., & Mackenzie, A. (2013). Intimate partner violencein the Canadian territorial north: perspectives from a literature review and a media watch. *InternationalJournalofCircumpolarHealth*,S72:21209.Retrievedfrom http://doi.org/10.3402/ijch.v72i0.21209

Moffitt, P., & Fikowski, H. (2017). Northwest Territories research project report for territorial stakeholders: rural and northern community response to intimate partner violence. Yellowknife: Faculties of Nursing and Social Work, Aurora College

Redvers, J. (2016). *Land based practice for Indigenous health and wellness in Yukon, Nunavut and the Northwest Territories.* Doctoral thesis. University of Calgary, Calgary, Alberta.

Redvers, J., Bjerregaard, P., Eriksen, H., Fanim, S., Healey, G., Hiratsuka, V., Jong, M., Larsen, C.V.L., Linton, J., Pollock, N., Silviken, A., Stoor, P., & Chatwood, S. (2015). A scoping review of Indigenous suicide prevention in Circumpolar regions. *International Journal of Circumpolar Health*, 74(1) 27509. doi:10.3402/ijch.v74.27509

Rendell, M. (2016). Domestic violence involved in the vast majority of NWT homicides. *CBC News North.* Retrieved from http://www.cbc.ca/news/canada/north/domestic-violence-involved-in-vast-majority-of-nwt-homicides-1.3879679

Shorey, R.C., Tiron, V., & Stuart,G.L. (2014). Coordinated community response components for victims of intimate partner violence: a review of the literature. *Aggression and Violent Behaviour*, 19(4), 363-371. Doi: 10.1016/j.avb.2014.06.001

Statistics Canada (2016, January 21). *Family violence in Canada: a statistical profile, 2014.* Retrieved from http://www.statcan.gc.ca/pub85-002-x/2016001/articel/14303-eng.htm.

Strauss, A., & Corbin, J. (1998). *Basics of qualitative research: grounded theory procedures and techniques.* Newberry Park: Sage.

Varcoe, C., Browne, A.J., Ford-Gilboe, M., Dion Stout, M., McKenzie, H., Price, R., Bungay, V...Merritt-Gray, M. (2017). Reclaiming our spirits: development and pilot testing of a health promotion intervention for Indigenous women who have experienced intimate partner violence. *Research in Nursing & Health*, 40, 237-254. doi: 10.1002/nur.21795.

Wuerch, M.A., Zorn, K.G., Juschka, D., & Hampton, M.R. (2016). Responding to intimate partner violence: challenges faces among service providers in northern communities. *Journal of Interpersonal Violence*, 1-21, doi:10.1197/0886260516645573

Zorn, K.E., Wuerch, M.A., Faller, N., & Hampton, M.R. (2017). *Perspectives in regional differences and intimate partner violence in Canada: a qualitative examination. Journal of Family Violence, 32, 633-644. doi: 10.1077/s.10896-017-9911-x*

18. Family Health and Local Capacity Building in a Developing Community in Greenland, seen from a Health Promotion Perspective

GERT MULVAD

This discussion paper is based on papers and reports from the population surveys on health and health prevention program. The discussion is about possible change in the society seen from health promotion perspective.

The population surveys on health in Greenland provide an insight into the incidence and distribution of different risk factors for disease among the adult population. The studies allow for the follow-up of morbidity and health over time and can be used to measure the development of public health in Greenland and thus constitute an important platform for prevention initiatives. Currently, four population surveys from 1993-1994, 1999-2001, 2005-2010, and 2014 have been conducted. In August 2017, the fifth population survey was initiated. (Christina Viskum Lytken Larsen)

Health Prevention Program is often seen as a top/down or a program coming from outside. Cultural and personal feelings. Self-definition of health and the good life. Feeling capable of taking care of one's own life, is keywords in a Health Promotion program. Identify resources and way of action. The goal is mobilizing energy to handle the everyday life and the stress situation in life.

Family values and the health and wellness of children and youth are the priorities for Inuit Health Steering Committee. Individuals must take responsibility for their own health, Families must take responsibility for ensuring the health and wellness of their children and Communities must take ownership over responses to emerging crises and rely less on external support.

Over the past few decades, Greenland has witnessed acceleration in development. The population in the settlements has lower educational possibilities than that of the population in the towns and cities, and there are fewer jobs for people with an education in the settlements. But there are several others areas where life in the settlements and in the towns differs: living accommodations, infrastructure and access to healthcare. Among the children of school age, there are huge disparities between city and settlement. Un-healthy lifestyle is more apparent in settlements. Child mortality is higher in the settlements than in the cities, but mortality in comparison to social strata has not yet been researched. As a result of this development, the traditional family structure, norms, and value systems have been impacted. Studies have also identified a number of serious social and psychological problems in Greenlanders that stem from this development. However, there is now an increasing focus in the Greenlandic society on social, health and schools, which points towards a better welfare in Greenland. Against this background, this chapter argues that family values, and the health of children and youth must be prioritized to ensure the healthy development of future generations. In response, I argue that an increased investment in children's education; social services; resources and increased training for new families; language; public health; and research can help to achieve this goal.

The family has always been the basis for childhood. It is necessary to maintain the family perspective in a community in transition. The well-being of a family depends on: cultural and personal feelings; self-definition of health and the good life; feeling capable of taking care of one's own life; identifying resources and way of action; and mobilizing energy to handle the everyday life and the stressful situations in life.

In the coming year, the Government of Greenland is planning to renew the daycare area through working with "the good daycare". The good daycare will focus on food, play and exercise, hygiene and indoor air quality, and a close relationship with parents. The Government will involve local resource people, parents, and professionals in the development process. Here, social and healthcare assistants work in close collaboration with educators so that children develop well, both in educational, health and socially. This municipality regulation on public schools reflect significant changes in the perception of children and learning. Whereas previously, children were unable to take part in shaping their own lives; they will be able to engage in equitable interaction with adults earlier. The Greenlandic school provides

a significant opportunity for improved welfare through the learning process. From family planning to having children until the child finishes elementary school, the focus will be on general perceptions of health, looking at determinants including early childhood development, education, material resources, housing, social exclusion, personal security, tradition, culture and language. The good school must have the necessary resources and the necessary educational and professional instruments, along with a focus on the family to create a much closer collaboration between health care, social services and the school system.

Second, strengthening welfare workers' and schoolteachers' capacity and emphasizing a close collaboration between the health, social, and educational systems can lay the groundwork for better welfare for families in Greenland and ensure that children experience healthy educational, social, and physical development. This can be achieved through better education and training, and measures to secure better salaries for these workers in the community. In turn, a good school must have the necessary resources, and the educational and professional instruments to provide quality education. Families must not become objects being thrown between systems; they must be active partners. This requires close personal contact between professionals. In addition, while recreation should be a shared responsibility in the communities, there must be public funding, both to ensure professionalism in the various recreational areas and to support voluntary initiatives.

Third, throughout the world, so many children have grown up in families with violence and with experience of neglect and sexual abuse. It is a global social issue and unfortunately a very common problem so we all need help to find solutions. Unfortunately, there is a tendency for the media to focus on children who are victims of neglect and sexual abuse, which often shifts the agenda to a treatment-oriented approach. All parents love their children and want to care for them. However, some need help with building their own capacity to take on the role as mother or father. In turn, the public services for pregnant women must be strengthened through an increased focus on care. Adequately caring for one's children is not always something that comes on its own. The healthcare system can better train young families and inform them about the care of the child and preparation for childbirth. As part of fostering the development of the child, education on how to be a new family should be prioritized as well. Increased communication and cooperation between new families and social services to ensure a safe environment for the new life must be established when needed and a focus on care and well-being is important. In addition, there needs to be a focus on food, play and exercise, hygiene and indoor air quality and a close relationship with parents during early child development.

Fourth, there is an increasing gap in the area of knowledge and language. Greenland is also part of the global community, where communication and knowledge are key factors for continued development. Increased knowledge for the individual is also the means to address increasing social inequality. Greenlandic is naturally the first language. It is the language that gives identity and ensures daily communication. But the global community and the historic ties to Denmark makes it necessary to be fully trilingual; Greenlandic, Danish and English education must be planned accordingly. Knowledge and communication are the future for us all, and children are the best positioned to naturally acquire these skills. This development must be planned for the future and with due regard to the past. Social inequality is one of the biggest threats to health and wellbeing.

Fifth, the municipality has recently broadly endorsed the draft for a Greenlandic Public Health Program which is based on a popular debate. The focus is on health in everyday life and in all sectors of society. It is a program based on better knowledge about health in the Greenlandic population. A knowledge that will improve the chances of enjoying a good, long life free from disease and discomfort. "Health promotion" are the key words in the Public Health Program.

Finally, social research and research on mental health with a focus on children and families' social and emotional development should be supported and followed up by increased educational research and development in these areas.

These are problems that people in Greenland have shared with other Inuit and other Indigenous peoples who have lived through similar societal changes. In response, we must find the necessary resources in the community for this targeted approach, where the strategy is development rather than a treatment. A treatment community is the most expensive solution. This is recognized both in the social, health and school services. The big challenge is to ensure grassroots support. This is necessary because the family and children's well-being is a prerequisite for a positive future for Greenland.

References

Health aspects of colonization and the post-colonial period in Greenland 1721 to 2014. P Bjerregaard, CVL Larsen – Journal of Northern Studies, 2016 – diva-portal.org

Colonial times … ? Finn Lynge, ARCTIC SOCIAL SCIENCES – Prospects for the International Polar Year 2007-2008 Era and Beyond Keynote presentations and other highlights from the Sixth International Congress of Arctic Social Sciences (ICASS VI) Nuuk, Greenland August 22-26, 2008

Three lifestyle-related issues of major significance for public health among the Inuit in contemporary Greenland: a review of adverse childhood conditions, obesity, and smoking in a period of social transition. P Bjerregaard , CVL Larsen – Public Health *Reviews*201839:5

Midtvejsevaluering af Inuuneritta II: Gennemført i 2017 (Danish) C Ingemann, CVL Larsen – 2018 – forskningsdatabasen.dk Befolkningsundersøgelsen i Grønland 2014 (Danish) Peter Bjerregaard, Inger Katrine Dahl-Petersen. https://www.sdu.dk/da/sif/publikationer/2016/befolkningsundersoegelsen_i_groenland_2014

http://www.inuitcircumpolar.com/icc-canada-health-reports.html

19. Theme II Review Questions

1. In your own words, define the social determinants of health. Find two examples of the social determinants of health that were presented in this chapter and explain how they contribute to one's health.

2. Is living in a northern and Indigenous community a social determinant of health? Why or why not?

3. How well equipped is the current healthcare system in your country to address the social determinants of health amongst patients? Why or why not?

4. Propose two strategies that can help healthcare professionals address the social determinants of health in your healthcare field.

5. Describe how gender, race, and income has impacted your health and quality of life

THEME III – CULTURE AND HEALTH

20. Introduction

BENTE NORBYE

Bente Norbye

When working in the rural and remote areas of the Circumpolar North, some of the challenges health professionals face in today's environment is a mismatch in the knowledge they have received through health care education, and the contextual knowledge of their patients. We are all part of a culture, and its values, its people, its practices and material manifestations. There are many different definitions concerning the understanding of culture, but in this context we will support an understanding of culture as a combination of: a) the world view, values and norms that are dominant for a group of people; b) the attitude, actions and practices dominant for the same group of people; and c) their material manifestation (Gule 2008).

As health professionals we are also members of a professional culture with particular language, knowledge, values, artefacts, and ways of performing in health care practices (Markauskaite & Goodyear 2017). Further, as professionals we have a public agenda and/or work obligation with standards for professional conduct. The knowledge we use in treatment and care needs to be valid and based on research evidence relevant to that professional conduct. Our own values might influence the way we, as health personnel, carry out treatment and care, and it can be challenging to provide treatment and care if the cultural norms, values and contexts are different and unknown to us. We need to be aware concerning values and norms different to our own and explore how treatment and care can be carried out in respect for the patients and the families we care for.

Understanding different cultures and values specific to place is critically important for health personnel. Both our own background and our profession might influence the way we see patients with their families and see value in different ways of living. Professional conduct and context-specific treatment and care are not necessarily in conflict, but when it happens, it is our responsibility to identify the conflict and see if there are other ways or means to achieve the health goal. The importance is understanding what the conflict might be and the reason behind it. We need to rethink what kind of knowledge we need and how it can be used and in relation to the patients and family concerned.

For people in communities with a high proportion of Indigenous people, Western ways of treatment and care might collide with traditional ways of attending to an issue, that might be based on aspects other than scholarly research based findings. Since no cultures are static or without change, it is important to understand peoples' background and the values of how they have lived and survived in the North, and include this with our professional knowledge. Colonial influences have altered traditional ways of living, often in detrimental ways. There have been numerous, well-meaning initiatives taken from "the outside world" to solve northern health issues, but with limited knowledge and cooperation of the people involved. This has caused distrust between those who are experiencing health issues and those trying to solve it. The recommended course of action to solve different kinds of challenges have often been drawn from an outside point of view and with an outside perspective of valid actions (Bjerregaard et al. 2004). Over generations this has created a gap between different ways of thinking, different values and knowledge systems. How can we ensure this gap becomes smaller in the future? How do we construct a bridge to combine different ways of thinking and ensure cultural safety for patients?

The chapters in this theme are covering themes from the Circumpolar North, and show how different knowledge influence how health care is received. They also demonstrate how important it is to relate and contribute to trusting relationships and discuss culturally safe approaches that reflect traditional knowledge in a modern context.

From the Northwest Territories in Canada, elderly women share their stories and knowledge through Sharing Circles. The article *Infant Feeding Teachings from Indigenous Grandmothers*, by Pertice Moffitt, Sabrina Lakhani, and Sheila Cruz, describes how families have supported and contributed to the feeding of infants historically. The Grandmothers hope to share their knowledge with new mothers as they can connect the past with the future and support new mothers. Elders hold an important place in many northern communities and cultures and storytelling empowers them as an important source of traditional knowledge.

Siv Kvernmo assesses *The Impact of Cultural Determinants on Indigenous Sami Adolescents' Well-Being and Mental Health*. Although Sami adolescents have as good mental health and well-being as their non-Indigenous peers, Kvernmo finds significant variation in mental health across groups of young Sami. In Sami-dominated contexts, where there are stronger ethnic supports, cultural practice in daily life, and cultural safety, youth had better health outcomes than those in majority mixed and Norwegian dominated contexts, which often expose the Indigenous youngsters to prejudice and racism. Kvernmo concludes that the concept of ethnic identity and ethnic discrimination are particularly relevant cultural determinants which should be addressed in interventions and studies of mental health in Indigenous youngsters.

In *Northern and Indigenous Ethical Imperative for Working with Communities* Julie Bull describes an important dimension of research in northern communities and with Indigenous peoples. The paper describes the need to evolve research strategies from *what* to do to *how* to do research. It is important to involve patients, families and communities, and form mutual relationships between researchers and Indigenous communities. This relationship should facilitate the development of methodologies, conceptual frameworks and meaningful recruitment strategies that relate to the communities and the theme that is being researched. The paper shows that individual ethical consent might be inadequate when conducting research related to a community as a whole.

The Norwegian paper *Establishing Trustful Relationships between Marginalized Indigenous People and Researchers/ Health Workers* by Snefrid Møllersen and Tonje Haanæs-Rensberg discusses how important it is to establish trustful relationships between marginalized peoples and researchers through a partnership model in research. This model shifts the emphasis from passive to active participation in research where participants' competence and expertise are recognized and taken seriously. The inclusion of reindeer herders' knowledge in this case was essential and both parties understood that the research findings were rooted in trusting relationships. This model can be useful for others who seek a more ethical conduct of research.

Both culture and health are interrelated, essential elements of the human experience. Hopefully, we can accept and learn from each other's ways of living and better understand what is valued by individuals, families and communities, and thus ensure that the highest professional standards are achieved.

References

Bjerregaard, P., Kue Young T., Dewailly, E., and Ebbesson, S. O. E. (2004). Indigenous Health in the Arctic: An Overview of the Circumpolar Inuit Population. *Scand J Public Health*, 32: 390–395

Gule, L. (2017) Profesjon og flerkulturalitet (Profession and Multiculturalism). In Anders Molander and Lars Inge Lerum (eds). *Profesjonsstudier (Studies of Professions)* (pp. 233 – 250). Oslo Universitetesforlaget. In Norwegian

Markauskaite, L., and Goodyear, P. (2017). *Epistemic Fluency and Professional Education. Innovation, Knowledgeable Action and Actionable Knowledge*. Dordrecht: Springer.

21. Infant Feeding Teachings from Indigenous Grandmothers: Generating Knowledge through Sharing Circles

PERTICE MOFFITT, SABRINA-AYESHA LAKHANI, AND SHEILA CRUZ

Traditional practices of mothering are important to the identities of Indigenous women, families, and their communities. Infant feeding is central to mothering. Traditional knowledge shared by Indigenous Elders is deeply respected in Canada's north and is alive in stories shared by grandmothers and great-grandmothers. Unfortunately, women's acquisition of breastfeeding knowledge and cultural practices were interrupted by the impact of colonization, patriarchy, residential schooling, and the subsequent loss of knowledge transmission between Elders and youth. The grandmothers wish to restore historical aspects of mothering and share their knowledge and mothering expertise with future generations. The purpose of this chapter is to introduce and recognize traditional knowledge gathered through sharing circles and interviews with grandmothers and great-grandmothers who share their own infant feeding practices and those of their ancestors and their children.

Key Terms: Breastfeeding, infant feeding, Indigenous mothers, health

INTRODUCTION

The Northwest Territories (NWT), Canada is home to a diverse ethnic population of mothers, including Indigenous (Dene, Métis, Inuvialuit) and non-Indigenous. This study comprises of three data collection methods: sharing circles with grandmothers, individual interviews with mothers of infants from birth to one year of age, and a retrospective chart audit of the 2016 cohort of NWT births. The stories and knowledge about infant feeding in this chapter are from mothers and grandmothers, who participated in Elder sharing circles conducted in four regions in the NWT from October to December, 2017. Their stories convey powerful messaging and wisdom related to the resiliency and resourcefulness of mothers, the need to survive hardships, and the desire to rekindle past practices. Preliminary findings from this work challenge the contemporary approach and perceptions of infant feeding practices to combine past and current understandings and values to better support mothers in breastfeeding.

BACKGROUND AND METHOD: TRADITIONAL KNOWLEDGE AND INFANT FEEDING

Today, breastfeeding is heralded as the "best" in many campaigns or as "saving lives" as described by Watson and Mason (2014) in the critique they wrote called "the power of the first hour" (p. 573). In their review, they describe the movement around colostrum in the first hour of an infant's life as the answer to addressing infant mortality. These authors question

the crisis, urgency and risk tone to messaging that suggests that global issues can be solved through these gendered universal and individualized actions. It would seem that this further disempowers mothers and their agency around feeding their babies. Thus, we are careful that we are honouring women's choice of how they feed their babies and that we are cognizant of the literature that suggests that physical contact, interactions between mother and baby, and close relationship are interconnected and play an important role in mothering and infant feeding (Kramer et al., 2008). In addition, we acknowledge that determinants of breastfeeding are contextual and complex (Moffitt, 2012; Moffitt & Dickinson, 2016).

Storytelling and oral tradition are entrenched in the lifeways of Indigenous northern peoples and are the format for talking and sharing about the past (Cruikshank, 1991). In this study, grandmothers, engaging in sharing circles with other local grandmothers, told stories about feeding and caring for their babies. The sharing circles were facilitated with semi-structured questions but heralded many impromptu stories. Traditional knowledge has been described as:

unifying theory and practice and cannot be separated from a way of being and a way of doing...it [traditional knowledge] seeks to make sense of diverse variables... purposely integrates subjective ways of knowing such as spirit, values and compassion...is fluid and generative, integrating the weave of pattern and variation into new ways of knowing (Arctic Institute of North America, 2014, p. 1).

There is not a great deal written about past infant feeding practices but there are some accounts in the anthropological literature (Hara, 1980; Helm, 1961, 1981; Petitot & Savoie, 1971; Ryan & Johnson, 1994). According to Hara (1980) in research conducted with "Hare Indians" of Fort Good Hope, babies were fed by mothers as soon as "the milk began to flow" (p. 267); and if they had plenty of milk, they would help with feeding other women's babies. She also reported that a granny raising a baby fed the infant bacon, guts, and animal brains, and stated that the baby grew up strong "had hardly any milk but is a tough good hunter." (p. 267) Hara cites Ross (1866) as recording that infants were not fed for "four days after birth...to render them capable of enduring starvation in the afterlife, an accomplishment which they are very likely to stand often in need of." (p. 267) At that time, if a mother chose to bottle feed, she made formula with canned milk, water, and sugar. Mothers, along with primarily being responsible for feeding their infants, undertook activities like visiting the trap line and collecting spruce brush. The community or family members' formula fed the babies at times of the mothers' absences for these activities.

FINDINGS

Three key themes were identified through the Elder sharing circles that will be presented in this brief report of infant feeding. The themes to be addressed are resiliency and resourcefulness of mothers, surviving hardships and rekindling past practices.

Resiliency and Resourcefulness of Mothers

The climate, geography, and ecology played a strong role in shaping the feeding and mothering practices of Indigenous mothers. Women fed their babies by whatever means they could to keep them alive and healthy. This is an aspect of their mothering that we heard from all of the grandmothers. One woman described her experience like this "...they [new mothers] tried anything, any kind of broth. They tried to make milk, because you know there wasn't milk there to buy.1" Sometimes, they would use fish broth, caribou broth, or boil rice and use the broth. One Elder described that she could not breastfeed because "her milk never came in."

Some grandmothers described the role of Elders in advising pregnant women. By noticing an imminent pregnancy, offering advice, and sharing knowledge, Elders identified their support and encouragement. One Elder said:

First of all, I think when you are pregnant the Elders always talk to you and that was the way I was. I used to visit

somebody across the river in [place] and then an Elder in [place] she said when are you going to have your baby? and I told her and she said when you have your baby you have to drink water and broth and soup, that nice broth eh, and that way so when the baby starts to take the breast its full eh your breasts are full so the baby has it easy to get on it.

The majority of women offered the baby the breast soon after birth even if they did not continue to breastfeed. Some women who had the support of Elders breastfed all of their children, while others shared that "they tried" sometimes as long as 3 to 4 months, but they had painful breasts and switched to the bottle stating that they had "suffered enough."

Grandmothers described times in their pasts when they were in the bush and everyone in the camp pulled together to help mothers deliver their babies. One Elder told of a time when she was 16 and her sister-in-law went into premature labour and had twins. They collected all of the hot water bottles they could to keep the babies warm and she stated, "my father in law was scrounging around for eyedroppers. That's what we fed them with every hour."

Surviving Hardships

Indigenous women shared stories in the past of weathering many hardships, in terms of mothering. Events of illness, such as tuberculosis and effects of colonization, whereby transmission of parenting knowledge from their families was lost, altered, and disrupted a continuity of past practices. Some new mothers felt isolated and on their own when they had difficulties with breastfeeding. They were reluctant to seek help because of their residential school experience. One grandmother shared:

You know those days I mean in the days of residential school. In those days, we never did talk about our body parts because I think we were too ashamed to say [anything about breastfeeding] to your kids. I never did hear it from my sisters or nobody in the family. They were so private.

Rekindling Past Practices

In the near past (the time of the grandmothers in this study), community women were supporting each other in birthing their babies. Several mothers spoke about another local woman being present at the birth of their baby and providing support. As well, knowledge around breastfeeding was translated by observing other women feeding babies. To this day, the Elders still hold strong beliefs that breastfeeding creates an exclusive and inimitable bond between mother and child. Many of them share the perception that today's world is very different from the one they grew up in. This gives rise to their strong desire to help future generations understand and bridge the connections between traditional practices and current ones.

CONCLUSION

Elders hold an important place in northern communities. The Elder sharing circles created an opportunity for grandmothers to come together to share their stories and reflect on their lives and influences on feeding their babies. The story telling was positively received and fostered strength and a sense of empowerment from each other's recollections through laughter, good will, and fellowship. Three themes, resilience and resourcefulness of mothers, surviving hardships, and rekindling past practices of infant feeding, were briefly highlighted in the chapter. The mothering experiences of Indigenous women are salient to mothers today. Community grandmothers are well positioned to be role models in supporting women in feeding their babies and addressing current mothering issues that occur in their communities. They wish to reclaim their roles and share their wisdom, support, and advice to new

mothers. Considering these traditional infant feeding practices and experiences of Elders, this chapter seeks to broaden the understanding of nursing students of the cultural and contextual factors that influence client decision-making. The process is a mechanism to bolster engagement and relationships between nurses, and new mothers and their families. Furthermore, it provokes thought on how services, programs, and healthcare providers can better incorporate Elders and their knowledge into maternal-child care. Thus, helping to promote and empower women with infant feeding and revive the lost aspects of mothering in Indigenous women.=

NOTES

1. To maintain anonymity in the small sample size dates and times of interviews are not included.

Additional Resources

Breastfeeding Committee for Canada at http://www.breastfeedingcanada.ca/Default_en.aspx

Baby Friendly Initiative http://breastfeedingcanada.ca/documents/Indicators%20-%20complete%20June%202017.pdf

REFERENCES

Arctic Institute of North America. (2014). ITI YATI: A symposium on traditional knowledge. Retrieved from https://arctic.ucalgary.ca/ita-yati-symposium-traditional-knowledge.

Cruickshank, J. (1991). *Life lived like a story: Life stories of three Yukon Native Elders*. Lincoln, NE: University of Nebraska Press.

Hara, H. S. (1980). *The Hare Indians and their world.* Canadian Ethnology Service Paper No. 63. Ottawa, ON: National Museum of Canada.

Helm, J. (1961). *The Lynx Point people: the dynamics of a northern Athapaskan band.* Bulletin No. 176. Ottawa, ON: National Museum of Canada.

Helm, J. (Ed.). (1981). *Handbook of North American Indians, Volume 6: Subarctic.* Washington, D. C.: Smithsonian Institution.

Kramer, M., Aboud, F., Mironova, E., Vanilovich, I., Platt, R., Matush, S., Igamnov…(2008). Breastfeeding and childhood cognitive development: new evidence from a large randomized trial. JAMA *Psychiatry*, 65(5), 578-584.

Moffitt, P. (2012). In the dark: uncovering influences on pregnant women's health in the Northwest Territories. In B.L. Leipert, B. Leach, W.E. Thurston (Eds.) *Rural women's health* (pp. 320-345). Toronto: University of Toronto Press.

Moffitt, P., & Dickinson, R. (2016). Creating exclusive breast feeding knowledge translation tools with First Nations mothers in Northwest Territories, Canada. *International Journal of Circumpolar Health*, 75, 1-8. Retrieved from http://dx.doi.org/10.3402/iijh.v75.32989

Petitot, E., & Savoie, D. (1971). *The Amerindians of the Canadian Northwest in the 19th century as seen by Emile Petitot Vol. 2 Loucheux Indians.* Ottawa, ON: Northern Science Group, Department of Indian Affairs.

Ross, B. (1866). Letter from Mr. Ross to George Gibbs, with detailed information relative to Chipewyan tribes, with abstract of Mackenzie River Dist., June 1, 1858, MS 144a Bureau of American Ethnology. National Anthropology Archives. Smithsonian Institution.

Ryan, J., & Johnson, M. (1994). *Traditional Dene medicine.* Lac La Marte, NT: Dene Cultural Institute.

Watson, Mason (2014). The power of the first: Is there a transnational birthing crisis? *International Feminist Journal of Politics, 17*(4), 573-594.   http://doi.org/10.1080/14616742.2015.1080908

Wood, K., & Van Esterick, P. (2010). Infant feeding experiences of women who were sexually   abused as children. *Canadian Family Physician, 56*(4), 136-142.

22. The Impact of Cultural Determinants on Indigenous Sami Adolescents' Well-being and Mental Health

SIV KVERNMO

The risk and protective factors influencing mental health in Indigenous children and adolescents may vary from non-Indigenous peers due to their Indigenous status and upbringing in ethnic diverse contexts. Ethnic contexts are categorized according to the density of Sami inhabitants; Norwegian dominated context by a low density of Sami members (<25%), the Mixed context by a medium density of Sami (25%–60%), and the Sami dominated context by a high density (>60%) of Sami. The impact of cultural factors, such as Indigenous identity, cultural activities, and Indigenous language competence on Indigenous children's health is sparsely studied. In previous studies, cultural determinants accounted for significant variation in mental health in Sami high school students, but mainly for emotional problems. Later studies have broadened our knowledge of the effect of cultural issues impact on Sami adolescents. The aim of this chapter is to suggest specific features of the Sami culture and Indigenous status are important to consider in the treatment and prevention of mental health problems in Sami youngsters.

Key Terms: Indigenous, Sami, adolescents, mental health, culture, determinants

Introduction

The health condition of Indigenous Sami children and adolescents has only been a topic of research for the last two decades. An increase in suicide rates in Sami adolescents and young adults in the late eighties forced policy makers, health professionals and researchers to place attention on the mental health conditions in the Sami population and the need for more knowledge. Later research has shown that Indigenous Sami adolescents have, in general, good mental health and well-being and do not differ from their non-Indigenous peers in rates of health problems (Margrethe Bals, Turi, Vittersø, Skre, & Kvernmo, 2011; Eckhoff & Kvernmo, 2014; S. Heyerdahl, Kvernmo, & Wichstrøm, 2004; Omma, Jacobsson, & Petersen, 2012). However, significant variation in mental health across groups of young Sami does occur (Kvernmo & Heyerdahl, 1998; 2003). A variety of cultural factors, as well as individual, family, and community characteristics can explain part of this variation. The impact of ethnic identity, acculturation, and cultural-related issues on mental health in Sami adolescents is the aim of this chapter.

In a recent systematic review of mental health in Indigenous young people in a diverse sample of high income countries, the prevalence of mental health problems was consistently high (Young, Hanson, Craig, Clapham, & Williamson, 2017). Across countries, children and young Indigenous peoples shared many of the same risks and protective factors. Children's negative relationship with their families and experience with adverse life events, including the experience of ethnic discrimination, were found as the most reliable predictors of mental health problems (Young et al., 2017). On the other hand, positive peer and family relationships, strong self-esteem, and optimistic attitudes seemed to contribute to positive mental health outcomes.

Although Young et al.'s (2017) study did not include areas of the Arctic, other studies of Arctic adolescents – Indigenous, as well as non-Indigenous – show that several of the identified risk and protective determinants in Young et al.'s (2017) study remain valid for Sami adolescents (Kvernmo & Heyerdahl, 2003; Kvernmo, Heyerdahl & Wichstrøm, 2004; Spein, Kvernmo & Sexton, 2004; Silviken & Kvernmo, 2007; Bals, Turi, Skre & Kvernmo, 2011; Reigstad & Kvernmo, 2017). A limited number of studies investigating the impact of cultural determinants on mental health in Indigenous people are found. This chapter presents those ethnic and cultural determinants among Arctic Indigenous adolescents with a particular focus on Sami adolescents.

Cultural Determinants

Ethnic Group Differences

The Sami population is, according to the ILO convention, no. 169, recognized as the Indigenous population in Norway. In some regions, they are the majority population as in the Sami core areas, but mainly they are in a minority position.

Studies among Indigenous and non-Indigenous adolescents in the Arctic area in Norway and Sweden have revealed few and small ethnic differences in mental health. Anxiety and depression, or emotional problems often referred to as the broader concept of "internalizing" mental health problems, have been studied in students in junior high school and high school students (Omma et al, 2012; Omma, Sandlund, & Jacobsson, 2013). While rates of anxiety and depression in Indigenous Sami students were not worse off or even similar in rates (Bals, Turi, Skre, & Kvernmo, 2010; Heyerdahl, Kvernmo, & Wichstrøm, 2004; Omma et al., 2012), substance use among Norwegian Sami adolescents and their parents, and internalizing problems (anxiety and depression) in Swedish Sami adolescents were less frequent compared to non-Sami peers (Spein, Sexton, & Kvernmo, 2007; Omma et al., 2012).

In a study from the 90's of suicide thoughts and attempts, no ethnic differences were found among Indigenous and non-Indigenous Norwegian high school students (Silviken & Kvernmo, 2007). Due to the difference in determinants of suicide attempts, the authors stated that, "Clinicians should take into account that risk factors can differ between ethnic groups and should be sensitive to culturally divergent behavior". In both ethnic groups, suicidal ideation, anxious/depressed problems, and eating behavior problems were associated with more suicide attempts. However, for Sami adolescents, factors diverging from the traditional cultural norms were associated with suicide attempts, such as alcohol intoxication, single-parent home and paternal overprotection, while among majority peers, vocational studies, not living together with parents, current smoking and experienced sexual intercourse were ethnic specific risk factors associated with suicide attempts. These findings correspond with results from a Swedish study of Sami and non-Sami young people (Omma et al, 2013).

A more recent study on junior high school students, the Norwegian Arctic Adolescent Health Study (NAAHS) showed a higher rate of suicide attempts and adverse life events in the Sami group compared to non-Sami peers (Reigstad & Kvernmo, 2017). In a comparison study between Sami and Greenlandic adolescents, Sami students rated their health considerably better than Greenlandic counterparts (89% versus 62%, respectively). In both ethnic groups, suicidal thoughts (risk) and physical activity (protective) were associated with poor and good self-rated health, respectively (Spein et al., 2013).

In spite of no or small ethnic group differences in mental health outcomes between Sami and non-Sami youngsters, research thus far has revealed significant variation within the Sami group. Culture-specific factors can partly explain this variation. The most prominent determinants will be presented in the following sub-sections.

Ethnic context and minority positions

Sami adolescents grow up and live in different ethnic contexts. Ethnic contexts are often categorized according to the density of Sami inhabitants (Kvernmo & Heyerdahl, 1996). The Norwegian dominated context is characterized by a low density of Sami members (<25%); the coastal context by a medium density of Sami (25%–60%); and the Sami dominated context by a high density (>60%) of Sami. Although the context categories are mainly based on density of Sami members and cultural features, such as different levels of forced assimilation, language, loss of ethnic identity and stigmatization, they are also characterized by revival of the Sami culture.

Sami-dominated contexts provide stronger ethnic support, cultural practice in daily life, and cultural safety than majority mixed and Norwegian dominated contexts, which often expose the Indigenous youngsters to prejudice and racism. Sami-dominated contexts are found to promote stronger ethnic or Indigenous identity, ethnic pride and practice, as well as better mental health. In contrast, Sami adolescents living in a distinct minority position in Norwegian dominated context seem to struggle with more internalizing, as well as externalizing (conduct and delinquent behavior) and attention problems than peers in majority Indigenous positions (Kvernmo & Heyerdahl, 1998, 2003). The ethnic context is therefore of importance for Sami children's and adolescents' mental health.

Acculturation Attitudes

Acculturation attitudes refer to the cultural and psychological changes, i.e. attitudes or behaviors, that occur as a result of continuous contact between people of different ethnic or cultural origin. The strategies the individual use in this process are mainly defined as four types: assimilation, integration, separation, or marginalization. The different strategies are associated with different mental health outcomes (Berry 1990; Berry & Sam, 1997). In the Young in North Study, separation attitudes, i.e. withdrawal into the original cultural group, was a risk factor and predicted internalizing problems in females. Among males, integration attitudes acted as a protective factor for externalizing, as well as social problems, while marginalization (not connected to any cultural group) was associated with mainly internalizing problems (Kvernmo & Heyerdahl, 2003). It must, however, be mentioned that the empirical basis for the four acculturation strategies have been questioned (Rudmin & Ahmadzadeh, 2001). Lacking evidence for the existence of the four ways of acculturating and the benefit of integration have been claimed by Rudmin (2001). However, in a study by Berry, Phinney, Sam, and Vedder (2006), more than 5000 immigrant youth from 13 countries which assessed among other concepts attitudes toward the four types of acculturation, supported the acculturation model.

Ethnic identity

Ethnic identity can be defined as the sense of belonging to one's ethnic group of origin and is a developmental process mainly taking place in adolescence as a part of the identity formation in general (Phinney, 1990). It is a salient issue in identity development for ethnic minority adolescents, Indigenous adolescents included. Ethnic identity is supposed to develop from a diffused/foreclosed stage, through exploration to achievement. In general, a strong and achieved Indigenous or ethnic identity is associated with good mental health in minority adolescents. Surprisingly, earlier studies among Sami adolescents revealed that amongst high school students, ethnic identity was a predictor of more mental health problems, but mainly in males (Kvernmo & Heyerdahl, 2004). On the other hand, ethnic identity was found to protect against substance use (Bals, Turi, Skre, & Kvernmo, 2010) .

When examining the different concepts of ethnic identity in young Sami adolescents, the Norwegian Arctic Adolescent Health Study (NAAHS) more recently found that ethnic exploration protects against both internalizing and

externalizing problems, while ethnic identity achievement acted the opposite way, particularly for those living in a Norwegian dominated area. Sami adolescents with a strong ethnic identity are possibly those individuals who expose themselves most as Sami and fight for their culture and people. This hypothesis was supported by the finding in the same study that ethnic discrimination was closely connected to externalizing problems (Bals, Turi, Skre & Kvernmo, 2010).

An interesting finding from the same study was the protective role of having a strong sense of national or Norwegian belonging. Youngsters who strongly identified as Norwegian had less anxiety and depression, which possibly expressed their bicultural competence and the advantage of this competence. Overall, the NAAHS study confirmed that externalizing problems in young junior high school students were more vulnerable to cultural determinants than internalizing problems were. In Canadian Indigenous adolescents, ethnic identification is found to fluctuate over time, but also to influence their psychosocial function. Students who consistently defined as Indigenous over time had the highest drop-out rate from school. In contrary, peers that, at first, did not declare Indigenous belonging, but later did, were more likely to complete school (Hallett et al., 2008).

Ethnic discrimination

Studies have shown that Sami adults and adolescents, similar to other ethnic minorities and Indigenous group, still have to deal with ethnic discrimination and racism, and the health outcomes of this adversity (Bals et al., 2010; Hansen, 2015). When ethnic context, socioeconomic status, and other cultural determinants controlled for, ethnic discrimination seem to contribute most to mental health problems in Sami adolescents.

Conclusion

Overall, Indigenous Sami adolescents are in good mental health. In contrast to other Indigenous peers, they are not in a worse position than their non-Indigenous counterparts. However, the variation in mental health within the Sami group highlights the need of a further attention on cultural determinants to be considered. The impact of cultural factors, such as Indigenous identity, cultural activities, and Indigenous language competence on Indigenous children's health is sparsely studied. The concept of ethnic identity and ethnic discrimination are particularly relevant cultural determinants which should be included in studies of mental health in Indigenous youngsters.

Additional Resources

Canino, I.A., & Spurlock, J. (2000). *Culturally Diverse Children and Adolescents Assessment, Diagnosis, and Treatment.* New York: The Guilford Press.

Kvernmo, S. Mental health of Sami youth. Int J Circumpolar Health. 2004 Sep, 63(3):221-34.

References

Bals, M., Turi, A. L., Skre, I., & Kvernmo, S. (2010). Internalization symptoms, perceived discrimination, and ethnic identity in Indigenous Sami and non-Sami youth in Arctic Norway. *Ethnicity & Health*, 15(2), 165-179. https://doi.org/10.1080/13557851003615545

Bals, M., Turi, A. L., Vittersø, J., Skre, I., & Kvernmo, S. (2011). Self-reported internalization symptoms and family factors in Indigenous Sami and non-Sami adolescents in North Norway. *Journal of Adolescence*, 34(4), 759–766. https://doi.org/10.1016/j.adolescence.2010.08.005

Berry, J. W. (1997). Immigration, acculturation and adaptation. *Applied Psychology*, 46, pp. 5-68.

Berry, J.W., Phinney, J.S., Sam,D.L., & Vedder, P. (2006). Immigrant youth in cultural transition. *Lawrence Erlbaum Associates*. Mahwah, NJ.

Berry, J.W., & Sam, D.L. (1997). Acculturation and adaptation. In

Berry, J.W., Segall, M.H.,& Kagitcibasi, C.(Eds.). *Handbook of cross-cultural psychology*, Vol. 3, Social behavior and applications. Boston: Allyn and Bacon pp. 291-326

Eckhoff, C., & Kvernmo, S. (2014). Musculoskeletal pain in Arctic Indigenous and non-Indigenous adolescents, prevalence and associations with psychosocial factors: A population-based study. *BMC Public Health*, 14(1), 1-10. https://doi.org/10.1186/1471-2458-14-617.

Hallett, D., Want, S. C., Chandler, M. J., Koopman, L. L., Flores, J. P., & Gehrke, E. C. (2008). Identity in flux: Ethnic self-identification, and school attrition in Canadian Aboriginal youth. *Journal of Applied Developmental Psychology*, 29(1), 62–75. https://doi.org/10.1016/j.appdev.2007.10.008

Hansen, K. L. (2015). Ethnic discrimination and health: the relationship between experienced ethnic discrimination and multiple health domains in Norway's rural Sami population. *International Journal of Circumpolar Health*, 74, 25125. Retrieved from http://www.ncbi.nlm.nih.gov/pubmed/25683064

Heyerdahl, S., Kvernmo, S., & Wichstrøm, L. (2004). Self-reported behavioural/emotional problems in Norwegian adolescents from multiethnic areas. *European Child and Adolescent Psychiatry*, 13(2), 64-72. https://doi.org/10.1007/s00787-004-0359-1

Kvernmo, S., & Heyerdahl, S. (1998). Influence of ethnic factors on behavior problems in Indigenous Sami and majority Norwegian adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 743–751. https://doi.org/10.1097/00004583-199807000-00014

Kvernmo, S., & Heyerdahl, S. (2003). Acculturation strategies and ethnic identity as predictors of behavior problems in arctic minority adolescents. *Journal of the American Academy of Child and Adolescent Psychiatry*, 42(1), 57-65. https://doi.org/10.1097/00004583-200301000-00011

Kvernmo, S., & Heyerdahl, S. (2004). Ethnic identity and acculturation attitudes among Indigenous Norwegian Sami and ethnocultural Kven adolescents. *Journal of Adolescent Research*, 19(5), 512-532. https://doi.org/10.1177/0743558403259991

Omma, L., Jacobsson, L. H., & Petersen, S. (2012). The health of young Swedish Sami with special reference to mental health. *International Journal of Circumpolar Health*, 71, 18381. https://doi.org/10.3402/ijch.v71i0.18381

Omma, L., Sandlund, M., & Jacobsson, L. (2013). Suicidal expressions in young Swedish Sami, a cross-sectional study. *International Journal of Circumpolar Health*, 72, 19862. https://doi.org/10.3402/ijch.v72i0.19862

Phinney, J. S. (1990). Ethnic identity in adolescents and adults: A review of research. *Psychological Bulletin*, 108, 499-514.

Reigstad, B., & Kvernmo, S. (2017). Concurrent adversities and suicide attempts among Sami and non-Sami adolescents: the Norwegian Arctic Adolescent Study (NAAHS). *Nordic Journal of Psychiatry*, 71(6). https://doi.org/10.1080/08039488.2017.1315175

Rudmin, F.W., & Ahmadzadeh, V. (2001). Psychometric critique of acculturation psychology: The case of Iranian migrants in Norway. *Scandinavian Journal of Psychology*, 42, 41-56.

Silviken, A., & Kvernmo, S. (2007). Suicide attempts among Indigenous Sami adolescents and majority peers in

Arctic Norway: Prevalence and associated risk factors. *Journal of Adolescence*, 30(4), 613-626. https://doi.org/10.1016/j.adolescence.2006.06.004

Spein, A. R., Pedersen, C. P., Silviken, A. C., Melhus, M., Kvernmo, S. E., & Bjerregaard, P. (2013). Self-rated health among Greenlandic Inuit and Norwegian Sami adolescents: Associated risk and protective correlates. *International Journal of Circumpolar Health*, 72(1), 19793. https://doi.org/10.3402/ijch.v72i0.19793

Spein, A. R., Sexton, H., & Kvernmo, S. (2007). Substance use in young Indigenous Sami: an ethnocultural and longitudinal perspective. *Substance Use & Misuse*, 42, 1379–1400. https://doi.org/10.1080/10826080701211693

Young, C., Hanson, C., Craig, J. C., Clapham, K., & Williamson, A. (2017). Psychosocial factors associated with the mental health of Indigenous children living in high income countries: a systematic review. *International Journal for Equity in Health*, 16, 153. https://doi.org/10.1186/s12939-017-0652-5

23. A Northern and Indigenous Ethical Imperative for Working with Communities

JULIE BULL

Indigenous Peoples around the world are mobilizing to (re)assert their inherent right to self-determination, a movement that is being both shaped and reshaped by globally significant developments, such as the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) and the Truth and Reconciliation Commission (TRC) in Canada. Innovations in ethics policies, led by Indigenous peoples, have enhanced guidance and practices in the ethical conduct of research involving Indigenous Peoples. Now, scholars around the world are looking to the Canadian example to learn how they too can begin creating policy in this area. As Northern and Arctic research grows, learning ethical imperatives of these regions and the Indigenous Peoples who live on these lands is essential. Unfortunately, and despite increased documentation about what to do in research involving Indigenous Peoples, there is little description of how to do it – there is a major policy-to-practice gap which this chapter begins to address.

Key Terms: Research Ethics, Human Protection, Governance

Introduction

In *Decolonizing Methodologies*, Maori scholar, Linda Tuhiwai Smith (1999) begins by saying, "the word itself, 'research', is probably one of the dirtiest words in the Indigenous world's vocabulary" (p. 1). To understand this sentiment in relation to colonialism requires examining shared histories of unequal power relations (between colonizers and the peoples of the lands they invaded) and ongoing colonial constructs and systems, such as how research often privileges researcher interests, needs, and benefits over those of communities. In Canada, a commitment to decolonize research is a commitment to support a process defined and led by Indigenous peoples to identify research priorities and co-create research products that are mutually beneficial. Now, scholars around the world are looking to the Canadian example to learn how they too can begin creating policy in this area.

It is argued that colonial academic culture, which privileges the knowledge acquisition and production of non-Indigenous peoples, results in research (about Indigenous peoples' by non-Indigenous peoples) that is of an exotic (and essentializing) nature (Kovach, 2009). This research often has little or no measured impact on health or social well-being, despite the claims made in funding applications regarding how positive and beneficial the research will be (Brant-Castellano, 2004). As northern and Arctic research grows, learning ethical imperatives of these regions and the Indigenous peoples who live on these lands is essential if the research is to have a positive impact. Unfortunately, and despite increased documentation about *what* to do in research involving Indigenous peoples, there is little description of *how* to do it – there is a major policy-to-practice gap which this chapter begins to address. Specifically, this chapter briefly describes the necessity of and responsibility to ethical research with Northern and Indigenous Peoples by considering self-determination, collective consent, and relational research practices that are essential components for researchers. A short synopsis of the impetus for these research practices lays the foundation for the discussion of Indigenous self-governance in research.

Learning from the Past to Change the Future

A pivotal moment in the early 2000s revealed that, nearly two decades after blood samples were taken from members of the Nuu-chah-nulth tribe in British Columbia—who, in the 1980's, consented to DNA research only related to genetic causes of rheumatoid arthritis, the 'residual' samples were being used for research beyond the original intention and was stored in another country. This was never disclosed to the community, and the community did *not* consent to the research or the travelling of their DNA (Atkins, Reuffe, Roddy, Platts, Robinson, & Ward, 1988; Dalton, 2002). Increased dialogue and policy development on Indigenous research ethics emerged alongside this significant and publically reported/known ethical breach.

To safeguard against and learn from situations like those experienced by the Nuu-chah-nulth, many communities formed their own research ethics mechanism1, as part of practicing self-determination in research in their communities (Nuu-Chah-Nulth Tribal Council Research Ethics Committee, 2008). The Nuu-chah-nulth event was significant in that it became a catalyst for reshaping the landscape of Indigenous research ethics. Increasing attention is now focused on Indigenous research ethics and implications of health research on collectives. Today, Indigenous research ethics policies in Canada are explicit about protecting communities and their data, providing self-determination in research, and creating more relevant and rigorous research.

Exercising Self-Determination In and Through Research

Indigenous peoples' right to self-determination in Canada and elsewhere around the world (Sium & Ritskes, 2013; UNDRIP, 2007) provides the grounds for Indigenous communities to develop their own research/ethics review processes and procedures. Two of the longest standing Indigenous community-based review systems in Canada can be found in Kahnawake (Code of Ethics, 1996) and Manitoulin Island (Guidelines for Ethical Aboriginal Research, 2001). As well, in 1998, the Steering Committee of the First Nations Regional Longitudinal Health Survey articulated OCAP®: the principles of *Ownership, Control, Access, and Possession* as an expression of self-determination in research. This was explicitly "a political response to tenacious colonial approaches to research and information management" (Schnarch, pp. 80-81). Today, many Indigenous and northern communities assert their self-determination in research as they continue to challenge projects that are based on racist, discriminatory, exploitive, and harmful research practices.

Honouring Self-Determination in Research Practice: It's all About Relationships

How to support self-determination and establish research governance for health research with Indigenous peoples is a topic long-debated by academics and community members alike; the conclusion is always the same: relationship building is a critical first step (Brant-Castellano, 2004; Kaufert, Commanda, Elias, Grey, Young, & Masazumi, 1999; Kovach, 2009; Martin, 2012; Moore, Castleden, Tirone, & Martin, 2017). Researchers are ethically and culturally obligated to build relationships on a foundation of respect, relevance, reciprocity, and responsibility in an authentic way (Bull, 2010; Kirkness & Barnhart, 1991). This usually begins with a conversation with recognized/recommended/respected 'community authorities'. Community authorities may be Elders, traditional teachers and healers, municipal or tribal leaders, local or regional Indigenous leaders, Chiefs and councils, or someone else designated to speak for the community. There may be multiple authorities present who are charged with different roles and responsibilities.

Working with Indigenous communities' self-determination (and collective consent) is similar to doing research with schools. School-based researchers are required to get approval from the school board, principal, teacher of the class, parents of children participating, and the children themselves to ensure that the whole community is involved and

benefitting. Researchers cannot obtain the students' (or the principal's or the parents') permission *alone* to do the research. While relatively straightforward in certain communities, like schools, this process of ethical community-engaged research does not always align with the realities of authority structures within Indigenous and Northern communities. For example, where there are no active Elders or governing council, or, alternatively, the 'obvious' authorities to approach are precisely those who, because of the power of their role, may block research others deem beneficial.

There is general agreement that in research where an entire community may be negatively implicated even if only few people from the community participate, individual consent is necessary but not sufficient (Burgess & Brunger, 2000; Kaufert et al., 2004; Weijer et al., 1999). Likewise, there is general agreement that individual informed consent is not sufficient for ethical health research involving Indigenous peoples (Brunger & Weijer, 2007; Bull, 2016; Moore, 2015). Given the intimacy of health information, and the small size of some communities, health research in particular can present genuine risks for socially identifiable populations (Weijer et al., 1999). By controlling their own research agenda, Indigenous peoples are able to use their spiritual and philosophical foundations (i.e., ontologies and epistemologies) to guide the work as a way of mitigating challenges embedded within Western sciences (Smith, 1999).

Conclusion

While respect, responsibility, relevance, and reciprocity are all valued characteristics in most social, health, and human research, these qualities are imperative in research with Indigenous and northern peoples as a means to respect and practice self-determination in research. The level and extent to which Indigenous and northern people and communities participate is decided by the community themselves serves to further this self-determination. Researchers do not get to decide when adequate engagement is achieved and must take direction from community partners throughout the duration of a project which is a requirement of the collective consent process. Relationships between researchers and Indigenous peoples facilitate the development of methodologies, conceptual frameworks, and recruitment strategies that are meaningful to communities while maintaining/improving academic rigour, demonstrating the importance of relational approaches to research with Indigenous and northern peoples.

Notes

1. These may be called a number of names and reflect many different levels of formality from full institutional review processes, to Band Council Resolutions, to Grandmothers Review. The key piece is that the community directs the researcher to what is required *beyond* what the researcher is required to do for the academy.

Additional Resources

Association of Canadian Universities for Northern Studies: Ethical Principles for the Conduct of Research in the North. http://acuns.ca/en/ethical-principles/

Canadian Institute for Health Research: Guidelines for Health Research Involving Aboriginal Peoples: http://www.cihr-irsc.gc.ca/e/29134.html

Toolbox of Principles for Research in Indigenous Contexts: Ethics, Respect, Equity, Reciprocity, Cooperation and Culture. https://centredoc.cssspnql.com/cgi-bin/koha/opac-search.pl?idx=kw&q=toolbox&limit=au%253ACommission%2520de%2520la%2520sant%25C3%25A9%2520et%2520des%2520services%2520sociaux%2520des%2520Premi%25C3%25A8res%2520Nations%2520du%2520Qu%25C3%25A9bec%2520et%2520du%2520Labrador&sort_by=relevance_dsc&limit=itype:LIVR

Tri-Council Policy Statement for Research Involving Humans: Research Involving First Nations, Inuit, Métis. http://www.pre.ethics.gc.ca/eng/policy-politique/initiatives/tcps2-eptc2/chapter9-chapitre9/

References

Atkins, C. J., Reuffe, L., Roddy, J. E., Platts, M. J., Robinson, H.S., & Ward, R. (1988). Rheumatic disease in the Nuu-Chah-Nulth native Indians of the Pacific Northwest. *Journal of Rheumatology*, 15, 684-690.

Brant-Castellano, M. (2004). Ethics of Aboriginal Research. *Journal of Aboriginal Health*, 1(1), 98-114.

Brunger, F., & Weijer, C. (2007). Politics, risk, and community in the Maya-ICBG Case. In J. V. Lavery, E. Grady, & E. J. Emanuel (Eds.), *Ethical Issues in International Biomedical Research: A Case Book* (pp. 35-42). New York, NY: Oxford University Press.

Burgess, M. M. & Brunger, F. (2000). Collective effects of medical research. In M. McDonald (Ed.), *The Governance of Health Research Involving Human Subjects* (pp. 117-152). Ottawa, ON: Law Commission of Canada.

Bull, J. (2016). A Two-eyed Seeing approach to research ethics review: An Indigenous perspective. In W.C. Van den Hoonaard & A. Hamilton (Eds.), *The Ethics Rupture: Exploring Alternatives to Formal Research Ethics Review* (pp. 167-186). Toronto: University of Toronto.

Bull, J. R. (2010). Research with Aboriginal Peoples: Authentic relationships as a precursor to ethical research. *The Journal of Empirical Research on Human Research Ethics*, 5(4), 13-22.

Dalton, R. (2002). Tribe blasts 'exploitation' of blood samples. *Nature*, 420, 111.

Kaufert, J. M., Glass, K. C., Freeman, W. L., & LaBine, L. (2004). *Background paper on issues of group, community or First Nation consent in health research*. Working Paper commissioned by the Aboriginal Ethics Policy Development Project and Canadian Institutes of Health Research-Ethics Office and Institute for Aboriginal Peoples Health. (110:126).

Kaufert, J. M., Commanda, B., Eilias, R., Grey, T., Young, K., & Masazumi, B. (1999). Evolving participation of Aboriginal communities in health research ethics review: The impact of the Inuvik workshop. *International Journal of Circumpolar Health* 58, 134-144.

Kovach, M. (2009). *Indigenous methodologies: Characteristics, conversations and contexts.* Toronto, ON: University of Toronto.

Kahnawáke Schools Diabetes Prevention Project. (1996). *KSDPP Code of Research Ethics.* Retrieved from http://www.ksdpp.org/code.html.

Kirkness, V. J., & Barnhardt, R. (1991). First Nations and higher education: The four Rs respect, relevance, reciprocity, responsibility. *Journal of American Indian Education*, 30(3), 1-15.

Martin, D. H. (2012). Two-Eyed Seeing: A framework for understanding Indigenous and non- Indigenous approaches to Indigenous health research. *Canadian Journal of Nursing Research*, 44(2), 20-42.

Moore, C. (2015). *Implementing Chapter 9 of the Tri-Council Policy Statement on the ethics of research involving Aboriginal Peoples in Canada: How's that going?* (Unpublished doctoral dissertation). Halifax, NS: Dalhousie University.

Moore, C., Castleden, H. E., Tirone, S., & Martin, D. (2017). Implementing the Tri-Council Policy on Ethical Research

Involving Indigenous Peoples in Canada: So, how's that Going in Mi'kma'ki?. *International Indigenous Policy Journal*, 8(2), 1-19. doi: 10.18584/iipj.2017.8.2.4

Nuu-Chah-Nulth Tribal Council Research Ethics Committee. (2008). *Protocols and principles for conducting research in a Nuu-Chah-Nulth context.* Vancouver: Nuu-Chah-Nulth Tribal Council Research Ethics Committee. Retrieved from http://www.cahr.uvic.ca/nearbc/documents/2009/NTC-Protocols-and-Principles.pdf

Schnarch, B. (2004). Ownership, control, access, and possession (OCAP) or self-determination applied to research, a critical analysis of contemporary First Nations research and some options for First Nations communities. *Journal of Aboriginal Health*, 14(16), 80-95.

Sium, A., & Ritskes, E. (2013). Speaking truth to power: Indigenous storytelling as an act of living resistance. *Decolonization: Indigeneity, Education & Society*, 2(1), I-X.

Smith, L. T. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples*. New York: Zed Books.

Weijer, C., Goldsand, G., & Emanuel, E. J. (1999). Protecting communities in research: Current guidelines and limits of extrapolation. *Nature Genetics*, 23, 275-280. DOI:10.1038/15455

United Nations. (2007). *Declaration on the rights of Indigenous Peoples (UNDRIP)*. Retrieved from www.un.org/esa/socdev/unpfii/documents/DRIPS_en.pdf.

24. Establishing Trustful Relationships between Marginalized Indigenous People and Researchers/ Health Workers

SNEFRID MØLLERSEN AND TONJE HAANÆS-RENSBERG

The Sami reindeer-herders' marginalization in the Norwegian society implies a lack of knowledge about their health-related life conditions. In conjunction with the first Nordic health study that used a participatory research model and ethical guidelines for research among Indigenous people, this study conducted an evaluation of the research process with participating reindeer-herders. In response, the reindeer-herders accentuated the importance of research objectives, which correspond to self-defined challenges; the inclusion of reindeer-herding knowledge; and the importance of a trusting relationship with the researchers. To reverse marginalization within health services, there is a need for a greater focus on ethical issues and integration of cultural knowledge.

Key Terms: Indigenous, Sámi reindeer herders, participatory research

Introduction

Most evidence-based knowledge production about health and health care automatically use theories and practices developed within the Western culture. This knowledge has often been demonstrated to be unsuitable to improve health outcomes among Indigenous populations, and confirmed marginalization, and increased Indigenous distrust in research (Cameron, Andersson, McDowell & Ledogaret, 2010).

In the 1940s, social psychologist Kurt Lewin developed action research to increase the usefulness of research to minority groups. Later on, the ecologic perspective was included and the model was renamed to 'Community Based Participatory Research' (CBPR).1 The CBPR approach implies that the researchers and the target group engage in projects of mutual benefit, focus themes of importance to the target group, build genuine partnerships, share knowledge, and cooperate through all phases of the research process (Israel, Schulz, Parker, & Becker, 1998). The request for cultural responsive approaches to Indigenous health issues presupposes identification of ethical dilemmas and respect for ways of knowing and doing in the participating Indigenous population. Several countries2 have prepared ethical guidelines in health research among Indigenous people, and participatory research is highlighted as a working model that ensure Indigenous influence and control.

Evaluation study

The Norwegian Reindeer-Herder Association and Sami Norwegian National Advisory Unit on Mental Health and Abuse performed a study addressing psychosocial life and working conditions in reindeer herding. The study used "Guidelines

for health research involving Aboriginal people" (CIHR, 2006), along with the CBPR. The purpose of the CIHR guidelines is to ensure culturally competent research that is beneficial to the Indigenous community through developing research partnerships that facilitate and encourage community participation within a framework of shared power and decision-making. Considering the future need for advisory tools for culturally responsive projects among Sami people, we conducted a qualitative evaluation of the Sámi reindeer herders' experiences and assessments with the participating research.3

First, themes about research of relevance to the reindeer herders were identified by a focus group. Then, individual semi-structured interviews with six reindeer herders that had participated closely in the research process were carried out. Observations of the discussion groups between reindeer herders and researchers served as additional contextual information.3

Three main themes were present throughout the interviews: research issues that corresponded to challenges of importance to the reindeer herders, inclusion of reindeer herders' knowledge, and development and maintenance of confidence in the project and the researchers. Additionally, access to unlimited information about the project, and expectations for the usefulness of results were accentuated as important.

Partnership characteristics that facilitate culturally responsive encounters

The reindeer herders had entered the project with diverse expectations. However, the partnership research model had evoked expectations of documentation about issues that were meaningful to their existence. The reindeer herders told that the partnership model put them into an active role, and that it welcomed input and contributions from the Sámi reindeer herder perspective. They found that the researchers listened to them, and their knowledge and competence were recognized and taken seriously. Furthermore, questions for transparency were met with understandable information and explanations.

Trust is a psychological state comprising the intention to accept vulnerability, based on the positive expectations of the intentions or behaviors of the other. Trust is guided by the willingness to be vulnerable, based on an evaluation of the competence and care of the other to protect you against risk (Hamm, 2014). Distrust might be a realistic and protective response to the tangible harm Indigenous peoples have endured in previous research relations. Historical oppression, power imbalance, and a lack of benevolence and reciprocity are emergent themes related to the Indigenous communities' development of distrust in the majority society and its representatives. Transparency and continuous communication foster reciprocal interactions, which in turn increase trust and commitment to partnership projects (Burnette & Sanders, 2014). The community has inherent rights to control and determine collection and use of Indigenous property, the data delivered to the researchers (CIHR, 2006, Art. 12). The reindeer herders linked the researchers' ability to understand and act in a respectful manner to the openness about the research process and the experience that reindeer herding knowledge mattered to research decisions. It was, however, stated that decisions were consensus-based. Though research objectives were perceived as corresponding to self-defined challenges, suppositions that research findings would be relevant, and the expectation that the practical significance of the results were guarded.

Conclusion and Challenges

The Sami reindeer herders' assessments of research with ethical guidelines for health research among Indigenous people combined with CBPR were positive. From their point of view, this research model fostered trust and changed their historically acquired reluctance to research. To the Sami reindeer herders, the most important elements of the working model were genuine impact upon the research process, along with access to meaningful research information and thereby developing meaningful research objectives and methods that corresponded to reindeer herders' way of

life. The findings indicate that the reindeer herders' positive evaluation of the research process and expectations to the findings were rooted in experience of trust. Trust was primarily associated with the combination of impact on and supervision of the use of reindeer herding knowledge throughout the research process.

Health promotion, at the individual and structural level, requires that health workers and health researchers bridge the gaps between Western authorized knowledge and the Indigenous body of knowledge. This includes recognition of the historically acquired power imbalance which impacts how relationships are built, which voices are listened to, and which assessments are valued. Indigenous empowerment and social participation are inextricably linked to changes in inequity in the health conditions of Indigenous populations (WHO, 2008). Therefore, working models have to address issues of power to move the clinical encounter towards dialogue and accountability that may foster cultural responsive and safe interventions (Kirmayer, 2012).

Ethical guidelines and CBPR operate as navigating tools for health workers, and aim to prevent disrespect, misleading, indifferent, or humiliating results. The ethical principles and communication procedures improve the knowledge base and provide a context for discussion of challenges and emerging possibilities. To exchange 'traditional 'objectification of Indigenous people into active engagement, both researchers and clinicians in cross-cultural relationships need to pay close attention to ethical dilemmas. The health system and its providers need to distinguish between recommendations founded in the majority culture and measures that will gain the health of minorities. Recognition of power imbalance means the willingness to abstain from decision making on behalf of the other.

Notes

1. Also named participatory action research, community based participatory research, community driven participatory research, community-involved research, and community-centered research.
2. Yet, there are no ethic guidelines for research among Nordic Indigenous people.
3. The evaluation study was a graduation assignment at medical school, University of Tromsø, Norway.

Additional Resources

Bull, J. R. (2010). Research with Aboriginal Peoples: Authentic Relationships as a Precursor to Ethical Research (2010). *Journal of Empirical Research on Human Research Ethics*, 13–22. doi: 10.1525/jer.2010.5.4.13.

United Nations. (2009). *State of the World's Indigenous Peoples.* Department of Economic and Social Affairs, ST/ESA/328. Sales No. 09.VI.13, New York, ISBN 92-1-130283-7.

O'Fallon, L. R., Tyson, F. L. & Dearry, A. (Eds.). (2000). *Successful Models of Community-Based Participatory Research. Final Report.* NIEHS, National Institute of Environmental Health Sciences, Meeting hosted by the NIEHS March 29-31, Washington, DC.

References

Burnette, C. E., & Sanders, S. (2014). Trust Development in Research with Indigenous Communities in the United States. *The Qualitative Report*, 19(44), 1-19.

Cameron, M., Andersson, N., McDowell, I., & Ledogar, R. J. (2010). Culturally Safe Epidemiology: Oxymoron or Scientific Imperative. *Pimatisiwin*, 8(2), 89-116.

Canadian Institutes of Health Research Ethics office. (2006). *CIHR Guidelines for health research involving aboriginal people* (2007 – 2010). Ottawa, ON: Canadian Institutes of Health Research. Retrieved from https://www.nri.nu.ca/sites/default/files/public/files/CIHR%20Ethics_Guidelines_Apri.pdf.

Hamm, J. (2014). *Understanding the Role of Trust in Cooperation with Natural Resources Institutions* (Doctoral dissertation). The Graduate College at the University of Nebraska, Nebraska, US.

Israel, B., Schulz, A., Parker, E., & Becker, A. (1998). Review of community-based research: Assessing partnership approaches to improve public health. *Annual Review of Public Health*, 19, 173-202. doi:10.1146/annurev.publhealth.19.1.173.

Kirmayer, L. (2012). Rethinking cultural competence. *Transcultural Psychiatry*, 49(2), 149–64. doi: 10.1177/1363461512444673.

World Health Organization (WHO). (2008). *Closing the gap in a generation. Health equity through action on the social determinants of health.* WHO Library Cataloguing-in- Publication Data. http://www.who.int/social_determinants/final_report/csdh_finalreport_2008.pdf.

25. Theme III Reflection Questions

1. Define and describe culturally safe care. Does the context of culturally safe care differ by health professions? In what ways can health professionals in that field further promote culturally safe care in their workplace? In what ways can postsecondary education promote culturally safe care?

    2. Identify an Indigenous healing practice that is used by Indigenous communities in your country, describe in detail how that practice works, and the way(s) it contributes to healing.

    3. Identify and describe one government policy and one historical event that has had an impact on health in northern and Indigenous communities.

    4. If you were to challenge yourself to learn more about Indigenous healing practices, what is one topic you would like to learn more about? Articulate the steps you would concretely take to learn more about that topic. Finally, explain knowing more about that topic can help you to improve as a health professional.

    5. What are the factors that help health professionals build a trusting relationship with patients in northern and Indigenous communities?

THEME IV – INNOVATIONS IN NORTHERN HEALTH CARE

Learning Objectives

1. Understand the benefits and challenges of telehealth services.
2. Discuss the barriers to adopting new and innovative methodologies to health care practices and systems.
3. Describe ethical and regulatory considerations when adopting telehealth and other technology-enhanced care methods.

26. Introduction

HEATHER EXNER-PIROT

Heather Exner-Pirot

One of the defining features of living in the Circumpolar North is remoteness: distance and separation from people, infrastructure and services. Historically, this has meant that northern communities needed to be self-sufficient in their provision of health care and other services. Communities were not remote so much as they were independent. However, through processes of modernization and globalization, and the introduction of the welfare state, communities and people have become much more interdependent. Modern health care, in particular, with its complexity and division of labour, has been built around a system of increasingly sophisticated practitioners and infrastructure. It is common in many parts of the North to have nurse-led stations or clinics in villages, small physician-led regional hospitals in towns, and large tertiary care centres, in urban centres. Acute or complex illnesses and injuries usually require diagnosis and treatment to be conducted in larger centres.

This model of care has implications for those living in rural and Indigenous communities in the North. Access to specialized health care services are limited by distance, time, and resources. A trip to an emergency room to deal with a trauma, a consultation with a specialist, or dialysis for chronic kidney disease become much more difficult to arrange. Poor weather can delay treatment or leave patients stranded in far off centres, away from their homes and families. Even minor things, such as getting a blood test, can take longer and be more expensive.

These are just the physical barriers. The cultural barriers for many northern and Indigenous residents to seek and access care in Western medical systems are well documented and can include: language difficulties; disregard for spiritual needs and practices; ineffectual treatment plans; and overt racism or prejudice.

While connectivity has created some challenges, it has also opened up many opportunities. Northern practitioners are able to communicate with other health care professionals much more easily. Patient records can be better managed. Overall, northern residents have better access to specialized care and expertise than ever before, even if gaps remain.

One avenue that is particularly promising in improving the access and quality of northern health care is the use of information communication technologies – i.e. the internet – in new and innovative ways. The information age promises to mitigate or erase the effects of time and distance, in affordable ways. Such technologies – telehealth, robotics, artificial intelligence, and informatics – are being applied to the health sector in new and exciting ways. They offer many opportunities for northern residents to access their health care services from their own community, saving time and money and increasing comfort. Yet, like many innovations, they seem to be occurring first and most rapidly in heavily populated and developed urban areas. Effort and attention needs to be applied to extending the application of new health technologies to northern, remote areas, where they are arguably needed the most. This chapter outlines a number of examples of what can be accomplished in northern health care with the use of technology, as well as the barriers to their implementation.

First, speaking from his experience as a practitioner in Labrador, Canada, Michael Jong provides telehealth guidelines in his chapter on *How to Use Telehealth to Enhance Care in Isolated Northern Practices.* They have been able to use telehealth for a wide variety of services, from point of care ultrasound to leading resuscitation to mental health assessments. Practical issues such as room set-up and training requirements are addressed.

Heather Exner-Pirot's chapter, on *Challenges to Telehealth Implementation,* outlines the potential of telehealth solutions to improving accessibility and quality of northern health care. However, a number of barriers to integrating telehealth into health care systems are identified; some of which are common across geographies, such as changing large systems' culture and behaviour, resolving payment issues, and securing patient privacy; and some of which are specific to the North, including connectivity/internet issues, the capacity limitations of small northern clinics, and the layers of jurisdiction that can impact efficient adoption and use.

Päivi Juuso, in her chapter on *eHealth as a Support for Older Adults at Home,* examines the use of eHealth solutions to the growing demographic reality of caring for older adults. In particular, she describes the ethical implications of

applying such technologies, including digital literacy and access, privacy concerns, and the need to involve older adults in their care plan.

In addition, two shorter commentaries are provided on specific cases of technology-enhanced health care. Marie-Claude Lyonnais and Christopher Fletcher describe the use of social media, particularly Facebook, in community health in Nunavik, Canada; and Yury Sumarokov summarizes the use of telemedicine in the Russian Arctic.

Health care is once again on the brink of transformation due to the possibilities that information communication technologies are opening up. It is critical that northern practitioners and administrators, and community members themselves, seek out and take advantage of the opportunities such innovations can provide in improving access to high quality health care delivery in the North.

27. How to use Telehealth to Enhance Care in Isolated Northern Practices

MICHAEL JONG

Aim: To learn how to use telehealth to enhance access to care in northern practices

Methods: A description of how telehealth can be implemented and what it can used for.

Results: Telehealth allows for care where the capacity to provide the service is not available locally. It benefits clients through allowing for treatment closer to home and local health providers through expedient advice from consultants at a distant site. Telehealth has the potential to save lives and reduce costs to the healthcare system. Training on the use of telehealth and proper equipment setup is necessary to make telehealth effective.

Conclusions: Telehealth is a useful system that support both patients and health staff in isolated northern practices

Key Terms: Telehealth, Northern practices

Introduction

There are many health care challenges for Canadians, but few are any greater than the challenge of providing care for those who live in northern, remote, and sparsely populated regions of this country. Despite much higher health care expenditures per capita in the three northern Territories compared to the Canadian average, the population health outcomes in the North continue to lag far behind that of the South (Young & Chatwood, 2011). Health expenditures are increasing across the country, but the increases are most pronounced in the territories (Canadian Institute for Health Information, 2015). The challenges of provision of health care is compounded by a shortage and high turnover of health professionals in the North (Cameron, 2011). One of the potential solutions for the high expenditures is to improve efficiency in access to care through telehealth (Mendez, Jong, Keays-White & Turner, 2013). Telehealth can support the work of northern nurses and other health care providers, reduce the stress of working in remote locations, and potentially improve recruitment and retention of health professionals, including but not limited to nurses (Jong, 2013). This chapter describes the services currently provided via telehealth in central Labrador and Labrador North Coast (see Figure 1), the impact of having the services delivered by telehealth, and the recommendations on how to implement telehealth in northern communities.
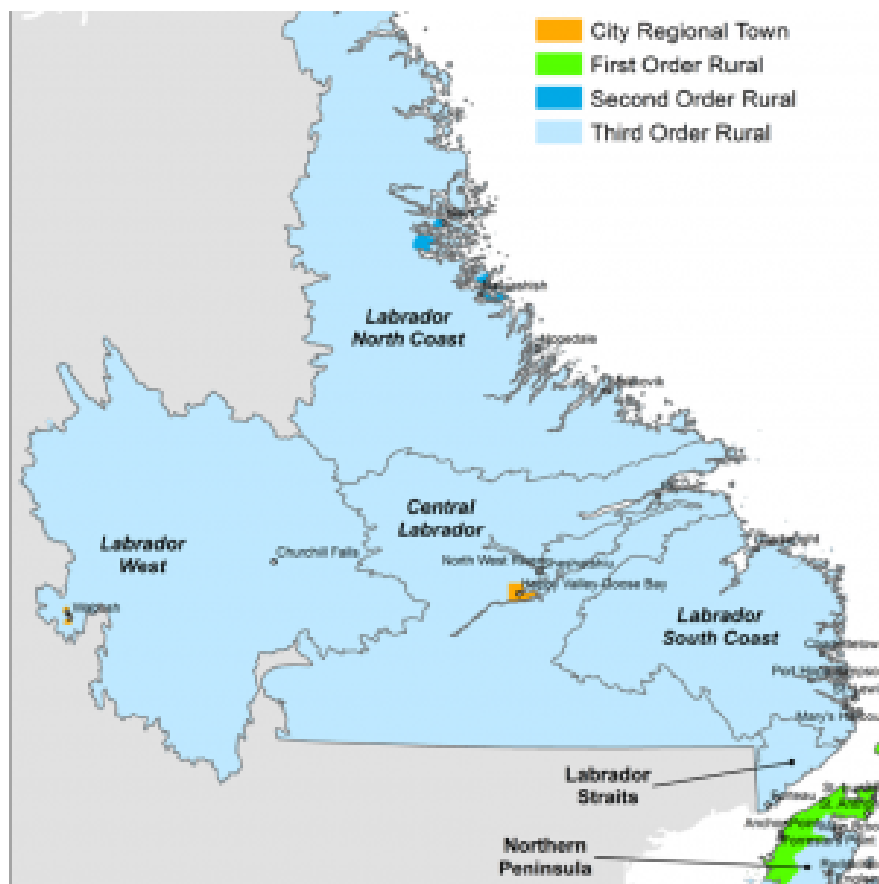
Figure 1 – Map of Labrador. The population in the largest community (Happy Valley-Goose Bay) in this region is 6,400. It is the administrative center and referral health center for Labrador. The smallest community has 150 residents and the total catchment population of the health center is 11,500. Telehealth is operational all the time as part of an essential health service in all our communities.

What Can Be Provided Via Telehealth

Our experience in Labrador shows there is a high acceptance of care via telehealth for both clients and nurses. When a physician consult is required for chronic disease management, telehealth can provide more timely care that is not impeded via the vagaries of travel by visiting providers to the remote communities. Other services provided in northern Labrador via telehealth are:

- Preoperative assessments and postoperative care, so that clients travel to the hospital only once for surgery.
- Simple fractures and dislocation care remotely.
- Assistance with procedures and surgeries via more experienced colleagues.
- Daily remote hemodialysis rounds.
- Teleoncology
- Point of care ultrasound with the aid of a local person and led remotely via video by an experienced health provider.
- Diagnoses and management of fractures and dislocations, intraocular eye injuries, heart failure, pericardial

effusion, pneumothorax, pneumonia, pulmonary edema/ARDS, pleural effusion, intraperitoneal fluid/bleed, cholelithiasis, cholecystitis, pancreatitis, renal stones, urinary retention, intra uterine and ectopic pregnancies.
- Mental health assessment and psychotherapy.
- Leading resuscitation remotely via video.

What Are the Potential Impacts?

Telehealth enables access to care closer to home. A 14-month study on robotic telepresence in a remote community in Labrador by Jong (2013) showed that the requirement for transportation of clients out to a referral center was reduced by 40%, which more than offset the cost of the telehealth system. All the nurses and physicians reported that they were satisfied with the system. Telehealth eased stress, especially with urgent/emergent cases. It improved job satisfaction and shared care. During 50% of consultations via telehealth, nurses reported learning something new. Clients expressed a high degree of comfort with consultations via telehealth. They and were more accepting of referrals for medical consultation via telehealth knowing that they do not have to leave the community for the service.

Over the past ten years, resuscitations in northern Labrador are routinely lead by Emergency Room (ER) physicians through telehealth. An average of two successful resuscitations per year are made possible through stat (immediate) videoresuscitation (Jong, 2010). Physicians are able to stabilize clients until the medevac team can fly into the communities. Critically ill clients are successfully managed via telehealth in remote communities for several days when inclement weather prevents air travel. Through telehealth, management of a client in the emergency room in a remote community is similar to that of a client in one of the trauma bays in the ER. In short, telehealth has a great potential to provide better access to care especially for remote communities in circumpolar regions where distances to referral centers are great and cost high.

How to Make It Happen

Telehealth equipment must be easily accessible if it is going to be used. Impediments to use include the amount of time needed to set up the telehealth consult. For videoresuscitation, urgent and immediate accessibility is crucial. In the facilities in Labrador, videoconference units are permanently stationed at a room at the center of the emergency department at the referral center. Stat calls from remote nursing stations are triaged the same way as any other clients who show up in the emergency room. Mobile videoconference units are positioned in the emergency rooms of all nursing stations. The units in the remote sites are on a mobile base with rollers so they can be moved around for use elsewhere. This maximizes the use of the units for other non-urgent consultations.

IT Infrastructure

The minimum bandwidth requirement for video transmission is 256 kbps. Video transmission can also be run through 3-G or faster cellular networks. A secure intranet can be used for telehealth. The other way to ensure security is by using the encryption provided with the telehealth software. Encryption will allow for private access via public Wi-Fi and cellular networks anywhere in the world.

A split screen on the videoconference units allows for visualization of the image at both sites. Ideally, the split screen can be altered so that the bigger image is of the distant site and the smaller image is of the local site (see Figure 1). At

the site with the client, a full screen of the distant command center is ideally the image on the screen so all participants can easily see the consultant.

The videoconference unit needs a video camera that can be controlled at a remote site. The camera needs the ability to zoom and to rotate 180 degrees sideways and 45 degrees up and 45 degrees down. The ability for presets is ideal and preferably it is controlled by the remote site. The best presets are usually the full view of the room, the cardiac monitor, and close-up of the client's upper torso. Autofocus in the camera is another useful feature.

The videoconference units need a good audio conference system. It is useful for the consultant situated in a noisy department, such as the emergency room, to have a remote headset to reduce distractions caused by the background noise. The background noise can be also reduced if the door to the room is closed. In Labrador, it has been our experience that inquisitive staff in an emergency department may pop in and start chatting before realizing the distraction to the team at the remote site.

Room Setup for Video Resuscitation

The best view of the resuscitation effort is from an oblique view at the end of the bed. The video camera sits on top of the video units ideally at about 7-8 feet high so the camera can see the person managing the airway at the end of the bed and the person doing chest compressions from the opposite side of the bed where the videoconference unit is located. The height of the camera allows for the leader at the distant command center to see from an above angle. It reduces the reflection from overhead lights in the room. The video screen needs to be high enough for the resuscitation team members to see the team leader.

Moreover, the videoconference unit in the remote resuscitation site needs to be far away enough from the team so that everyone involved can see the team leader. The unit is usually at one corner of the room. The bed and monitors are at the diagonally opposite corner of the room. The monitors are ideally located at head height at the end of the bed so they will be less likely to be obstructed by the remote team members.
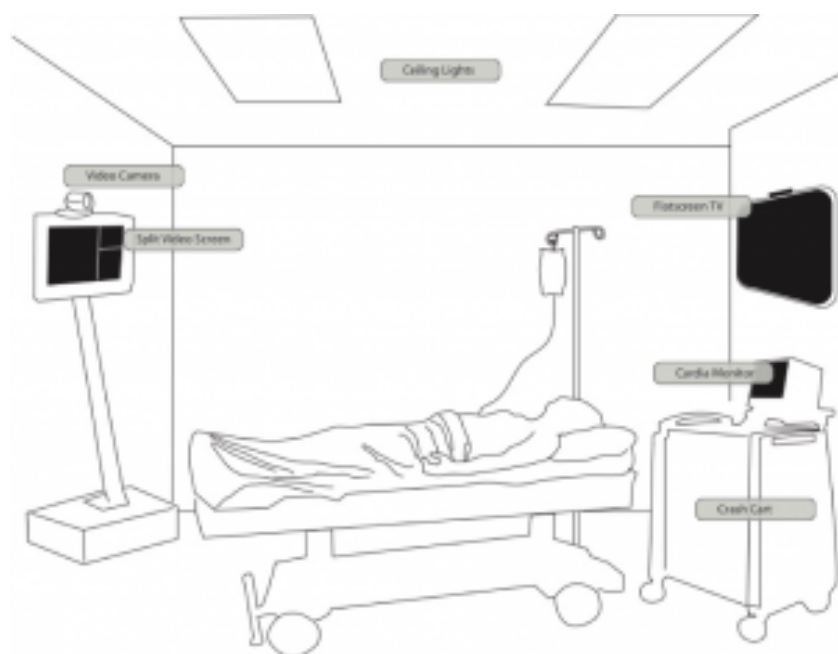

Figure 2 – Telehealth Videoresuscitation Room setup. This figure shows the video unit (video camera on top of video

screen) at one corner of the room, the bed and monitors at the diagonally opposite corner of the room, and the monitors located at head height at the end of the bed (Jong, 2010, p. 522).

Training

Training in the running of a code using simulation and video is strongly recommended. Besides allowing the team to practice resuscitation, it helps to organize the layout of the room and the setup of the videoconference unit. It is very important for the team leader at the distant site to learn to control the remote camera, which is in essence the remote eye. With practice, it is possible to unconsciously and competently control the remote camera to move seamlessly from the views of room, client, and monitors. The remote team leader has most of the necessary information without asking the remote team members who are already fully occupied with the resuscitation effort. The remote lead is able to see the vitals on the cardiac monitor, check the drip rate on the IV pump, provide feedback on the quality of CPR, summarize for the team, provide clear directions, and receive constructive feedback.

The quickest way to focus upon and capture an item of interest in the remote site is to first zoom out completely, place the item, e.g., cardiac monitor, in the middle of the screen, and then zoom in until the item occupies the full screen.

The consultant or lead at the referral center needs to be cognizant of the view seen by the remote team. If the intention is to offer eye contact, there is a need to look at the camera which is usually at the top of the computer screen. For most video consults, it is best to place the client's face on the top of the screen so that the client perceives that eye contact is made when looking at the face. It is also better to have the face and chest view of the health provider for most consults. Consultants or leads should avoid showing the table and notes that they are taking simultaneously, so the scribbling of the notes does not distract the client. To maintain a respectful interaction, it is best for the remote health provider not to look down but to have the camera at eye level.

It is often easier to show a health provider at a distant site what to use and how to use it on the video than to describe it. For example, it is easier to show in the video screen the setup for an improvised flutter valve for needle chest decompression using a large bore IV cannula and a finger of a glove than to describe it.

Conclusion

Telehealth is a valuable tool especially in remote practice where there are limited human and technical supports. It provides clients' access to care closer to home and supports for northern nurses and others in difficult emergent situations. For telehealth to be successful, proper setup and training are required.

Additional Resources

Bradford NK, Caffery LJ, Smith AC. Telehealth services in rural and remote Australia: a systematic review of models of care and factors influencing success and sustainability. Rural Remote Health [Internet]. 2016 Oct-Dec;16(4):4268. Epub 2016 Nov 6. PubMed PMID: 27817199.

Nunavut telehealth project impact evaluation report. Montreal (QC): Infotelmed Communications Inc; 2003 Sep 26

References

Cameron, E. (2011). *State of the Knowledge: Inuit Public Health, 2011*. Prince George, BC: National Collaborating Centre for Aboriginal Health.

Canadian Institute for Health Information. (2015). *National Health Expenditure Trends, 1975 to 2015*. Retrieved from http://www.cihi.ca/sites/default/files/document/nhex_trends_narrative_report_2015_en.pdf.

Jong, M. (2010). Resuscitation by video in northern communities. *International Journal of Circumpolar Health, 69*(5), 519-527. doi:10.3402/ijch.v69i5.17686

Jong, M. (2013). Impact of robotic telemedicine in a remote community in Canada. In L. Van Gemert-Pijnen and H. C. Ossebaard (Eds.), *Proceedings of the Fifth International Conference on eHealth, Telemedicine, and Social Medicine* (pp. 168-171). Nice, France: International Academy, Research, and Industry Association.

Mendez, I., Jong, M., Keays-White, D., & Turner, G. (2013). The use of remote presence for health care delivery in a northern Inuit community: A feasibility study. *International Journal of Circumpolar Health, 72*(1), 21112. doi:10.3402/ijch.v72i0.21112

Young, T. K., & Chatwood, S. (2011). Health care in the north: What Canada can learn from its circumpolar neighbours. *Canadian Medical Association Journal, 183*(2), 209-214. doi:10.1503/cmaj.100948

28. Challenges to Telehealth Implementation

HEATHER EXNER-PIROT

Introduction

The use of technology in improving the delivery of health services has become fundamental to modern healthcare. Telehealth – the means of delivering medical information and health care through the use of telecommunication technologies – holds particular promise for vast portions of the Circumpolar North, due to the uneven distribution of specialized care between rural and urban population centers; the substantial distances which often must be travelled to receive health care; and challenges to recruitment and retention of health professionals in rural, remote and Indigenous communities.

Despite the promise and the need, telehealth use in most of the Circumpolar North remains in an early adoption phase rather than a normal part of health care delivery. The technology exists; but the processes and uptake are evolving slowly. This chapter will provide an introduction to telehealth, its promise to contribute to care, and the current challenges to implementation for communities in the Circumpolar North.

What is Telehealth?

Telehealth is a means of delivering medical information and health care through the use of telecommunication technologies. This may include providing clinical services to patients from a distance, monitoring a patient's vital signs from a remote health care facility, transmitting x-rays from a patient at a northern clinic to a radiologist in an urban hospital, or broadcasting continuing education programs to physicians, Registered Nurses (RNs) and other providers.

Telehealth does not typically create new or different health care services. It simply provides a new way to deliver existing services. On the clinical side, telehealth bridges the distance between patient and health care provider by allowing patients to remain in their communities, while being seen by a health care provider at a distant site. This enables those living in northern communities or areas that are underserved to have improved access to health care. Telehealth also saves time and money by reducing the amount of travel time and expenses, as well as reducing the time patients are off work or away from family responsibilities.

With the use of videoconferencing, remote presence robotics, or other equipment, a patient can have a live, real-time interaction with a specialist as if they are in the same room. The health care provider is able to conduct a sufficient examination of their patients by asking them about their past history and current symptoms; getting information from on-site providers, such as the local RN; and using electronic diagnostic equipment and other peripheral devices to mirror that of an in-person visit. This can be done by understanding the requirements from a provider perspective and identifying what peripherals are needed to ensure the patient is cared for the same way as in-person.

Though live-interactive videoconferencing,and increasingly remote presence robotics, are traditional forms of technology used in telehealth, there are others, such as remote monitoring equipment, used in home health and intensive care programs. In both cases, clinical data is collected from the patient and transmitted to a health care provider at an offsite location. The provider reviews the data and acts accordingly based on the findings. The clinical data may includea patient's weight, blood pressure, heart rate, oxygen saturation, and blood glucose, as well as other measurements, such as laboratory data, depending on the patient's condition.

Store-and-forward imaging is another technology used in telehealth that allows x-rays, CT scans, MRI images, digital images, and other images to be transmitted from the patient site to a physician located at a distant health care facility. In

the case of tele-radiology, images are sent to a radiologist to be read and the results are transmitted back to the patient site.

Telehealth also includes non-clinical services. Many telehealth sites can be connected simultaneously for collaborative purposes, such as continuing professional education, grand rounds, administrative meetings, and mentoring, amongst others. The use of telehealth for these professional development and networking functions also reduces travel time and expenses.

There is a large body of evidence confirming the central promise of telehealth: that it provides consistently high quality care at a lower cost. A few summaries of the growing body of telehealth research are available (McLean et al, 2013; American Telemedical Association, 2015). Generally, the research has demonstrated that:

- Telehealth outcomes are generally found to be equivalent or higher than in-person services (e.g. Dellifraine & Dansky, 2008).
- Patient satisfaction rates are as high or higher than in-person care (e.g. Sucher et al, 2011; Gustke et al, 2000).
- Costs can be lower than hospital based services (e.g. Holt et al, 2018; Cryer et al, 2012; Baker et al, 2011; Darkins et al 2008; Kohl et al, 2007)

There are many types of medical care that have been delivered via telehealth that achieve these kinds of positive results, including tele-stroke care, tele-pharmacy, tele-psychiatry, tele-optometry/ophthalmology, tele-dermatology, tele-rehabilitation, remote monitoring, and other uses. Given this strong track record across diverse disciplines and services, it should not be assumed that certain types of health services cannot be delivered, or are inappropriate, via telehealth.

Implementation Challenges

Introducing new systems and processes in large bureaucracies is often difficult. Northern contexts add additional layers of complexity. This section highlights some of the barriers to the implementation of telehealth.

Culture and Behaviour

It can be incredibly difficultto change the culture and behaviours of large, complex systems, such as health care. Many of the processes are path dependent on other processes and cannot be easily changed in isolation. Interjecting telehealth processes into existing systems promises a struggle with the status quo.

It will be difficult to change behaviours without either making telehealth as easy, or easier,than existing processes, and/or by providing performance or financial incentives to adopt new practices. Incentives can motivate and reward change and assist in more timely adoption of new processes. Implementing telehealth may require incentives at five levels:

1. The payer (i.e. government or insurance company), to save money/resources and/or improve services;
2. The client, to receive better/more convenient/more accessible services;
3. The local health care provider who is with the patient, often a nurse, who may need to provide additional or different care than they would if the patient was simply sent to see the provider/specialist in-person; and
4. The provider/specialist at the linked facility providing the expertise/diagnosis/treatment, who will need to be paid at the same rate, and not be inconvenienced by using technology over an in-person visit.
5. The administrators responsible for particular clinics or health regions need the resources to host and install

telehealth equipment and connections, and the human resources to coordinate appointments.

If telehealth is conceived as a plan that provides equivalent services at the same price, but requires expensive new technology and supports; or expands services but also costs, it will be difficult to get health ministries or insurance companies to invest in them. A critical mass of usage is required to realize the cost benefits of investments in telehealth.

Fear/Distrust in Reliability and Ability of the Technology

A major concern often shared by northern health care professionals is about the reliability of telehealth, given the often inferior connectivity in their communities. This concern is certainly valid; the potential benefits of telehealth provide a solid business case for further investing in rural and remote community broadband access. However, many telehealth devices are optimized for low bandwidth, and even remote communities typically have internet access at the community health centre. A greater concern is the cost of this connectivity, which can be prohibitive. However, medical transportation also entails some connectivity issues, including loss of cellular coverage over long distances.

Payment for Services

One of the biggest current obstacles to implementing telehealth is the difficulty and confusion around payment for services. Physicians and other providers will not go out of their way to provide online and virtual services if they cannot get paid for them.

The best practice has been to seek legislation that ensures health care providers are paid the same rate for telehealth services as for in-person visits. Ideally, no distinction would be made in how services are delivered, but focus rather on what service is being delivered.

Trends in telehealthare to move from expensive hardware-based telehealth room systems to software solutions like Skype for Business, Vidyo, etc. Legislation, privacy policies and billing codes need to be developed for these new technologies.

Jurisdictional Issues

In a similar vein, telehealth uptake can be hindered by restrictions to the ability of remote/offsite health care providers to provide care to patients who are not receiving care in the same region in which they are licensed. For example, if a patient is geographically in northern Saskatchewan, but seen by a physician in another province, the College of Physiciansand Surgeons of Saskatchewan holds that it is responsible for licensing that physician. Other Colleges have taken the geographic locationof the physician to determine which regulatory body is responsible for the licensure. For Registered Nurses in Canada, a fee is required to practice in different provinces, but licensure is not an issue.

In the United States, several states have made moves to allow providers to provide care across the country, through an inter-state compact, so long as they are licensed in the state of their physical location. Other jurisdictions may want to explore similar options to facilitate most effective telehealth use across borders.

Telehealth use raises additional issues in terms of professional conduct and privacy issues that need to be reviewed.

Privacy and Policy Implications

There are likely to be policy and liability implications associated with introducing telehealth and associated equipment. This can take time and resources to figure out. One example is the introduction of a remote presence robot into a hospital, which can create privacy issues. Who can access the robot and where can the robot travel to within a clinic?

The best practice is to maintain the same standards and practice guidelines for telehealth as for in-person visits.

Northern Clinic Capacity

In northern Canada, as elsewhere in the Circumpolar North, many community health clinics are frequently short-staffed and over-burdened. Efforts to keep clients in their home community using telehealth are likely to transfer some responsibilities for care onto local nursing and other staff. This could be challenging without appropriate training and support.

In addition, the comprehensive adoption of telehealth processes will require Information and Communications Technology (ICT) supports and maintenance. Many communities and smaller regions may not yet have the capacity to support a minimum standard of support and service.

Resources will need to be assigned to ensure there are not strong disincentives at the local level to adopt telehealth.

Need a Critical Mass of Users and Specialists

In order to obtain the financial benefits of telehealth, a critical mass of usage will need to be obtained. An up-front investment in technology, training, and resources is required to adopt and implement telehealth practices. If only a small number of practitioners subsequently use tele-health, the investment will not be a good one. Many telehealth suites in northern Canada, for example, are under-utilized. There needs to be enough specialists on one end, and local providers on the other, leveraging the service to make it viable. Therefore, a commitment is needed at a variety of levels.

Sustainability

There are likely to be "early adopters" who are enthusiastic about the potential of telehealth and eager to use the system. This may be a necessary condition for telehealth implementation, and for finding and supporting champions. However, for telehealth to be successful and sustainable, it will need to be adopted beyond single champions and pilot projects and become part of "normal" operations.

Post-secondary health sciences programs can be instrumental in normalizing telehealth by teaching the practice and theory to students before they are licensed practitioners, invoking an expectation of telehealth use in their clinical practice.

Standardization of technologies across jurisdictions, would improve uptake, ease of coordination, cost effectiveness and the patient experience.

Conclusion

Telehealth has the potential to transform health care in the North, by expanding access and reducing transportation needs and costs. The technologies exist; northern health care systems must find a way to implement and integrate telehealth tools in to their services.

Additional Resources

Agency for Healthcare Research and Quality (May 2013) [blog]. *Telehealth Improves Access and Quality of Care for Alaska Natives.* Retrieved from https://innovations.ahrq.gov/perspectives/telehealth-improves-access-and-quality-care-alaska-nativesAmerican Telemedical Association (April 2015). *Research outcomes: Telemedicine's Impact on Healthcare Cost and Quality.* Retrieved from: https://higherlogicdownload.s3.amazonaws.com/AMERICANTELEMED/3c09839a-fffd-46f7-916c-692c11d78933/UploadedImages/Policy/examples-of-research-outcomes—telemedicine's-impact-on-healthcare-cost-and-quality.pdf

Canadian Health Informatics Association (COACH). (2015). 2015 *Canadian telehealth report.* Prepared by the Canadian Telehealth Forum. Toronto: Author. Retrieved from https://ams.coachorg.com/inventory/PurchaseDetails.aspx?Id=cbfff94e-365d-48b4-a8fa-4040b4ab2356

Mendez, I., Jong, M., Keays-White, D., & Turner, G. (2013). The use of remote presence for health care delivery in a northern Inuit community: A feasibility study. *International Journal of Circumpolar Health*, 72. doi: 10.3402/ijch.v72i0.21112

References

Baker, Laurence C., Scott J. Johnson, Dendy Macaulay, and Howard Birnbaum Integrated Telehealth And Care Management Program For Medicare Beneficiaries With Chronic Disease Linked To Savings *Health Affairs September 2011* 30:91689-1697;

Cryer, Lesley, Scott B. Shannon, Melanie Van Amsterdam, and Bruce Leff (June 2012). "Costs For 'Hospital At Home' Patients Were 19 Percent Lower, With Equal Or Better Outcomes Compared To Similar Inpatients" in *Health Affairs*, 31(6) pp.1237-1243.

Darkins, Adam, Patricia Ryan, Rita Kobb, Linda Foster, Ellen Edmonson, Bonnie Wakefield, Anne E. Lancaster (December 2008). "Care Coordination/Home Telehealth: The Systematic Implementation of Health Informatics, Home Telehealth, and Disease Management to Support the Care of Veteran Patients with Chronic Conditions" in *Telemedicine and e-Health*, 14(10), pp. 1118-1126.

Dellifraine JL, Dansky KH (2008). "Home-based telehealth: a review and meta analysis" in *J Telemed Telecare*, 14(2), pp. 62-6.

Gustke, S.S., Balch, D.C., West, V.L., and Rogers, L.O. 2000. "Patient satisfaction with telemedicine" in *Telemedicine Journal*, Spring 6(1), pp. 5-13.

Holt, Tanya, Nazmi Sari, Gregory Hansen, Matthew Bradshaw, Michael Prodanuk, Veronica McKinney, Rachel Johnson,

and Ivar Mendez (2018). "Remote Presence Robotic Technology Reduces Need for Pediatric Interfacility Transportation from an Isolated Northern Community" in *Telemedicine and e-Health*, 24(11), pp. 1-7.

Kohl, Benjamin A, Frank D Sites, Jacob T Gutsche, Patrick Kim (2007). "Economic Impact of eICU Implementation in an Academic Surgical ICU, Anesthesiology and Critical Care", in *Crit Care Med.* University of Pennsylvania, Philadelphia, PA, 35(12), p. A26.

Sucher, Joseph F. S. Rob Todd, Stephen L. Jones, Terry Throckmorton, Krista L. Turner, Frederick A. Moore (2011). "Robotic telepresence: a helpful adjunct that is viewed favorably by critically ill surgical patients" in *The American Journal of Surgery* 202 (6), pp. 843-47.

29. Social Media for Health in Nunavik (Commentary)

MARIE-CLAUDE LYONNAIS AND CHRISTOPHER FLETCHER

The instant global connection afforded by the internet is now so much a part of daily life that it is becoming hard to imagine when it wasn't. Social media have reshaped the ways we all interact, our relations with kin, the very notion of friendship, the ways we entertain, and the ways we position ourselves as socio-political actors, shifting, in the process, the constraints of time and geography on belonging. In Northern Canada the development of the internet has been slowed by the technological limits associated with a huge area without road or landline connections. In Nunavik, the Inuit land claims region of Northern Québec, where we have been looking at the use of social media as a means to circulate health information, social media have been widely integrated into the lives and homes of people beginning 2010. Facebook in particular is very popular. The low bandwidth required to operate the platform means that it works reasonably well even in an environment where the bandwidth available for a whole community is less than that of a single house in a southern urban center.

Health-related content of Facebook pages is broad and touches many of the most important social determinants of health among them quality relationships, financial and material resources, social inclusion, healthy local food, work, emotional support, educational opportunities, access to community activities and health services. Every community has multiple public pages that encourage discussion and provide information on topics ranging from hunting to items for sale to community events. Regional and national pages are also popular and in some cases draw disparate communities into new configurations around ideas, history, events, food, and politics. Facebook groups have a growing role as a site where people may express their emotional states and, in some cases, extreme distress. In many instances acts of reaching out for help to friends and community members is effective in marshalling support and solace. These positive stories are balanced against instances of cyberbullying and hurtful gossiping that can bring the recipients to terrible anguish.

While young people are the primary users of social media, the enthusiasm for Facebook reaches all age groups, including unilingual Inuktitut-speaking Elders, who are integrating this mode of communication into their routines. We see many analogies to the community radio stations and the UHF radios favored by hunters on the land. Facebook is so important that, when faced with an economic choice, more and more homes are choosing to cancel traditional telephone service and retain only an internet connection for access to the internet. In this situation Facebook is an important way to be connected to the community and the principal means to be contacted. Facebook has become a privileged way to maintain links with and follow the lives of loved ones. The photo and video capacities of the platform are particularly sought out and transcend language and dialectical differences. While local radio remains a core means of communication, some services and organizations are now turning to Facebook to be in contact with the population. As such, social media plays multiple roles: it is, for instance, a local newspaper; a site for classified ads, places of exchange, and requesting a service or traditional food; and a platform for asking questions and calling on elected officials. Facebook is an exceptional cultural vector and a social mirror that Inuit communities have appropriated in their own way, molding its use to their own reality.

Facebook has undeniable strengths to support professionals and various health care workers in their work. Community social and health workers were quick to recognize the potential of social media for education and as a means of monitoring community health issues. There is a clear consensus among them about the need to have a presence on the social media, yet they are largely prohibited to do so by policy set outside of the region. The Nunavik health system is under the control of the Québec system, which prohibits the use of Facebook for professional purposes. Some interveners, by force of circumstances, work around this rule by using social media informally outside their working hours.

Despite the undeniable importance of Facebook in Northern communities, we have noted a growing divide between

institutional and everyday personal use of the technology. As in the case of the health system, it is quite common for local and regional organizations to block social media on their worksites and to prohibit people from interacting in an official capacity online. While there are justifiable concerns about confidentiality and productivity in the workplace, it seems that opportunities to better engage with and listen to local communities are being missed.

The 'Feeding My Family' page is a prime example of the effective use of Facebook for community health. Here, concern about the effects of high food prices on family health evolved from a page with a few members posting photographs of prices at local stores to one with thousands of members in North and South. The virtual community produced actual protests at stores and offices in several communities, and ultimately had repercussions on national northern food and health policy. Similarly, it is now generally accepted that the 2011 Nunavik Regional Government referendum was defeated in part because the proponents did not gauge and contribute to the local social media discussion about the impacts the agreement would have. Some organizations have been granted an exemption to set up pilot projects most of which are limited to using Facebook as a "promotional" showcase of their activities. In doing so they choose to reproduce the model of a poster, and miss the opportunity and challenge of engaging in dialogue through this medium.

Given the potential benefits to community health efforts, we believe it is time to explore ways to allow health care, social service and community workers to have use of social media as part of their efforts to engage with community. Social media already provide a new and powerful voice for northerners, rallying people and communities around common issues, and providing opportunities for Nunavummiut to voice their concerns.

The time is ripe to work within the evolving community mediascape to build knowledge, tools, and skills that promote health and reduce inequalities within communities and between the North and South. There is a strong regional commitment to transform the Westernized health model by prioritizing Inuit values and knowledge. For this to occur, it is necessary to have full community participation, especially among young people. To be successful, this must be done with respect for Inuit culture, and social and communicative norms. Social media are already playing a role in these important objectives.

30. eHealth as a support for older adults at home

PÄIVI JUUSO

In several industrialized countries, healthcare and social services are challenged by the growing and aging population. An increased number of older adults leads to an increased need of help and support in daily life. A shortage of younger people who can care for the aging population, especially in remote areas, necessitates better and more effective health care systems and technologies. eHealth can be a complement to traditional health and social services. For a sustainable and long-term plan for the person in need of support, it is important to reason about values affected when implementing and using eHealth as support at home. Implementation should, therefore, always be done based on the individual's needs. This chapter focuses on ethical aspects when implementing eHealth solutions as support for older adults at home.

Key Terms: eHealth, older adults, ethics

Introduction

The future increase in the population of people over 80 years leads to increased need of help and support in daily life (Rechel et al., 2013). Simultaneously, urbanization leads to increased number of working age people in cities and a decreased number of those individuals in remote areas (Eurostat, 2016). This future demographic prediction necessitates better and more effective health care systems and technologies, in order to meet older adults' needs and enable them to age-in-place, particularly in rural areas. eHealth gives possibilities and can be a complement to traditional health and social services. There is not one single definition of eHealth but according to World Health Organization (WHO, 2018), eHealth is the use of information and communication technologies (ICT) for health. This can include ICT tools and applications, such as video/tele technology, robots, alarms and security systems, surveillance, etc. all with the common aim to support older adults to live at home as long as possible. The concepts of assistive or welfare technology are also commonly used (cf. Michel & Franco, 2014). In order to achieve the best outcome, such eHealth services have to be developed through active work in collaboration with different actors (Kernisan, 2016). An awareness of not being the single solution to people's feelings of security at home is also an important consideration, as are feelings of being healthy and having someone to rely on (Petersson et al., 2012). The process of development and implementation of eHealth should therefore include thoughtful reasoning regarding values and ethical aspects of such services. This paper focuses on potential ethical aspects of implementing eHealth solutions as support for older adults at home.

Methods

A systematic literature review was conducted to identify relevant literature (cf. Smith et al., 2011). Suitable search terms were identified through a pilot search in several databases, which resulted in search terms e-Health, technique, ethics, and older adults. Studies published between 2003 and 2016 were included and after limitation to reviews, fourteen studies from international journals were included in the analysis.

Results

The results reveal several ethical aspects of importance when developing and implementing eHealth solutions to support older adults at home. First, dignity has to be respected which means the person's right to their own life and integrity, autonomy, and informed consent. In order to promote dignity, aspects such as independence, participation, security and safety, beneficence, equity, and justice have to be taken into consideration.

Second, access to different eHealth solutions is an important potential ethical issue, independent of where you live, your economic situation, or your knowledge. Everyone should have access to the service if it can cater to his or her needs (Magnuson & Hanson, 2003; McLean, 2011).

A third important aspect to take into consideration is contextual and cultural differences in experiences with using technology (Hofman, 2013; Korhonen et al., 2015). This means that questions about for whom and for what purpose the solutions are developed are important, as well as the importance of asking older adults what they want (cf. Hofmann, 2013; Lauriks et al., 2007; Magnuson & Hanson, 2003; McLean, 2011).

Fourth, values, such as autonomy and independence, are important in relation to support from technology at home and eHealth solutions can promote the sense of independence, but technological solutions may also inadvertently promote the opposite (Dahler et al., 2016). If the focus is on activity, there is a risk of exclusion of people with disabilities as for example frail older adults. Instead, promoting independence and autonomy should be based on the older adults' own free will to choose what, how, when and with whom they want to do whatever they want, including support from eHealth solutions. This perspective increases the older adults' empowerment and can facilitate the will to use technology at home (cf. McLean, 2011; Novitsky et al., 2015; Swijsen, et al., 2011). A wish to stay at home as long as possible has shown to increase the acceptance for eHealth solutions. Cultural values and differences can, however, affect this (Peek et al., 2014), which is why it is important to evaluate what independence means for each person (McLean, 2011).

eHealth solutions can decrease the burden on family members, but it can also increase the dependence on the technology (Dahler et al., 2016; Hofman, 2013; Korhonen et al., 2015). From a participatory perspective, older adults should be a part of the development of eHealth solutions (Bjering et al., 2014; Novitsky et al., 2015; Piau et al., 2014; Swijsen et al., 2011; Topo, 2009). Although this can sometimes be problematic, the older adult should be a part of the implementation process (cf. Dahler et al., 2016), as well as their family members, as their opinions have great importance in the acceptance (or rejection) of the technology (Dahler et al., 2016; Novitsky et al., 2015; Peek et al., 2014; Piau et al., 2014).

Finally, Fischer et al. (2014) showed that if the technology is beneficial for the older adults' feeling of security and safety, they may be willing to forgo their privacy. According to Swijsen et al. (2011), the fear of violence on one's privacy and integrity was small, as long as there was a balance between the need of surveillance and preserving the integrity of their autonomy. However, it is important to ensure confidentiality regarding information of the older adults and storage of data (Hofmann, 2013; Magnuson & Hanson, 2003). To be able to control the technology by themselves might protect the older adults from intrusion (Mordini et al., 2009), but it could be a problem for those elders with cognitive disabilities (Novitsky et al., 2015).

Conclusion

During the planning, implementation and post-implementation stages of utilizing eHealth, it is important to bear in mind the ethical aspects related to eHealth solutions for support at home for older adults. This is irrespective where the older adult lives, even though organizational and infrastructural conditions affect peoples' equal possibilities to be part of different eHealth solutions. Furthermore, older adults are not a homogenous group, but have different needs based on living, cultural and socioeconomic conditions, as well as level of frailty. eHealth solutions should be used as a complement to health- and social services, but cannot alone support independence, activity, and social interaction.

Hence, eHealth cannot completely replace the physical contact with healthcare personnel and other caregivers. In addition, one has to keep in mind that not only individual disabilities may be limiting, but also factors in the environment where older adults live, such as lack of proper infrastructure, may be challenges as well. According to WHO (2016), a lack of funding has been shown to be the biggest barrier for eHealth solutions, as the cost for the society can increase in the initial face of the implementation. In order to be equally available for everyone, development of the solutions is important, as well as of equipment and connectivity. Schrader et al. (2016) showed that low levels of ICT literacy is a barrier for engagement in eHealth as support in daily life for people in remote areas. For a successful implementation of eHealth solutions, the primary focus should be on changing working methods for the healthcare personnel and the need to involve the user (i.e. older adult), instead of focusing solely on the technological solutions.

Additional Resources

RemoAge website: http://remoage.eu/

Lecturers to listen: https://www.youtube.com/results?search_query=remoage

Lecturers of the concept of Aging-in-place: https://www.youtube.com/results?search_query=aging+in+place

Casey, M., P. S., Heaney, D., L., ÓLaighin, G., Matero, M., S., U., Alrutz, K., Eadie, F., &

Glynn, L. G. (2013). Implementing transnational telemedicine solutions: A connected health project in rural and remote areas of six Northern Periphery countries. *European Journal of General Practice*, 19, 52–58.

References

Bjering, H., Curry, J., Maeder, A. (2014). Gerontechnology: The importance of user participation in ICT development for older adults. *Investing in E-Health: People, Knowledge and Technology for a Healthy Future.*

Dahler, A.M., Rasmussen, D.M., & Andersen, P.T. (2016). Meanings and experiences of assistive technologies in everyday lives of older citizens: a meta-interpretive review. *Disability and Rehabilitation.*

Eurostat. (2016). *Urban Europe. Statistics on cities, towns and suburbs.* European Untion.

Fischer, S.H., David, D., Crotty, B.H., Dierks, M., & Safran, C. (2014). Acceptance and use of health information technology by community-dwelling elders. *International Journal of Medical Informatics*, 83, 624-635.

Hofmann, B. (2013). Ethical challenges with welfare technology: A review of the literature. *Science and Engineering Ethics*, 19, 389-406.

Kernisan, L. (2016). Promises and pitfalls: Technology and the future of delivering eldercare. *Journal of the American Society on Aging*, 40.

Korhonen, E-S., Nordman, T., & Eriksson, K. (2015). Technology and its ethics in nursing and caring journals: An intergrative review. *Nursing Ethics*, 22, 561-576.'

Lauriks, S., Reinersmann, A., Van der Roest, H.G., Meiland, F.J.M., Davies, R.J., Meolaert, F., Mulvenna, M.D., Nugent, C.D., & Dröes, R.M. (2007). Reviewof ICT-based services for identified unmet needs in people with dementia. *Ageing Research Reviews*, 6, 223-246.

Magnusson, L., & Hanson, E.J. (2003). Ethical issues arising from a research, technology and developement project to support frail older people and their family carers at home. *Health and Social Care in the Community*, 11, 431-439.

McLean, A. (2011). Ethical frontiers of ICT and older users: cultural, pragmatic and ethical issues. *Ethics & Information Technology*, 13, 313-326.

Michel, J-P., & Franco, A. (2014). Geriatricians and technology, JAMDA, 15, 860-862.

Mordini, E., Wright, D., Wadhwa, K., De Hert, P., Mantovani, E., Thestrup, J., Van Steendam, G., D'Amico, A., & Vater, I. (2009). Senior citizens and the ethics of e-inclusion. *Ethics & Information Technology*, 11, 203-220.

Novitzky, P., Smeaton, A.F., Chen, C., Irving, K., Jacquemard, T., O'Brolcháin, F., O'Mathúna, D., & Gordijn, B. (2015). A review of contemporary work on ethics of ambient assisted living technologies for people with dementia. *Science Engineering Ethics*, 21, 707-765.

Piau, A., Campo, E., Rumeau, P., Vellas, B., & Nourhashemi, F. (2014). Aging society and gerontechnology: A solution for an independent living. *The Journal of Nutrition, Health & Aging*, 18, 97-112.

Peek, S.T.M., Wouters, E.J.M., van Hoof, J., Luijkx, K.G., Boeije, H.R., & Vrihoefj, H.J.M. (2014). Factors influencing acceptance of technology for aging in place: A systematic review. *International Journal of Medical Informatics*, 83, 235-248.

Petersson, I., Lilja, M., & Borell, M. (2012). To feel safe in everyday life at home – a study of older adults after home modification. Ageing and Society, 32, 791-811. Doi: 10.1017/S0144686X11000614

Rechel, B., Grundy, E., Robine, J.M., Cylus, J., Mackenbach, J.P., Knai, C., & McKee, M. (2013). Ageing in the European Union. *The Lancet*, 381(9874), 1312-1322.

Schrader, G., Bidargaddi, N., Harris, M., Newman, L., Lynn, S., Peterson, L., & Battersby, M. (2014). An eHealth Intervention for Patients in Rural Areas: Preliminary Findings From a Pilot Feasibility Study. *JMIR Research Protocols*, 3(2):e27. Doi: 10.2196/resprot.2861.

Smith, V., Devane, D., Begley, C.M., & Clarke, M. (2011). Methodology in conducting a systematic review of systematic reviews of healthcare interventions. *BMC Medical Research Methodology*, 11:15.

Topo, P. (2009). Technology studies to meet the needs of people with dementia and their caregivers. A literature review. *Journal of Applied Gerontology*, 28, 5-37.

World Health Organization. eHealth at WHO. [Online]. 2018. Available from: http://www.who.int/ehealth/about/en/.

World Health Organization. Global diffusion of eHealth: Making universal health coverage achievable [Online]. 2016. Available from: http://apps.who.int/iris/bitstream/handle/10665/252529/9789241511780-eng.pdf;jsessionid=E98EB393DA64D61E0C2B4A42688C5F7C?sequence=1.

Zwijsen, S.A., Niemeijer, A.R., & Hertogh, C.M.P.M. (2011). Ethics of using assistive technology in the care for community-dwelling elderly people: An overview of the literature. *Aging & Mental Health*, 15, 419-427.

31. Telemedicine & e-Health in the Russian Arctic (Commentary)

YURY SUMAROKOV

Telemedicine and e-health services are successfully used in the Arctic regions all over the world (Woldaregay et al., 2017). Very long distances and problems of availability of medical services have created the need for wide use of distance technologies and e-health solutions.

Telemedicine in Arctic Russia was introduced in the 1990s. The first Arctic telemedicine network was established with efforts of an enthusiastic team in Arkhangelsk oblast in 1997 (Sorensen et al., 1999). The first network was organized in the framework of international co-operation projects and with the support of the Norwegian Center on Telemedicine (NST) based in Tromsø, Norway (Bye & Manankov, 2007). It became clear that trained staff and quality of communication lines were the main instruments of telemedicine distribution and development.

Now telemedicine is widely used as a complementary service in most Arctic regions of Russia, such as Arkhangelsk oblast, Nenets Autonomous Okrug (NAO), Yamal-Nenets Autonomous Okrug, Taymir, Yakutia (Sakha) and Chukotka. It is mostly used in sparsely populated areas, where the distances are quite long and delivery of health services is difficult. The most active use of telemedicine is developing in the Nenets Autonomous Okrug. For example, in NAO, 17 health centers are connected to a disperse telemedicine network. Teleconsultations with Nenets Okrug Hospital and external hospitals are occurring every day with real results and high economic effect. This was one of the reasons why Naryan-Mar hosted two international conferences on Arctic Telemedicine in 2014 and 2016 (see Arctic Telemedicine). The Conference participants from many Russian Arctic areas and guests from other parts of the world demonstrated a wide spectrum of different telemedicine and e-health solutions for Arctic needs.

The telemedicine used in Arkhangelsk oblast and NAO cover the different distant diagnostic possibilities including traditional needs of cardiology, surgery, neonatology, distant ECG, X-Ray and even telepsychiatry.

A new bill on telemedicine was introduced in Russia in 2017 (Muravin, 2017). It will allow the patients to legally obtain remote consultations from doctors on the Internet. The newly introduced bill provides a legal framework for use of information and telecommunication technologies in health care. The bill regulates all the telemedicine activities, including: distant visits to a healthcare practitioner followed by the issue of patient assessment reports and treatment advice, distant case conferences, e-prescriptions, using telemetric data, maintaining patients e-records and information exchange.

References

Arctic Telemedicine. Retrieved from, http://www.arctelemed.ru/doklady.

Bye S.M., & A. Manankov (2007). Telemedicine in practice in Arkhangelsk region, Russia: from a blank page to routine operation. *International journal of circumpolar health.* 66(4): 335-350.

Muravin A. (2017). Legal Highlights: Digital medicine. First steps to regulating telemedicine in Russia. *The Moscow Times.*

Sorensen T., A. Rundhovde, V.D. Kozlov (1999). Telemedicine in north-west Russia. *Journal of telemedicine and telecare.* 5(3): 153-156.

Woldaregay A.Z., S. Walderhaug & G. Hartvigsen (2017). Telemedicine Services for the Arctic: A Systematic Review. *JMIR medical informatics.* 5(2): e16.

32. Theme IV Reflection Questions

1. What is telehealth?
2. What health care services can be delivered via telehealth?
3. What considerations should be taken when introducing technology-reliant interventions in northern and Indigenous communities? How might you address them?
4. How might social media be used to impact community health in northern and Indigenous communities?
5. Describe a technological innovation in your clinical experience. How did improve care?

THEME V – PROFESSIONAL PRACTICE IN NORTHERN AND INDIGENOUS COMMUNITIES

33. Introduction

HEATHER EXNER-PIROT

Professional practice is unique in northern health care. The work is often complex and demanding, with limited resources. Work hours can be long, with no alternatives in case of an emergency or high volume of patients. Health care practice can be isolating, with fewer opportunities for interprofessional collaboration or professional development. Stress and fatigue, leading to burnout, are common. For these and other reasons many northern regions face perennial shortages in nurses, physicians, mental health counsellors and other health care personnel.

Yet, those who practice in the North often express how rewarding it is. There is often a sense of real contribution to the well-being of the community and connection to patients that can be difficult to match in large urban centres. The range of duties and practice situations is broad and variable, offering new challenges and opportunities for competency development. And practitioners can experience a satisfying autonomy in their professional practice, while being an integral member of what is likely a small health care team. Working in the North means living in the North, with its recreational opportunities, vibrant cultures, strong sense of community, and access to nature. Northern health care is not for everyone, but for many it offers the best possible combination of professional satisfaction and lifestyle.

Much of the discourse on northern human health resources revolves around recruiting and retaining southern health professionals, and subsequently ensuring they can practice in a culturally competent manner. But the northern health care landscape has been evolving in the past two decades, with more and more northern post-secondary institutions offering health care education and more northerners filling health care positions in their own communities and regions. Making health education accessible in the North is an important trend that several chapters describe here. However, the growing presence of northern health care practitioners has added an additional layer of complexity in health care practice. Northerners who are health professionals in their own communities may face lateral violence from those who resent their success and influence; may feel pressure to assume additional responsibilities within the clinic or hospital as a 'representative' of the family or community; and may have difficulty isolating professional from personal relationships and obligations. Patients may prefer local health care practitioners, for cultural or language reasons; or may prefer practitioners from outside the community to safeguard privacy and confidentiality – for example, for sensitive issues such as sexual activity, substance abuse, or domestic violence. For these reasons, self-care is necessary to reduce fatigue, burnout, and stress, and ensure health care professionals are well enough to address their patients' complex needs.

This theme is divided into two parts. The first examines the practice and regulation of health professionals in the North. Many similarities between northern and rural practice can be identified. Yet, due to its remoteness and culturally distinct character, northern practice entails a number of unique features.

Lois Berry articulates the importance of leadership in her chapter on *Nursing Leadership for Northern Health*. Registered nurses working in the north play a key role in addressing the challenge of quality and accessibility of health services for northerners. However, many will play additional roles in small communities including coach, municipal committee member, or campaign chairperson. Berry describes various aspects of leadership – critical, transformative, educative, ethical and inclusive – that are required to ensure nurses leverage their position to have the best possible impact on community health.

Martha MacLeod, Leana Garraway, Steinunn Jonatansdottir and Pertice Moffitt provide analysis from their Canada-wide survey on rural and remote nurses in their chapter *What Does it Mean to Be a Nurse in Canada's Northern Territories*? They outline the themes and highlights in the northern nursing experience. Positive elements included the ability to practice to the full scope of their profession, a high level of autonomy, and the opportunity to make an impact in their community. Challenges include professional isolation, addressing the social determinants of health of their clients, and ensuring they provide culturally safe care.

Pertice Moffitt, Rachel Munday and Jan Inman outline the professional conduct considerations unique to the North in their chapter on *Professionalism and Professional Conduct in the Northwest Territories and Nunavut, Canada*. In

Canada, nursing is a self-regulated profession. This means there is a designated professional body which oversees disciplinary actions for unprofessional conduct such as incompetence, bullying, and addiction. The authors describe the importance of responding to allegations and complaints to maintain the high trust of the public in nurses and other health professionals, especially those working in the North where responsibilities are high and supervisory oversight may be minimal.

Lastly, Brenda Dawyduk addresses the importance of recognizing job stress and burnout amongst northern health professionals and potential self-care strategies one can take to mitigate the hazards of stress and burnout. While self-care practices are personal, Dawyduk underscores the importance of recognizing the need for northern health professionals to find a balance between self-care and other-care.

The second part of this theme focuses on improving local capacity to educate health care professionals, administer health care systems and conduct health research, an important goal across the Circumpolar North. Several chapters describe particular efforts in that regard.

Lea Rättyä and Tiina Ervelius discuss the nurse-deaconess model of education in Finland and a new collaboration between the Diaconia University of Applied Sciences and the Sámi Education Institute in their chapter on *Nurse-Deaconess Education in the Sámi Region*. Graduates of the diaconal nursing program qualify both for registration as nurses and as a deaconess of the Evangelical-Lutheran Church of Finland, and provide holistic care encompassing both the spiritual as well as traditional health care. The program was established to increase the number of health professionals with a good command of the Sámi culture and culturally sensitive professional practices.

Kim Diamond and Susan Starks describe the supply side of health care personnel in their chapter *Educating Health Care Providers in the Yukon*. Yukon College in that Canadian territory has a long history of offering diploma and certificate courses in health careers such as Licensed Practical Nurses and Health Care Aides, with strong local and Indigenous uptake. They describe their efforts to indigenize their programming to ensure cultural safety in both education and health care delivery.

Rural regions around the world, and perhaps especially in the Circumpolar North, face particular problems in recruiting and retaining health professionals. Sirkka Saranki-Rantakokko, Eija Jumisko, and Outi Hyry-Honka discuss a project by Lapland University of Applied Sciences to address this issue in their chapter *Off-Campus Nurse Education – An Education Model Impacting Regional Health Care Services in Finnish Lapland*. Their model of incorporating nursing education into on-the-job training has resulted in positive outcomes including strong connections between the education and working life, adoption of new methods in the practice setting, and high employment and retention rates of graduates.

Gert Mulvad describes capacity building efforts in his chapter on *Health Research and Professional Education in Greenland*. Three initiatives stand out: the development of specialist medical education in Nuuk; the establishment of a nursing education program at the University of Greenland; and the creation of a Greenland Centre for Health Research. Combined, these efforts are having a huge impact on Greenlandic health care.

Pertice Moffitt and Grete Mehus outline a unique example of circumpolar relations in their chapter *Northern Partnership between Two Schools of Nursing in Norway and Canada: A Historical Perspective*. They developed a student mobility opportunity between their respective schools: Aurora College in Northwest Territories and Finnmark University College, later the Arctic University of Norway UiT, in northern Norway. Students learned about cultural similarities and differences and broadened their knowledge of nursing practice approaches.

Together, the chapters show a welcome evolution in northern health care and practice. Regions are producing more of their own health care practitioners, and in more contextually relevant ways; practitioners are assuming greater leadership roles; and the professions are advancing their standards of practice. Self-determination is a widespread and important goal across the Circumpolar North; developing uniquely northern health care systems with local health care professionals is an important step towards achieving it.

34. Nursing Leadership for Northern Health

LOIS BERRY

Accessibility to health services in the sparsely populated regions of the north is heavily dependent on the availability of health professionals, particularly nurses, who make up the largest category of health providers in these regions. In turn, registered nurses working in the north play a unique and key role in addressing the challenge of quality and accessibility of health services for northerners, which often results in northern nurses being called upon to provide leadership both within the health care settings in which they practice and in the community. In this chapter, the roles northern nurses play and its inherent need to provide leadership within the community is described. Following, the chapter descripts a model of critical leadership that can guide and support nurses in their work of ensuring equitable and accessible health and community services to northern populations.

Key Terms: northern nursing, leadership, critical leadership, northern healthcare, healthcare leadership

Introduction

This chapter discusses the leadership that is often expected of nurses practicing in the north. In the first section of this chapter, the unique roles played by nurses in rural and remote northern settings are described. These roles result in northern nurses being called upon to provide leadership both within the health care settings in which they practice, and in the community. The latter part of the chapter describes a model of critical leadership, which can guide and support nurses in their work of ensuring equitable and accessible health and community services to northern populations.

The Health Care Context in the North

Registered nurses working in the north play a key role in addressing the challenge of quality and accessibility of health services for northerners. Accessibility to health services in the sparsely populated regions of the North is heavily dependent on the availability of health professionals, particularly nurses, who make up the largest category of health providers in these regions (Exner-Pirot & Butler, 2015).

Nurses have unique and varied roles in ensuring the health of rural and remote communities (Coyle, M. et al., 2010; Martin Misener et al., 2008; McLeod et al., 2017a; Riley & Middleton, 2017. Some work in isolated primary health centers, delivering a wide variety of services, ranging from chronic disease management to diagnosis and treatment of common health conditions. Some work in community-based services delivering immunization, and pre and post-natal care, or in small in-patient units providing step down care post-surgery, or palliative care as part of a community-based end of life care program. Some provide service in remote health centers, where their jobs range from resuscitating, stabilizing and transporting acute trauma patients, to taking x-rays, and fixing the clinic computers. Regardless of the service provided, the breadth and depth of what is required of these nurses often differs considerably from the more specialized services

delivered in urban centers (Coyle, M. et al., 2010; Martin Misener et al., 2008; McLeod et al., 2017a; Riley & Middleton, 2017).

Unlike their southern counterparts, northern nurses' roles often do not end at the health center door or at the completion of their scheduled work days. Health care in the north is highly relational. Nurses who live and work in the communities they serve are tightly woven into the fabric of that community, and have close and lasting relationships with patients and families, sometimes spanning several generations (Moules, MacLeod, Thirsk & Hanlon, 2010). Many nurses play multiple roles in small communities in addition to their health care roles—team coach, municipal committee member, campaign chairperson, etc. At its best, the caring that emerges in rural and northern settings is based on the strong, multifaceted, complex interpersonal relationships with clients, families, and their communities (Berry, 2017; Cody Chipp, M. et al., 2010; Crooks 2004). As a result, confidentiality, anonymity, role confusion, and proximity may all prove challenges (Moules et al, 2010; Nelson, 2010). Nurses working in northern communities are compelled to develop and communicate a clear sense of their roles in relation to the boundaries between the personal and professional.

The role of the nurse in a small community has been described as a "generalized specialist" (Berry, 2017; MacLeod, 2008). These practitioners require a broad knowledge base, as they are confronted with health problems that would immediately induce consultation with and referral to specialists or other health providers in the south. However, unlike their southern counterparts, health professionals in remote regions are often not surrounded by a broad variety of other health and social services professionals with assigned managerial functions and continuing education roles to support the front line work of delivering health care, nor is there a designated workforce whose job it is to produce institutional and public policy to support health and health initiatives. In places where these specialized managerial and educational positions are not available, these roles are shared amongst those health professionals present in the community, and are often not assigned to particular positions, but are dependent on the skills of those occupying these positions at the time. Nurses working in northern communities assume a variety of the above roles at varying times and have opportunities to contribute to the planning and delivery of health care in ways that may not present themselves as readily to nurses working in the south.

Most health care teams in the North are small. In many communities, the core members of the team work closely together, sometimes over many years, building strong team relationships (Berry, 2017; McLeod et al., 2017; Moules et al., 2010). In a study of northern Canadian nurses, 58% reported living in the northern community in which they worked (MacLeod et al., 2017). In other situations, health services are supplemented by, or delivered entirely by itinerant nursing staff who come and go, either in short rotations of one to two weeks, or in short contracts (MacLeod et al., 2017b).

Unlike in most health services delivered in the south, northern nurses' work is often aided by highly valuable individuals from the community working in auxiliary roles, who are familiar with the local language, culture and customs. In communities large enough to have staffed clinics or hospitals, maintenance and clerical staff, as well as personal care aides are frequently from the community and provide a strong link to it for nursing staff. In community health in more remote regions, registered nurses' work is often aided by community health representatives, who are hired to work in local health care programs to support basic health promotion activities. They arrange or provide transportation to immunization, foot care, and other specialty clinics. They deliver medications that have been dispensed, and encourage community members to utilize health care services. They assist in communicable disease tracing, and explain local cultural practices, community health needs, and issues to health professionals from outside the community (Northwest Territories Health and Social Services Careers, 2011). They have limited training, perhaps provided on the job, and provide an important trusted link to community members for nurses.

In some isolated communities, nurses may be some of the very few members of the community with any post-secondary education. This, in tandem with their trusted role as health care providers in the community, gives them a unique skill set and frequently involves them in community discussions with respect to health and social policy and programming decisions.

There has been much attention paid in the last decade to the importance of interprofessional collaboration in health care in order to effectively meet patient, family, and community needs (Canadian Interprofessional Health Collaborative, 2010). Collaborative practice in the south engages many different health professions: nursing, medicine, dentistry, physical therapy, pharmacy, dietetics, etc. In small communities in the north, when looking for other professionals with

whom to share in delivery of health care services, often the only other professionals present in the community are teachers and police officers. Nurses and other health professionals in the North are often supported by telemedicine consultation services provided by health professionals remotely. Health and social policy and programming discussions often involve uniquely diverse groups of professionals and community leaders within the community, and unique and varied mechanisms for communication with professionals outside the community, bringing broad perspectives to the table.

One of the most important aspects of the nursing role in the northern context is that many nurses are working in Indigenous communities. While the importance of the understanding of Indigenous culture and health practices, the impact of colonization, and the importance of cultural safety approaches in the provision of health care are beyond the scope of this chapter, it is important to address the issues of jurisdiction that arise when providing care in the North. In some instances, nurses are working directly for Indigenous communities that have control of their own health services. In other instances, nurses are working directly for governments who provide health care services to Indigenous communities. In some cases, multiple different levels of government services may be involved, as is the case in Canada, where Indigenous people from a community that has control over its own health services may require services from federal or provincial service providers, or both. Nurses are often the health care professionals who are left to make their way through the jurisdictional issues that arise when trying to access timely, funded health care services for their patients, across jurisdictional boundaries. With few other professionals in the community on whom nurses can rely on; multiple and changing jurisdictional services and policies; intense and long term relationships with the community; engagement of auxiliary health care workers to link them closely with the community; and broad, eclectic, ever-changing roles, northern nurses are provided rich opportunities that differ significantly from the roles of their southern counterparts. Northern nurses have unique occasions to provide positive leadership that impacts the health and well-being of their communities. Northern communities look to nurses for information and decision making on all things health-related, and rely on the skills of nurses in identifying and addressing community health challenges, solving problems, and articulating policy solutions. Leadership from nurses is often expected, sought, and relied upon.

Leadership for Health in Northern Communities

Faced with the challenges of providing accessible, equitable, quality care to northern communities, in unique roles and unusual circumstances, and with a deep personal and professional commitment to the people they serve, nurses are frequently called on to provide both formal and informal leadership. The *critical leadership model* can assist nurses in prioritizing actions and approaches when working in northern communities, or in any situations where issues of equity and social justice arise. *Critical leadership* has five major components: critique, reflection, education, ethics, and inclusion. This model is based on the historical work of critical adult educators Foster (1989) and Ryan (2003). It was developed as a result of a study looking at the leadership experiences of nurse leaders striving to increase the diversity of the nursing profession (Berry, 2010).

Leadership is Critical

Leadership in the delivery of health care services in the North requires reflection on what and how services are delivered, and whose needs are being met in the way the services are constructed. Are these services organized in ways that meet the needs of the patients, families, and communities in which they are delivered, or in ways that meet the needs of the providers of the care, and the funding agencies that fund it? Nurses must especially understand and critically reflect upon their own role in relation to existing community structures, governance and norms, especially

when working cross culturally. Critical leadership requires one to look at who is benefitting from the way that services are delivered, and whether this approach meets the needs of the population served (Berry, 2010; Foster, 1989).

Leadership is Transformative

Northern nurses need to reflect on the possible. They cannot simply accept "what is" and "we don't do that here". What can be done to improve service? What would work better? What does this community believe that it needs? Are those needs being met? Transformative leaders maintain a passion for excellence driven by a commitment to their clients and communities, and what could be. Transformative leaders ask "why" and look at "what if". They avoid getting bogged down by the day-to-day, but keep their eye squarely on the goal of service (Berry, 2010; Foster, 1989).

Leadership is Educative

A significant part of critical leadership is looking analytically at tradition and "the way we've always done things", and envisioning new ways to move forward. This requires vision, a sense of the possibilities, and the ability to engage others in reflection and envisioning the possibilities. Educative learners are open to learning. They link current activities with the larger picture and transformative goals. Educative leaders are role models and advocates. They create opportunities for others. Educative leaders are engaged and engage others in their vision (Berry, 2010; Foster, 1989).

Leadership is Ethical

As previously noted, the way in which northern nurses' lives intertwine with northern residents requires that nurses recognize the ethical challenges that arise in the provision of northern health care, including issues of anonymity, confidentiality, proximity, and more. In addition, nurses are challenged by their codes of ethics not only to provide ethical care, but to ensure that the system in which they work is morally purposeful in addressing issues of access and equity. Ethical leadership is positive and authentic (Berry, 2010; Foster, 1989)

Leadership is Inclusive

Northern nurses involved in the planning and implementation of health care need to practice inclusive leadership. Inclusive leadership ensures that the process of planning care is in itself inclusive of those who require and receive the care. In addition to the process being inclusive, so too must be the outcome of the planning process, thereby creating a welcoming, respectful, and accessible service. Thus, the inclusive aspect of critical leadership is both a process, and an outcome (Berry, 2010; Ryan, 2003). The goal of inclusion as both process and outcome is especially important when considering the provision of culturally safe, accessible, high quality services to northern Indigenous communities.

Conclusion

Nurses working in northern communities are leaders by virtue of their roles in health care and in the community. Using an approach to leading that is critical, transformative, educative, ethical and inclusive contributes to the creation and delivery of high quality, equitable, and accessible health services that meets the needs of the northern communities in which nurses work.

References

Berry, L. (2017). Rural and remote health care. In B. Kozier, Erb, A. Berman, S. Snyder, M. Buck, L. Yiu, & L. Ferguson (Eds.), *Fundamentals in Canadian Nursing: Concepts, Process and Practice* (pp. 2262-270). Toronto, ON: Person Education Canada.

Berry, L. (2010). *Making a diversity difference: Stories of leadership in creating a more inclusive nursing profession* (Doctoral dissertation). Retrieved from the University of Saskatchewan Electronic Theses and Dissertations https://ecommons.usask.ca/handle/10388/etd-07262010-084241.

Canadian Interprofessional Health Collaborative. (2010). A *National Interprofessional Competency Framework*. Retrieved from https://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf

Cody Chipp, M.S., Dewane, S., Brems, C., Johnson, M., Warner, T., & Roberts, L. (2011). *Journal of Rural Health*, 27, 122-130.,

Coyle, M., Al-Motlaq, M., Mills, J., Francis, K., Birks, M. (2010). Australian Health Review, 34(2), 239-45.

Crooks, C. (2004). Is rural nursing a speciality?. Online Journal of Rural Nursing and Health Care, 4(1), 1-4.

Exner-Pirot, H. & Butler, L. (2015). *Healthy Foundations: Nursing's Role in Building Strong Aboriginal Communities*. Ottawa: Conference Board of Canada.

Foster, W. (1989). Toward a critical practice of leadership. In J. Smyth (Ed.), *Critical Perspectives on Educational Leadership*. (pp. 39-62) London: The Falmer Press.

MacLeod, M., Martin-Meisner, R., Banks, K., Morton, A.M., Vogt, C., & Bentham, D. (2008)."I'm a different kind of nurse": Advice from nurses in rural and remote Canada. *Nursing Leadership*, 21(3), 40-53.

MacLeod, M., Stewart, N.,Kulig, J., Anquish, P., Andrews, M.E. et al. (2017a). Nurses who work in rural and remote communities in Canada: A national survey. *Human Resources for Health.* 15(34) 1-11.

MacLeod, M., Stewart, N., Kulig, J., Olynick, J., Jonatansdorrir, S., & Kosteniuk, J. (August, 2017b). *Registered Nurse National Survey Report*: *Nursing Practice In Rural and Remote Canada.* Prince George, BC: Nursing Practice in Rural and Remote Canada II.

Martin Misener, R., MacLeod, M., Banks, K., Morton, A. M., Vogt, C., & Bentham, D. "There's rural, and then there's rural": Advice from nurses providing primary healthcare in northern remote communities. *Nursing Leadership*, 21(3), 54-63.

Moules, N., MacLeod, M., Hanlon, N., & Thirsk, L. (2010). "And then you see her in the grocery store": The working relationships of public health nurses and high-priority families in northern Canadian communities. *Journal of Pediatric Nursing*, 25, 327-334

Nelson, W. (2010). Health care ethics and rural life: Stigma, privacy, boundary conflicts raise concerns. *Health Progress*, 91(5), 51-54.

Northwest Territories Health and Social Services Careers. (2011). Community health representative. Retrieved from http://www.practicenorth.ca/index.php?page=community-health-representative.

Riley, K. & Middleton, R. (2017). Supporting rural emergency nurses to provide autonomous and life-saving care during resuscitation. *Australian Nursing and Midwifery Journal* 25(5), 44.

Ryan, J. (2006). *Inclusive Leadership.* San Francisco: Jossey-Bass.

35. What Does It Mean to be a Nurse in Canada's Northern Territories?

MARTHA MACLEOD, LEANA GARRAWAY, STEINUNN JONATANSDOTTIR, AND PERTICE MOFFITT

This chapter illustrates what it means to be a nurse in Canada's northern territories. In a nation-wide survey of nursing practice in rural and remote Canada, a total of 365 nurses from the Yukon, Northwest Territories, and Nunavut provided narrative answers to the question, "what does it mean to be a nurse in rural and remote Canada?" The answers, which ranged from a few words to lengthy descriptions of experience, were analyzed thematically. This chapter outlines the themes, and highlights what stands out for the nurses in their experiences of living and working in northern communities.

Key Terms: northern nursing practice, nurse practitioners, registered nurses, licensed practical nurses, registered psychiatric nurses, experience

Introduction

The aim of this chapter is to illuminate the experience of nurses in Canada's northern territories: the Yukon, Northwest Territories (NWT), and Nunavut. The territories are located above the 60th parallel, and comprise 39% (3,496,285 km2) of Canada's land mass, but less than 1% of Canada's population (113,604 people). Two communities have more than 10,000 residents: Whitehorse in the Yukon, and Yellowknife in NWT; the remaining 51.8% of the population live in in widely dispersed, small communities. The territories share many features of geography and weather, and are home to a variety of persons speaking a range of languages (Statistics Canada, 2017). Nursing practice is shaped in many ways by the territories' physical, geographical, social, and cultural contexts.

This chapter is based on findings from a study of nursing practice in rural and remote Canada. The study (RRNII) consisted of an analysis of documents (Kulig, Kilpatrick, Moffitt, & Zimmer, 2013); an analysis of the Nurses' Database (Place, MacLeod, Moffitt, & Pitblado, September 2014a; Place, MacLeod, Moffitt, & Pitblado, September 2014b); and a nation-wide survey, which included all nurses in the territories (MacLeod et al., 2017). The 27-page mailed survey sought to answer the questions: 1) what is the nature of nursing practice in rural and remote Canada? 2) How can the capacity of nursing services and access to nursing care in rural and remote Canada be enhanced? The survey was distributed in 2014 to all 1913 active practising nurses (nurse practitioners, registered nurses, licensed practical nurses, and registered psychiatric nurses) in the three northern territories. A total of 621 nurses responded, of whom, 365 provided narrative answers to the final question in the survey, "what does it mean to be a nurse in rural and remote Canada?" This chapter draws on their responses to this question, which ranged from a few words to lengthy descriptions of experience. The responses were entered into NVivo 10, and were analyzed thematically in a several-stage iterative process by the co-authors (Nowell, Norris, White, & Moules, 2017).

Findings

Although there were some differences in emphasis among nurse practitioners, registered nurses, licensed practical nurses, and registered psychiatric nurses, there was remarkable consistency in what they wrote. Their responses have been combined in the discussion that follows.

In their responses, the nurses wrote positively of many aspects of working in the territories, including the interconnection of their experiences of nursing practice with their experiences of living in northern communities, the opportunity to enact a broad scope of practice, their ability to use a wide range of skills, and practice with considerable autonomy and responsibility. They also wrote about valuing the opportunity to make a difference in communities where nurses may be the only healthcare providers. The nurses mentioned several challenges related to the complexity of northern nursing, including the challenges related to isolation, geography, and cultural dynamics (see also Martin-Misener et al., 2008). Three themes stood out, however, about what it means to be a nurse in the territories: facing the social determinants of health, being a resilient practitioner, and becoming culturally competent environments.

Facing the Social Determinants of Health

People living in the northern territories experience many health disparities (Canadian Polar Commission, 2014). Nurses wrote about how the determinants of health impacted the people in their communities. As one nurse noted:

Homes that are overcrowded, often without running water, sparsely furnished, inadequately heated. Homes where food supply is scarce, where money is short, where laundry cannot always get done because there is no water or because families cannot afford to pay their utility bills.

Access to services was also identified as a major concern throughout the territories, particularly in reaching higher levels of services, "*when sick patients with trauma come in a lot of the time we can't deal with it so patients are sent to our nearest centre, which is in Alberta (Edmonton)*." Nurses across all three territories described the limitations of mental health services and how the lack of services impacted their day to day practice, "*Due to a lack of mental health and /or addictions services clients use us as their counselors*".

The nurses' everyday practice was shaped by their communities' experiences of the social determinants of health, including the lack of ready access to services.

Being a Resilient Practitioner

Nurses experience a largely generalist practice in most, if not all northern practice settings (Anonymous, 2004; Anonymous, 2008; Tarlier, Johnson, & Whyte, 2003; Vanderspank-Wright & McMillan, 2016; Vukic & Keddy, 2002). Northern practice demands resilience: adaptability, resourcefulness, and creativity. Nurses indicated that, "*[northern nursing practice] means being incredibly adaptable because there are no training programs that address all aspects of your responsibilities*". Another noted, "*one needs to be resourceful. Every health care professional in an under-serviced community will encounter patients, scenarios and challenges that are outside their scope and comfort level. This variety and autonomy is both exciting and difficult.*" Creativity is needed. As one nurse wrote, "*staff are creative in dealing with situations where resources, equipment etc. are not readily available*". Another nurse gave an example, "*There's no lift team, no IV team, no respiratory therapists, no wound care nurse, there's me and my coworkers and we're up for the challenge.*"

Nurses mentioned the importance of working as a team and being aware of one's own strengths while working with the limitations, "*it means making do with fewer resources. It means having great assessment skills. It means trusting your*

judgment. It means building a strong team and good work relationships." Importantly, nurses "*must know the system well enough to care and advocate for patients*".

Becoming Culturally Competent

Indigenous persons make up 85% of Nunavut, 50.7% of the Northwest Territories, and 22.8% of Yukon's population (Statistics Canada, 2017). Many northern nurses found it "*challenging to work in rural communities and with Indigenous persons. A set of life skills, flexibility, knowledge, independence, and proper decision making is required, as well as being able to understand and work with cultural differences.*" Nurses noted a need to understand the communities' history and how colonization influences the people they care for (Greenwood, de Leeuw, Lindsay, & Reading, 2015), and how not to inadvertently perpetuate colonial practices (Rahaman, Holmes, & Chartrand, 2017).

Some nurses reflected how they learned to understand and respect Indigenous ways of knowing and being. For instance, one nurse described, "*I was able to understand their culture and beliefs better when I was able to live in it.*" Nurses learned about Indigenous peoples and their culture through taking "*every opportunity to get to know the people living in the community*" and "*participating in community events*".

Nurses commented on the many cultures and languages in some communities, and that "*It is vital that nurses are self-aware and promote culturally safe environments for their patients, especially in such a vibrant, multicultural community.*" Others indicated how it was too easy to make assumptions, and that they learned to "*provide information that actually fit with the reality of the clients I was seeing. It made me a better provider and refocused my care to understanding their world and 'meeting people where they are at'*".

Conclusion

This chapter highlights what stands out for nurse practitioners, registered nurses, licensed practical nurses, and registered psychiatric nurses in their experiences of living and working in northern communities. Nurses noted that they were faced by the social determinants of health on a daily basis, and in responding, their practice was shaped in new ways. Nurses were required to become resilient practitioners, and they found ways to learn how to become sensitive to the cultural realities of the communities within which they lived and worked. There are many complexities and challenges of nursing in Canada's northern territories, but there are also great opportunities. Just as Anonymous (2014) note, northern nurses have many opportunities for ensuring that persons' concerns are heard. They can make considerable contributions in addressing health inequities and improving access to respectful, responsive health care.

Additional Resources

Canadian Institute for Health Information (CIHI). (2017). *Regulated nurses, 2016: Canada and jurisdictional highlights*. Ottawa, ON: CIHI.

National Collaborating Centre on Aboriginal Health. (2017). *Social Determinants*. Retrieved from https://www.ccnsa-nccah.ca/28/Social_Determinants.nccah.

Nursing Practice in Rural and Remote Canada (RRNII Study) (including Fact Sheets on survey results for Nunavut, Northwest Territories and Yukon). Retrieved from *https://www.unbc.ca/rural-nursing*.

References

Canadian Polar Commission. (2014). *Health and wellbeing in the Canadian North: Recent advances and remaining knowledge gaps and research opportunities*. Retrieved from www.polarcom.gc.ca/sites/default/files/health_and_wellbeing_summary.pdf.

Greenwood, M., de Leeuw, S., Lindsay, N. M., Reading, J. (2015). *Determinants of Indigenous people's health in Canada*. Toronto, ON: Canadian Scholars Press.

Kulig, J., Kilpatrick, K., Moffitt, P., & Zimmer, L. (2013). *Rural and remote nursing practice: An updated documentary analysis*. Lethbridge, Canada: University of Lethbridge. RRN2-02. Retrieved from https://www.unbc.ca/rural-nursing.

MacKinnon, K. & Moffitt, P. (2014). Informed advocacy: Rural, remote, and northern nursing praxis. *Advances in Nursing Science* 37(2), 161-173

MacLeod, M., Stewart, N., Kulig, J., Anguish, P., Andrews, M. E., Banner, D., Garraway, L., Hanlon, N., Karunanayake, C., Kilpatrick, K., Koren, I., Kosteniuk, J., Martin-Misener, R., Mix, N., Moffitt, P., Olynick, J., Penz, K., Sluggett, L., Van Pelt, L., Wilson, E., & Zimmer, L. (2017). Nurses who work in rural and remote communities in Canada: A national survey. *Human Resources for Health* 15(34), 1-11 DOI 10.1186/s12960-017-0209-0.

Martin-Misener, R., MacLeod, M., Banks, K., Morton, M., Vogt, C., & Bentham, (2008). "There's rural, and then there's rural": Advice from nurses providing primary healthcare in northern remote communities. *Nursing Leadership* 21(3), 54-63.

Place, J., MacLeod, M., Moffitt, P., & Pitblado, R. (September 2014a). *Fact sheet: Nursing employment in the Northwest Territories and Nunavut*. Prince George, BC: Nursing Practice in Rural and Remote Canada II. RRNII-01-11. Retrieved from https://www.unbc.ca/rural-nursing.

Place, J., MacLeod, M., Moffitt, P., & Pitblado, R. (September 2014b). *Fact sheet: Nursing employment in the Yukon*. Prince George, BC: Nursing Practice in Rural and Remote Canada II. RRNII-01-12. Retrieved from https://www.unbc.ca/rural-nursing.

MacLeod, M. L., Kulig, J. C., Stewart, N. J., & Pitblado, J. R. (2004). *The nature of nursing practice in rural and remote Canada*. Retrieved from http://www.fcass-cfhi.ca/Migrated/PDF/ResearchReports/OGC/macleod_e.pdf.

Nowell, L. S., Norris, J. M., White, D. E., & Moules, N. J. (2017). Thematic analysis: Striving to meet the trustworthiness criteria. *International Journal of Qualitative Methods* 16, 1-16. DOI: 10.1177/1609406917733847

Rahaman, Z., Holmes, D., & Chartrand, L. (2017). An opportunity for healing and holistic care: Exploring the roles of health care providers working within northern Canadian Aboriginal communities. *Journal of Holistic Nursing* 35(2), 185-197.

Statistics Canada. (2017). *Population and dwelling counts, for Canada, provinces and territories, 2016 and 2011 censuses – 100% data*. Retrieved from http://www12.statcan.gc.ca/census-recensement/2016/dp-pd/hlt-fst/pd-pl/Table.cfm?Lang=Eng&T=101&S=50&O=A.

Tarlier, D. S., Johnson, J. L., & Whyte, N. B. (2003). Voices from the wilderness: an interpretive study describing the role and practice of outpost nurses. *Canadian Journal of Public Heath* 94(3), 180-184.

Vanderspank-Wright, B., & McMillan, K. (2016). Critical care nursing north of the 60th parallel: a qualitative pilot study. *The Canadian Journal of Critical Care Nursing* 27(3), 12-17.

Vukic, A. & Keddy, B. (2002). Northern nursing practice in a primary health care setting. *Journal of Advanced Nursing* 40(5), 542-548.

36. Professionalism and Professional Conduct in the Northwest Territories and Nunavut, Canada

PERTICE MOFFITT, RACHEL MUNDAY, AND JAN INMAN

The practice of community health nursing in the Canadian Arctic has mostly been conducted by nurses from away who are recruited to the North. Recruitment is often aimed at nurses with a background in critical and emergency care so that they can be somewhat prepared for a new expanded primary health care role in the remote communities. This targeted consideration may address some of the clinical skills required for remote nurses but is short-sighted in terms of professionalism, cultural competency, and healthy workplace rapport. Nurses do not always know or understand the Northern context and, in particular, the worldviews and practices of Indigenous peoples of the north. Orientation to the community and the community health nurse role in a remote setting is often lacking. In adjusting to a change in scope of practice, personal and professional isolation and/or unhealthy behaviours acquired over years of practice and not so apparent in an urban setting, some nurses demonstrate incompetence, bullying and slander, and addiction. This chapter looks at professional conduct, as it is regulated in the Northwest Territories and Nunavut, in light of this context and seeks to identify professional values and practices along with socially just and culturally safe care.

Key Terms: professionalism, professional conduct, professional nursing and ethics

Introduction

Despite the fact that professional responsibilities are engrained in: curricula across Canada, Standards of Nursing Practice, Scope of Practice, Competencies, Codes of Ethics (documents that are distributed to new graduates, registered nurses, and nurse practitioners), and continuing competency requirements are in place, unprofessional conduct is present in nursing practice across Canada, including the North. One could argue that this is influenced by many personal, contextual, systemic, and sociopolitical factors. As nurses become comfortable with their role and practice, some seasoned nurses become complacent about what is acceptable behaviour. For example, although nurses are well versed in the concept of confidentiality, when approached by a patient in the Northern store in a small community, the nurse must be vigilant about disclosure even though the community member may be openly sharing. The everyday socialness of the small community needs to be navigated astutely. Furthermore, there is a blurring of the personal and professional self in social media, as reported through research conducted with nurses in Italy and Britain (Levati, 2014). This, too, is also occurring in northern Canada, as local community members engage in Facebook and other forms of social media. At times, this might be as simple as texting a photo to a nursing colleague, who might then share it with unrelated others.

Regardless of these influences and the relatively small number of nurses being disciplined, it is alarming to the public and to the nursing profession when there is a poor outcome at the hands of a nurse, requiring a nurse's license to be revoked, suspended, and/or conditions applied. It is also interesting to note that in these remotely populated territories, when a nurse is charged or being investigated for a criminal offense, particularly when there was a poor outcome for a patient in care, or if a criminal act has occurred, the story is often aired by the Canadian Broadcasting Corporation's CBC

North (Bird, 2016; Burke, 2015; CBC News, 2017). Radio, along with today's use of Facebook, comprise primary sources of communication in northern communities, so any wrongdoings or alleged wrongdoings are known by all. This does not necessarily mean that a formal complaint has been lodged against the Registered Nursing Association of the Northwest Territories and Nunavut (RNANTNU) member, but it does mean there is considerable expression of public opinion.

It has been suggested that the incidence of unprofessional conduct for nurses is small in developed countries (Hudspeth, 2009). In fact, nurses have been said to be one of the most trusted health care providers in Canada (Huffington Post, 2017). In Canada, some nurses are concerned that the regulatory function of the College of Nursing has superseded a social justice mandate (Duncan, Thorn & Rodney, 2014). In spite of adequate undergraduate preparation to lead an exemplary professional nursing life, many nurses will hold individual beliefs and may argue that what happens in their off-duty time is not relevant to the nursing profession at all (Lipscomb, 2013).

In this chapter, we will highlight governance for registered nurses, remote nursing practice, the nature of complaints against registered nurses, and considerations about the professional conduct of registered nurses.

Governance and Self-regulation

The Nursing Profession Act for the Northwest Territories (NWT) was established in 1975 and has underwent amendments over the years; in 1999, the NWT divided into two territories: a much smaller NWT and the newly formed territory of Nunavut. In response, the Nursing Profession Act was amended to provide legislated direction to both territories; in 2002, the act was amended again to accommodate nurse practitioners (Government of the NWT, 2003).

RNANTNU is the self-regulating body for registered nurses and nurse practitioners who practice nursing in the two territories. Professional conduct is reviewed by the Professional Conduct Committee that consists of a Chairperson, Deputy Chairperson and the Director, Professional Conduct. This committee meets monthly to review new complaints, monitor current and past complaints, and close complaints. Section 32 of the Act defines unprofessional conduct in the following way1:

- (1) An act or omission of a nurse constitutes unprofessional conduct if a Board of Inquiry finds that the nurse (a) engaged in conduct that (i) demonstrates a lack of knowledge, skill or judgment in the practice of nursing, (ii) is detrimental to the best interests of the public, (iii) harms the standing of the nursing profession, (iv) contravenes this Act or the regulations, or (v) is prescribed by the bylaws as unprofessional conduct; or (b) provided nursing services when his or her capacity to provide those services, in accordance with accepted standards, was impaired by a disability or a condition, including an addiction or an illness (GNWT Justice, 2004, p. 29).
- (2) Examples of unprofessional conduct include: a) practice that fails to meet accepted standards; b) the abandonment of a patient in danger without first ensuring that the patient has obtained alternative medical or nursing services; c) verbal or physical abuse of a patient; d) irresponsible disclosure of confidential information about a patient; e) providing false or misleading information respecting birth, death, notice of disease, state of health, vaccination, course of treatment or any other matter relating to life or health; f) the impersonation of another member or health professional; g) obtaining registration or employment through misrepresentation or fraud; h) the failure, or refusal, without reasonable cause, to respond to an inquiry, or to comply with a demand for the production of documents, records, or other materials made by an investigator under sub-section 39(1) a conviction for a criminal offense, the nature of which could affect the practice of nursing.

There are many considerations for remediation when it is found that a complaint against a registered nurse is justified. The consequence of unprofessional conduct can vary from letters of discipline to conditions on the nurse's license to suspension or removal from the registry. The process is often through a settlement agreement and may take the shape of medical care, counselling, coursework or reflective papers. These processes help to establish that the nurse is fit and competent to resume nursing practice. The magnitude of loss for a nurse experiencing discipline is recognized

and careful and thorough consideration is given to resolve the matter in a just manner. Of utmost importance for the committee is protection of the people we serve, residents of the Northwest Territories and Nunavut.

Nursing Practice in Remote Settings in Canada

Literature about nursing practice in remote communities of Canada is increasing, particularly with two large national studies on rural and remote nursing (McLeod et al., 2017). Nurses who are employed in remote settings are most often the only health care practitioners providing primary health care, including maternal and child health, primary care, emergency care, monitoring and surveillance of chronic conditions, and close involvement with education, housing and sanitation departments; are working in professional isolation; and have described feeling like outsiders in these communities (Tarlier, Browne & Johnson, 2007). Recruitment and retention of nurses in remote Canada is problematic with staffing instabilities contributing to turnover, short stay, and agency nurses (Kulig, Kilpatrick, Moffitt & Zimmer, 2015). Furthermore, the practice of northern nurses in primary settings has been critiqued and described as colonizing nursing practice (Rahaman, Holmes & Chartrand, 2007). It is suggested that the colonized nature and power imbalances between nurses and their clients leads to fragmentation of care.

Nature of Complaints against Nurses

The Professional Conduct Committee of the nursing association receives complaints against nurses. Statistical data in terms of the number of complaints and the type of complaint are established, tabled, and monitored yearly. This dataset is used in the following section.

The nature of the complaints against nurses working in the Northwest Territories and Nunavut vary, and include addiction to alcohol and/or drugs, breaches of confidential patient information, and care and practice that does not meet acceptable clinical or professional standards. The incidence of nurses contributing to toxic work environments2 is on the rise and in clear violation of Standards of Practice and the Code of Ethics for Registered Nurses and Registered Nurse Practitioners.

Inappropriate and unprofessional use of social media3 is another area of concern related to professional conduct for nurses coming to work in northern Canada. Many of the nurses coming to work in the various community health centres scattered across the North are excited for the challenge, as well as the experience of seeing and living in the North. When sharing on social media, all nurses need to be cognizant of the scope of distribution of information in electronic form, the fact that many postings to social media are permanent, and posting anonymously does not protect against the possible consequences of a breach of confidentiality.

Documentation4 is an integral part of nursing care and unfortunately, the lack of accurate and complete documentation, is often the basis for a complaint of poor professional practice. In the community health centres in both Nunavut and the Northwest Territories, SOAP format is used for documentation. Many nurses coming to work in the North in the expanded practice role are not familiar with SOAP documentation. The Community Health Nurse (CHN) will receive a brief orientation to the format; however, audits of the charts and the new CHN's documentation may not happen early enough to give guidance and provide feedback. Even today, the thinking continues, "If it isn't charted/documented it hasn't been done – the care was not given." (personal communication, Director Professional Conduct, February 1, 2018)

Another common complaint is poor or lack of sound clinical judgement when caring for clients. This is directly linked to the nurse's failure to adhere to established policies, guidelines, and government directives, and the non-availability of good clinical orientation and mentorship, which in turn may be related to lack of staffing and the fact that nursing staff for the majority of health centres typically number from two to five nurses in total. Because of the instability of the

nursing workforce in Nunavut, in particular, and the North in general, the nurses may not be fully informed regarding the use of these policies, guidelines, and directives.

Clinical judgement5 does appear in complaints to the Professional Conduct Committee. Community health nurses working in an expanded advanced practice role need to demonstrate they have sound clinical judgement, are strong critical thinkers, and are clinically competent to perform this independent and critical nursing role. These attributes are unlikely to have been acquired by a nurse who has minimal post-graduate experience and more likely to be subsumed in a nurse whose prime motivator for working in the North is the enhanced salary scales and tax incentives.

Professional Conduct

Vulnerability is a part of every nurse's practice in terms of "making an error, breaching or failing to meet a standard, and proneness to being reported to a nurse regulatory authority." (Pugh, 2011, p. 21). Pugh (2011), in a grounded theory study on 21 Australian nurses alleged with unprofessional conduct, identified personal and professional vulnerability in their everyday contexts. He described two kinds of vulnerability – one related to poor decision making related to below standard practice and the other linked to motivations in the workplace to report nurses such as, whistleblowing or a duty to report. We suggest that this vulnerability escalates in a remote setting where nursing practice is described as being in a fishbowl. Nurses and their nursing practice are central to what is happening in the community. The way a nurse acts or does not act in both her/his personal and professional life is open for scrutiny.

Conclusion

As a self-regulating profession, nursing relies upon provincial and territorial Associations to fulfil its mandatory obligations to protect the public from unsafe nursing practice. The Professional Conduct Committee of RNANTNU accepts and investigates complaints and provides remedial action where needed. RNANTNU has a high proportion of its members practicing as community health nurses with an expanded scope of practice, mostly in very remote and isolated settings, where oversight of practice is minimal.

It is important to acknowledge that cultural competence is essential for nurses working with Indigenous peoples. The governments of both Nunavut and Northwest Territories recognize the importance for new nurses to realize the history of colonization and the devastation this had and continues to have on Indigenous people. Both governments have developed a guide to understanding the history and impact of Residential School (GNWT, GN & Legacy of Hope Foundation, 2013). Since the territories have a short-term and revolving workforce in remote communities, it is vital that a targeted effort is directed towards nurses working in remote communities to acquire and understand this history, the effects it has had on the health of individuals and communities, and move forward with strategies at all levels for reconciliation. Hines-Martin and Nash (2017) have recommended key concepts to combat social disparities : social justice, social determinants of health, interprofessional, practice and community engagement. These authors suggest that this will lead to improved health outcomes. For interprofessional practice and community engagement to be realized, there needs to be a more permanent workforce to build relationships with individuals and communities and get out of some of the nursing silos that exist. When these steps are taken, professionalism can be achieved.

It is incumbent upon every member of the Association to be aware of not only their own scope of practice and individual competencies but also policies and statements which govern the practice of nursing. These would include at a minimum scope of practice, standards of practice, code of ethics all to be found on the RNANTNU website. Similar documents are available on all other provincial/territorial association and CNA and CNPS websites. In order to practice nursing competently all nurses should be very familiar with the contents of such documents and revisit them frequently throughout their nursing career.

Notes

1. The act is quoted verbatim in this chapter to give the reader an opportunity to consider the legislation.

2. Furthermore, workplace bullying is defined as "harassing, offending, socially excluding someone or negatively affecting someone's work (Lutgen-Sandvik, Tracy, & Alberts, 2007; Waschgler, Ruiz – Hernandez, Llor -Esteban & Jimenez -Barbero, 2013). This kind of bullying, when carried out in the health care sector by a colleague is known as lateral or horizontal workplace bullying/violence and when carried out by a superior is known as vertical workplace/bullying/violence (Waschgler et al., 2013). Other terms used to describe this behaviour in literature include, "nurses eating their young", verbal abuse, disruptive behaviour and incivility" (Sauer, 2012, 1). See the Canadian Nursing Student Association's Position Statement on Creating and Empowering Environment for Nursing Students to Eliminate Bullying in the Nursing Profession.

3. The Registered Nurses Association of the Northwest Territories and Nunavut position statement on Social Media identifies benefits and risks to the professional registered nurse and registered nurse practitioner regarding the use of various online and mobile social media tools. The benefits identified include, "Using social media allows for rapid, convenient, and efficient exchange of information. Social media promotes education, research, and evidence based practice by providing opportunities for health care professionals to network, collaborate, and disseminate knowledge. Social media provides a platform for nurses to engage in advocacy and promote the nursing profession" (RNANT/NU, 2015). The risks associated with the use of social media include, "RNs and NPs must be aware of the professional and legal risks associated with the inappropriate use of social media. Such risks include: confidentiality and privacy breaches, violation of professional boundaries, damage to professional integrity, defamation of character (nurse, client, and / or organization), public mistrust, and employment consequences. Violations may result in disciplinary action by RNANT/NU leading to loss or suspension of nursing license, and /or civil or criminal proceedings by individuals or organizations" (RNANT/NU, 2015).

4. Documentation is a crucial component of safe, ethical, and effective nursing practice, irrespective of the context of practice or whether the documentation is paper – based or electronic. Documentation is defined as any written or electronic recoding that describes the status of a client or the client care provided (Lyeria & Barry, 2014). RNANT/ NU Documentation Guidelines states, "Documentation establishes accountability, promotes quality nursing care, facilitates communication between health care providers and conveys the contribution of nursing to health care. Documentation is neither separate from care nor optional. Documentation is a vital part of nursing practice" (RNANT/NU, 2015, p. 4).

5. Sound clinical judgement is directly related to the nurse's ability to think critically. "Higher cognitive skills are essential competencies for nurses joining the technologically and increasingly complex health care environment to provide safe and effective nursing care. Educators and clinical facilitators have recognized that newly qualified nurses do not meet the expectations for entry level clinical judgement and are held accountable for finding adequate learning experiences as preparation for such practice demands". (van Graan, Williams, & Koen, 2016, p. 1) The American Association of Colleges of Nurses' definition of critical thinking states, "Critical thinking underlies independent and interdependent decision making. Critical thinking includes questioning, analysis, synthesis, interpretation, inference, inductive and deductive reasoning, intuition, application and creativity".). Benner, Hughes, and Sutphen (2008) also indicate, "The growing body of research, patient acuity and complexity of care demand higher – order thinking skills. Critical thinking involves the application of knowledge and experience to identify patient problems and to direct clinical judgments and actions that result in positive patient outcomes." (p. 2)

References

American Association of Colleges of Nursing. (1998). *The essentials of baccalaureate education for professional nursing practice.* Washington, DC: American Association of Colleges of Nursing.

Bird, H. (August 15, 2016). Inuvialuit woman says uncle's stroke mistaken for drunkenness. *CBC News North.*

Burke, A. (May 11, 2015). "It's too late for us". Nunavut mother says son's pneumonia death preventable. *CBC News North.*

CBC News (February 21, 2017). She kept asking for help: Iqaluit woman monitored daily by nurses dies from liver failure.

Duncan, S., Thorne, S., & Rodney, P. (2014). Evolving trends in nurse regulation: What   are the policy impacts for nursing's social mandate? *Nursing Inquiry, 22*, 27-38.   doi:10.1111/nin12087

Government of NWT, Government of Nunavut and the Legacy of Hope Foundation. (2013). The Residential School System in Canada: understanding the past-seeking   reconciliation-building hope for tomorrow (2nd ed). Retrieved from   https://www.ece.gov.nt.ca/sites/ece/files/resources/northern_studies_10_teaching__guide.pdf

Hines-Martin, V., & Nash, W. (2017). Social justice, social determinants of health, interpersonal practice and community engagement as formative elements of nurse   practitioner managed health center. *International Journal of Nursing and Clinical   Practices*, 4, 218. doi.org/10.15344/2394-4978/2017/218.

Hudspeth, R. (2009). Understanding discipline of nurse practitioner by boards of nursing. *Journal of Nurse Practitioners*, 5(5), 365-371.

Huffington Post. (2017, June 15). *Canada's most and least respected professions: sorry, politicians and car salespeople.* Retrieved   from   http://www.huffingtonpost.ca/2017/06/15/most-least-%20respected-professions-canada_n_17124362.html.

Kulig, J.C., Kilpatrick, K., Moffitt, P., & Zimmer, L. (2015). Recruitment and retention in rural nursing: it's still an issue. *Journal of Nursing Leadership, 28*(2), 40-50. doi:10.12927/cjnl.2015.24353

Levati, S. (2014). Professional conduct among registered nurses in the use of online social networking sites. *Journal of Advanced Nursing*, 70(10), 2284-2292.

Lipscomb, M. (2013). Some may beg to differ: individual beliefs and group political claims. *Nursing Philosophy, 14*, 254-270.

Lutgen – Sandvik, P., Tracy, S. J., & Alberts, J. K. (2007). Burned by Bullying in the American Workplace: Prevalence, Perception, Degree and Impact. *Journal of   Management Studies, 44*(6), 837 – 862.

Pugh, D. (2011). A fine line: the role of personal and professional vulnerability in   allegations of   unprofessional conduct. *Journal of Nursing Law, 14*, 21-31. doi: 10.1891/1073- 7472.14.1.21

Rahaman, Z., Holmes, D., & Chartrand, L. (2017). An opportunity for healing and holistic care: exploring the roles of health care providers working within the Northern Canadian Aboriginal communities. *Journal of Holistic Nursing*, 35(2), 185-197. doi: 1-.1177/08980116650773

Sauer, P. (2012). So Nurses Eat Their Young? Truth and Consequences. *Journal of   Advanced Nursing*, 66(12), 2732 – 2742.

Tarlier, D.S., Browne, A.J., & Johnson, J. (2007). The influence of geographical and social distance on nursing practice and continuity of care in a remote First   Nations community. *Canadian Journal of Nursing Research*, 39(3), 126-148.

Van Graan, A.C., Williams, M.J.S & Koen, M.P. (2016) Professional nurses' understanding of clinical judgement: A contextual inquiry. *Health SA Gesondheid*, 21, 280 – 293.

Waschgler, K., Ruiz – Hernandez, J., Llot – Esteban, B., & Jimenez – Barbero, J. (2013). Vertical and Lateral Workplace Bullying in Nursing: Development of the Hospital Aggressive Behaviour Scale. *Journal of Interpersonal Violence*, 28(12), 2389 – 2412.

37. Self-Care Practice for Northern Practitioners

BRENDA DAWYDUK

Introduction

Health professionals in northern communities are often exposed to high levels of occupational stress in their day-to-day work and are at greater risk of experiencing burnout. By virtue of their work, health professionals are exposed to a plethora of challenges including workload, rapidly advancing knowledge, jurisdictional and bureaucratic requirements, workforce issues, and social isolation. This can lead to severe distress, burnout, or physical illness. In the end, healthcare workers may be unable to provide high quality healthcare services. Stress and burnout can also be costly because affected healthcare workers take sick leave and may even change jobs. It is important to have an optimal balance between self-care and other-care. Being aware of the joys and hazards of the work, the essence of burnout, ways to maintain the personal and professional self, and having a personalized self-care action plan are vital to endurance of working in the North. The importance of optimal work-life balance for health practitioners, prevention of burnout and self-care will be discussed in this chapter.

Job Stress

The term job stress is not foreign to health professionals and is experienced daily. During stressful times, there is a temporary adaptation process that takes place that is often is followed by mental and physical symptoms. Not recognizing or ignoring the symptomatology can lead to burnout (Schaufeli, 2007). Beyond the day-to-day stress, working in remote northern areas has its own list of factors that contribute to job stress. Some of the unique issues of working in remote areas include social isolation, high visibility and accessibility, lack of available and cost of healthy food, dual or multiple relationships (example: physician and hockey coach), access to too much personal information on patients, lack of access to land-based activities such as a boat or ski-doo, heightened scrutiny by community members, increased responsibility, feelings of powerlessness, and limited access to professional development.

Burnout

There have been many terms used in the literature to describe burnout. Despite the variations, key words such as fatigue, frustration, stress, depletion, helplessness, emotional drain and cynicism were commonly noted. These words point to a profound weariness and drain of the self as key components of burnout (Soderfeldt, Soderfeldt & Wang, 1995). Burnout is known to develop dysfunctional attitudes and behaviors towards the recipients of one's care or services, one's job, and/or the organization one is working for (Schaufeli, 2007).

Self-Care

Self-care is a means used to prevent burnout. It is a spectrum of knowledge, skills, and attitudes, including self-reflection and self-awareness, identification of burnout, recognizing inappropriate coping skills (alcohol and drugs), and

implementing appropriate professional boundaries (limit patient access outside of work). Self-care is important and may be a new concept to some, as – for the most part – health professionals receive inadequate self-care training during their education (Sanchez-Reilly et al., 2013).

Personally acknowledging the risk for burnout and taking responsibility to actively participate in self-care (wellness) is essential to avoid the burnout trap (Bakker & Costa, 2014). Self-care strategies are very individualized, and are a therapy for job stress management and prevention of burnout. They are not passive exercises; engagement and commitment are required to maximize their benefits. Personalized self-care interventions are effective and should be the foundation of all strategies directed at preventing emotional exhaustion and burnout in general (Schaufeli, 2007).

Personalized Self-Care Plan, Finding Your Outlet

Finding a creative outlet that is enjoyed and has benefits beyond providing much-needed stress relief; it also makes one become a better healthcare professional. Getting creative whether through the arts, hobbies, or by getting out into the great outdoors, can not only help to unwind, but it could also provide an effective way to manage stress and recover from the demands of the North.

Although self-care strategies are personal, the following list of strategies will provide a foundation to get started or support to carry on with one's current self-care practices.

Table 1 – Strategies to mitigate stress and burnout and promote well-being

· Regularly evaluate and regulate six areas of work life: workload, control, reward, community, fairness, and values.

· Create a network of peers and coworkers and stay well connected. During off hours, distance yourself from work both emotionally and cognitively.
· Look for opportunities for engagement with activities congruent with work and interests. Sign up for classes of interest and inspiration. Tap into one of your passions with online courses if not offered locally.
· Balance empathy and compassion with objectivity. Observe for feeling of powerlessness.
· Strive for self-awareness, share feelings and responsibilities and set limits to avoid overload of work.
· Adopt a healthy lifestyle with exercise and vacations. Tap into the technology available to you do develop and stick to your own type of exercise that works for you. A 10-minute stretch exercise in the workplace has proven to reduce anxiety levels and exhaustion symptoms, while improving the mental and physical well-being of health care workers.
· Promote work-life balance through recreation and hobbies. Get involved locally with clubs, recreational activity. Keeping protective boundaries is important in community settings.
· Practice mindfulness, meditation and reflective writing. Many apps, internet resources are available for free or a minimal cost.
· Enhance spiritual development to find deeper meaning in personal and professional relationships.
· Prioritize personal relationships with family and friends. Keep in contact with meaningful relationships in person or via technology when available.

(Romani, Ashkar, 2014 & Sanchez-Reilly et al., 2013).

Conclusion

Self-care practices require a personal commitment and are essential for work-life balance while working in the North. Paying attention to your attitudes, thoughts (positive vs. negative), mood (content vs. irritability), and habits (healthy vs. unhealthy) will assist to guide where you are at on the work life balance continuum. The challenges are real and never ending. Stay healthy colleagues as burnout is a common and a serious entity with devastating personal and professional consequences. Be good to yourself so you can be good to your patients.

References

Bakker, A. B., & Costa, P. L. (2014). Chronic job burnout and daily functioning: A theoretical analysis. *Burnout Research*, 1(3), 112–119. doi.org/10.1016/j.burn.2014.04.003.

Romani, M. & Ashkar, K. (2014). Burnout among Physicians. *Libyan Journal of Medicine*, 9(1), 23556. DOI: 10.3402/ljm.v9.23556

Sanchez-Reilly, S., Morrison, L., Carey, E., Bernacki, R., O'Neill, L., Kapo, J., Peruakoil, V., deLima Thomas, J. (2013). Caring for oneself to care for others: physician and their self-care. *Journal Support Oncology*, 11(2), 75-81.

Schaufeli, W. (2007) Burnout in Health Care. In: Carayon, P., Ed., *Handbook of Human Factors and Ergonomics in Health Care and Patient Safety*, Lawrence

Erlbaum, Mahwah, 217-232. Soderfeldt, M., Soderfelt, B., & Warg, ,L. E. (1995). Burnout in social work. Social Work, 40, 638-646. Retrieved from http://www.jstor.org/stable/23718210

38. Nurse-Deaconess Education in the Sami Region

LEA RÄTTYÄ AND TIINA ERVELLIUS

Aim: *To enable cultural themes as a part of professional academic studies in nurse-deaconess education.*

Methods: *Developing the nurse-deaconess curriculum in cooperation with the Sámi Education Institute. Adding to the curriculum Sámi cultural and Sámi language studies and organizing education in the Sámi region in a project funded by the EU. This also includes developing a model of a culturally sensitive nurse-deaconess education within the Sámi culture.*

Results: *Culture has an important role in people's health. Through adding culturally sensitive knowledge of Sámi culture into the curriculum, the graduating nurse-deaconesses have better competence in culturally sensitive, individual, holistic and client-centred care of patients with a Sámi background.*

Conclusions: *After this project the model of culturally sensitive nurse-deaconess education can also be used and tested in other cultures.*

Key Terms: culturally sensitive, Sami, registered nurse, deaconess, curriculum

Nurse-deaconess Education in Finland

Deaconesses were the first educated registered nurses in Finland. In 1867, deaconess education began in the Helsinki Deaconess Institution and more Deaconess Institutions were founded in different cities in Finland soon after. In the early days, deaconesses took care of the sick and dying people at their homes; they helped the poor and gave spiritual support to those who needed it (Rättyä, 2014). In the early days, deaconesses were women, but nowadays there are also male deaconesses.

Diaconia University of Applied Sciences (Diak) is the only University in Finland where students can study to become a registered nurse-deaconess. According to students, studying at Diak gives them opportunities to make the world a better place and helps them find their calling and place in the world of work (Diaconia University of Applied Sciences 2017a). Graduates of the Bachelor of Health Care, Diaconal Nursing program qualify both as a registered nurse and as a deaconess of the Evangelical-Lutheran Church of Finland, consisting of 240 credit points (ECTS) (Diaconia University of Applied Sciences, 2017b).

Deaconesses are health care professionals whose work involves holistic health promotion, helping people gain personal resources, and supporting hopefulness, independence, and inclusion. In nursing practice, a holistic view of the human condition and people's well-being is a particular strength of deaconesses (Diaconia University of Applied Sciences, 2017c). In holistic care, the whole person and the whole life situation of the patient or client is taken into account. That can mean mental, emotional, social, spiritual, and practical help like nursing intervention, guidance, or financial support to the client (Rättyä, 2009). Holistic care is easier if there is understanding of the context where people live (e.g. northern environment, nature, attitudes, values, communality, traditions), which includes a respect and knowledge of Sámi culture and lifestyle.

The program provides comprehensive theoretical knowledge and clinical skills for nursing practice, as well as religious studies. A deaconess carries out preventative and outreach work by assisting and supporting individuals, families,

groups, and communities in various life circumstances. The health care competencies of deaconesses are valuable in church community work, for example, when working with seniors, children or people with disabilities. As a parish worker, a deaconess works in close cooperation with health and social services and various organizations (Diaconia University of Applied Sciences, 2017d). Diaconal nursing shares many similarities with Faith Community Nursing (Balint & George, 2015; Ziebarth, 2016).

Developing Culturally Sensitive Knowledge of Sami Culture into the Nurse-deaconess Curriculum

Culture has an important meaning to one's health, especially in the circumpolar countries (Tervo & Nikkonen, 2010). Towards this theme, there has been growing research interest in the past few years (see for example Catwood et al., 2017). The Sami are Indigenous people and their homeland is situated in the northern Arctic areas of Finland, Norway, Sweden, and Russia. The amount of Sami living in Finland is estimated to be about 10,000. There are challenges for the provision of education, services, and communications in the Sami language (Sami Parliament, 2018). This is why we started the co-operative project Nursing-Deaconess education at the Sami region together with the Sami Education Institute at Ivalo (2015-2018). The main aim of this co-operative project is to increase the amount of professionals, both in healthcare and in churches' diaconal work, with a good command of Sami culture and culturally sensitive working methods towards the Sami.

Developing the Nurse-Deaconess Curriculum

The need for this project and curriculum development came from the Sami people. They have been in co-operation with curriculum development from the beginning. Content planning to the courses, teaching, presentations in seminars, guiding the practical training and evaluation have been a part of the curriculum development and project.

This project is generating a model of culturally sensitive teaching method suitable for both nursing and deaconess teaching and studying in the context of Sami culture. This includes developing the curriculum towards Sami cultural issues.

The basic Sami cultural course (5 credits) includes knowledge about Sami history and modern times. It includes knowledge about traditional professions (reindeer herding, artisan, berry-picking, fishing and hunting), traditional food (about reindeer meet, fish and hunted animals, berries), traditional way of living in northern natural environment, and meaning of family and social interaction to well-being (Tervo & Nikkonen, 2010).

Three Sami languages are spoken in Finland: North Sami, Inari Sami and Skolt Sami. Students could choose one of these to study. First, there is a language course (6 credits) to learn all the basics, then a course about Sami language in nursing (4 credits), and a third course on Sami language in deaconess's work (1 credit.)

Several tasks in studying academic themes were included to take into account Sami cultural themes. This way, students could deepen their knowledge about the Sami culture. Examples of themes included nursing for children, adults, and elderly people in the Sami context. For example, students observed the reindeer herders at the reindeer round-up to understand the challenge of first aid there (Ervelius, Nuottila & Vilminko, 2016). Furthermore, at least one of the practice placements of each student is located in a Sami area to learn and practice how to meet and help Sami people in a culturally sensitive way. All of the students have completed their thesis, including developing nursing or/and deaconess working methods at the Sami context.

The Co-operational Project Nurse-Deaconess Education at the Sami Region

The project helped nurse-deaconess education through its contacts and partnerships. It was possible to have all the professionals and local authorities involved in this education, and students made several visits to different organizations who are working in co-operation with Sami. Both Diak and the the Sami Education Institute have a lot of experience in online teaching. This co-operative project provided a good opportunity to develop together online teaching methods and test new ideas.

The results of this project and education are being analysed. Already now we have reached positive feedback from local professionals both in nursing and parish environments (Ervelius & Blomster, 2016). Evaluation is conducted by analysing curriculum and interviewing nursing students, Sami people, and local social, health care, and parish workers. The main results will be in working methods in the context of the Sami culture and also Sami language speaking skills. Local health care organizations and parishes seem to be satisfied with this curriculum because some of the students have already graduated and offered several working opportunities in the Sami homeland.

As a result of this project, a model for culturally sensitive teaching methods has been developed that is suitable for both nursing and deaconess teaching, and studying within the context of Sami culture. This model can be adapted into curriculum development work in other cultures too.

Additional Resources

EU-project: Nurse-deaconess education in the Sámi region. Retrieved from https://www.eura2014.fi/rrtiepa/projekti.php?projektikoodi=S20056.

Gävert T. 2016. Diaconia barometer 2016: findings in brief E-Book. Retrieved from https://finna.fi/Record/diana.111710.

References

Balint K. A., & George N. M. (2015). Faith Community Nursing Scope of Practice. Extending Access to Healthcare. *Journal Christian Nursing*, 32(1), 34-40. Retrieved from https://www.nursingcenter.com/cearticle?an=00005217-201503000-00013.

Chatwood, Susan, et al. (2017). Indigenous Values and Health Systems Stewardship in Circumpolar Countries. *International Journal of Environmental Research and Public Health*, 14(12), 1462-1482.

Diaconia University of Applied Sciences 2017a. Retrieved from https://www.diak.fi/en/.

Diaconia University of Applied Sciences 2017b. Retrieved from www.diak.fi/en/admissions/degree-programmes/ba-programmes/ba-of-health-care-diaconal-nursing/.

Diaconia University of Applied Sciences 2017c. Retrieved from www.diak.fi/en/admissions/degree-programmes/ba-programmes/ba-of-health-care-diaconal-nursing/.

Diaconia University of Applied Sciences 2017d. Retrieved from www.diak.fi/en/admissions/degree-programmes/ba-programmes/ba-of-health-care-diaconal-nursing/.

Ervelius, T., & Blomster, M-L. (2016). Opintojen ohjaus osana saamelaisalueen sairaanhoitaja-diakonissakoulutusta. In Gothóni, R., Karjalainen, A. L., Koistinen, P. & Marjo Kolkka (Eds.) *Osallistavaa oppimista ja kehittämistä*. Helsinki:

Diakonia-ammattikorkeakoulu. Retrieved from https://www.theseus.fi/bitstream/handle/10024/121673/DIAK_opetus_3_9789524932806.pdf?sequence=1&isAllowed=y.

Ervelius, T., Nuottila, K., & Vilminko, S. (2016). Koulutus tasa-arvon ja yhdenvertaisuuden tuottajana. In Gothóni, R., Hyväri, S., Kolkka, M., & Vuokila-Oikkonen, P. *Osallisuus yhteiskunnallisena haasteena – Diakonia-ammattikorkeakoulun & TKI-toiminnan vuosikirja 2*. Retrieved from https://www.theseus.fi/bitstream/handle/10024/117560/Ty%C3%B6el%C3%A4m%C3%A4_7_9789524932752.pdf?sequence=6&isAllowed=y

Rättyä, L. (2009). *Diakoniatyö yksilöllisenä ja yhteisöllisenä auttamisena yhteiskunnallisessa muutoksessa* (Doctoral dissertation). Kuopio University, Kuopio, Finland.

Rättyä, L. (2014). Finlands Long History of Parish Nursing. Perspectives. A *Newsletter for Faith Community Nursing*, 13(1).

The Sámi Parlament. Historia – taustat. Retrieved from http://www.samediggi.fi/historia-taustat/.

Tervo, H., & Nikkonen, M. (2010). "In the mountains one feels like a dog off the leash" –

Sámi perceptions of welfare and its influencing factors. *Nordic Journal of Nursing Research*, 30(4), 9-14. Retrieved from http://journals.sagepub.com/doi/abs/10.1177/010740831003000403.

Ziebarth, D. J. (2016). Wholistic Health Care: Evolutionary conceptual analysis. *Journal of Religion and Health*, 55(5), 1800–1823.

39. Educating Health Care Providers in the Yukon

KIM DIAMOND AND SUSAN STARKS

Yukon College, located in Canada's northwest, has offered a variety of nursing and health-related programs since its inception in 1963, allowing Yukoners the opportunity to live, learn, and work in place. The College's programs and courses have prepared students to practice nursing skills, enhance well-being in communities, and meet their continuing education needs as northern health care providers. Close to 30% of credit students at Yukon College are First Nations. Yukon College is committed to decolonization, indigenization, and reconciliation, and this continues to inform its evolving health program content and delivery. This chapter provides a historical snapshot of Yukon College health-related programming and a glimpse of an educational future where programming responds to the changing needs of the Yukon, First Nations, and the wider northern community.

Key Terms: Yukon College, health programs, indigenization, Elders, reconciliation

Introduction: Educating Health Care Providers in the Yukon

The Yukon is a sparsely populated region of 38,455 people in Canada's northwest (Yukon Bureau of Statistics, 2017). It is home to fourteen First Nations, eleven of which have comprehensive land claims and self-government agreements (Council of Yukon First Nations, n.d.). Yukon College is the sole post-secondary institution in the territory, and one in three (30%) students self-identify as First Nations (Yukon College, 2016). At the official opening of the college in 1988, Mrs. Angela Sidney, a highly respected Yukon Elder and honored guest, sang an ancient Tlingit song to convey her feelings about what Yukon College could mean for young people in the future. According to Sidney (2015), "The reason I sang this song is because that Yukon College is going to be like the Sun for those students. Instead of going to Vancouver, or Victoria, they're going to be able to stay here and go to school here. We're not going to lose our kids anymore. It's just going to be like the Sun for them!" Yukon College's mandate, articulated in the *Yukon College Act*, is to "provide educational programs, services, and activities to meet the needs of people in the Yukon" (Yukon College Act, 2002, p. 1). The College prioritizes capacity building, support for economic development, and relationship building, particularly in meeting First Nations' interests (Yukon College, 2016). The College has provided health care-related programming since its inception and is committed to the idea of offering Northerners the opportunity to live, learn, and work in place. This chapter provides a historical snapshot of Yukon College health-related programming and a glimpse of an educational future where programming responds to the changing needs of the Yukon, First Nations, and the wider northern community.

History of Yukon Health Care Provider Education

A variety of health care related programs and courses have been delivered by Yukon College over its fifty-five-year history. Specifically, Longstanding Certified Nursing Assistant, Practical Nurse, Nursing Home Attendant/Home

Support Worker (NHA/HSW), and Health Care Assistant programs have been offered, alongside a range of short-term programs, professional development opportunities, and continuing education courses for local health care providers.

Certified Nursing Assistants/Licensed Practical Nurses

From 1963 to 1995, a 10-month Certified Nursing Assistant (CNA) program was delivered twice a year in the Yukon with approximately 271 graduates in total. In 2000 and 2003, a Practical Nurse Access certificate was offered, modeled after a British Columbia program that used the NHA/HSW program as an entry requirement. Fifteen students graduated from this program (K. Diamond, personal communication, May 10, 2018). By 2005, CNA certificate programming in Canada evolved to Practical Nurse (PN) diploma programming, in part due to the fact that Registered Nurse (RN) entry to practice became a degree rather than a diploma. PN diploma programs reflected an expanding PN scope of practice and helped LPNs establish a distinct professional identity (Pringle, Green & Johnson, 2004). The Yukon followed suit with the delivery of the first two-year PN diploma at Yukon College in 2008. The PN curriculum was brokered through Bow Valley College in Calgary, Alberta. To date, five cohorts totaling more than 60 students have graduated, and a move to annual intakes is anticipated in 2019 (S. Starks, personal communication, May 15, 2018).

Health Care Aides/Assistants

A Nursing Home Attendant/Home Support Worker program, based on an Okanagan College curriculum, was initiated in 1996. In 2002, federal funding supported the development of a Home and Community Care Program, which included courses from the NHA/HSW program and was delivered in rural Yukon communities. The NHA/HSW program ran until 2009 when the College adopted the British Columbia licensed curriculum for the Health Care Assistant (HCA) program, which continues today. More than 85 students completed the NHA/HSW program and 76 students have graduated from the HCA program to date (K. Diamond, personal communication, May 10, 2018).

Registered Nurses

Although there has been interest in RN education in Yukon since the early 1980s, a 2001 feasibility study recommended that Yukon College offer PN education rather than develop a RN diploma or degree and encouraged the delivery of arts and science courses that would allow students to complete part of their RN education in Yukon before transferring out (Hanson & Associates/Malloch Graham & Associates Management Consultants, 2001). Interestingly, Camosun College in Victoria now offers a Whitehorse Field School opportunity for first- and second-year nursing students, making Yukon a destination for RN students from other jurisdictions (Camosun College, 2018).

Other Health Care Programming

A Community Health Representative (CHR) program was designed in 1986 and delivered twice between 1988 and 1993. At the request of the Yukon Government, the NHA/HSW program was suspended in 1998, so faculty and community stakeholders could develop a Northern Addictions Worker certificate for frontline addictions workers, which was ultimately not delivered (K. Diamond, personal communication, May 10, 2018).

Continuing Education for Health Care Providers

Yukon College has also supported a number of the continuing education and upgrading needs of CNAs, LPNs, and RNs, including refresher courses, medication administration, pharmacology, and health assessment. Eight students completed an RN refresher program and 14 completed a CNA refresher program between 1981-1996 (K. Diamond, personal communication, May 10, 2018). The College has further assisted with clinical practice placement for students taking RN programs elsewhere and supported Yukon RNs pursuing their nursing degrees through the University of Victoria and other distance courses and programs.

Towards Indigenizing Programs

Yukon College's diverse health programming provides Yukoners the opportunity to access quality education, leading to meaningful employment here in the territory. In 1973, the Council for Yukon Indians stated that "the whole Yukon is our school. In the past we learned from our surroundings" (The Council for Yukon Indians, 1973, p. 21). Through its various decolonization, indigenization and reconciliation initiatives, Yukon College is striving to embed this perspective in its institutional life and educational programs. Where we learn matters, but so too does what and how we learn.

Yukon College's goals of indigenizing the institution and acting on the Truth and Reconciliation Commission's (TRC) calls to action are evident in its work to date. Some milestones include: becoming a charter signatory of the national Indigenous Education Protocol (Yukon College, 2016); developing Yukon First Nations core competency requirements for faculty, staff, and students; working internally with First Nations Initiatives to develop new Indigenous curriculum and reviewing existing curriculum for Indigenous content; developing a First Nations research protocol; and initiating a First Nation Elders-on-campus program. Program-level instructors aspire to indigenize their courses in meaningful ways. College health programs pay special attention to the TRC's Calls to Action on education and health. The TRC highlights that reconciliation requires an "awareness of the past, acknowledgement of the harm that has been inflicted, atonement for the causes, and action to change behavior" (TRC, 2015, p. 6).

Since 2012, the HCA and PN programs have offered an eight-hour workshop on Residential Schools and Caregiving for their students and faculty that is delivered by First Nations Initiatives (FNI) staff. This workshop includes: a history of settlement in Canada/Yukon and its impact on First Nations; current legislation affecting First Nations people and communities in Yukon; a history of residential schools in Canada and Yukon; and the impact of intergenerational trauma on survivors and descendants and appropriate nursing care for those affected. Additionally, FNI staff deliver a further half-day workshop to address competencies related to heritage and culture, governance, contemporary issues, and First Nations world views and history.

Moreover, collaborative learning opportunities reinforce these competencies. Students work with First Nations liaison workers during a portion of their clinical experience, and staff from the First Nations Health Program at Whitehorse General Hospital share knowledge of traditional foods in class. Students learn that colonialism, as de Leeuw, Lindsay and Greenwood (2015) and McGibbon, Mulaudzi, Didham, Barton and Sochan (2014) assert, is a significant determinant of health – one that has yet to be fully accounted for – and that decolonization is iterative rather than an outcome. Elders are invited into classrooms to speak with students on several topics. One example is an HCA program initiative that includes Elders facilitating a learning activity in a palliative care course. Elders share their knowledge and beliefs related to end of life. Students learn about Indigenous ways of knowing and are invited to experience ceremony from a worldview that may be different from their own. This leads to an appreciation of multiple perspectives and "two-eyed seeing", highlighting the importance of alternative ways of knowing and encouraging students to "constantly question and reflect on the partiality of [their] perspective" (Martin, 2012, p. 31). Anonson et al. (2014) explore the impact of Elders in the post-secondary classroom, noting that the "learning spirit" (p. 3) was traditionally developed through story-telling and ceremonies led by Elders. The presence of Elders in the classroom strengthens the learner's ability to understand

how content is both relevant and connected (Anonson et al., 2014). Faculty and students learn to value Indigenous pedagogy. HCA students report that this learning touches them deeply and allows them to honor their thoughts and feelings about the role of ceremony at end of life. By extension, they recognize the importance of attending to the spiritual needs of those in their care. Holistic learning experiences benefit all students, and Elders in the post-secondary classroom embody this approach (Anonson et al., 2014).

Future Directions

An exciting future includes Yukon College's transition to Yukon University and community interest in rural health program delivery. A priority for the new Associate Vice President Indigenous Engagement and Reconciliation role is the indigenization of Yukon College/University. Health program instructors will engage in teaching and learning that incorporates Indigenous perspectives, aims to decolonize, and supports reconciliation. Indigenous scholars suggest reconsidering the primacy of western ways of knowing and integrating instructional methods embedded in an Aboriginal pedagogy including: talking and sharing circles; participant observations; experiential learning; modeling; meditation; prayer; ceremonies; and story-telling – informing health program teaching strategies (Battiste, 2002; Pete, Schneider & O'Reilly, 2013). Students will learn to be health care providers at home in the Yukon and grow through authentic learning experiences grounded in cultural safety and humility. In turn, they will develop excellence in supporting the health needs of the individuals, families, and communities they care for.

Additional Resources

First Nations Health Programs https://yukonhospitals.ca/whitehorse-general-hospital/programs-and-services/first-nations-health-programs

Council of Yukon First Nations https://cyfn.ca/

First Nations Health Authority http://www.fnha.ca/wellness/cultural-humility/webinars

First Nations Initiatives https://www.yukoncollege.yk.ca/about-us/governance-first-nations-intiatives

First Nations Education Steering Committee http://www.fnesc.ca/

References

Anonson, J., Huard, S., Kristoff, T., Clarke-Arnault, V., Wilson, V. & Walker, M. (2014). The role of Elders in post-secondary educational institutes. *The Canadian Journal of Native Studies* 34(2), p. 1-18.

Battiste, M. (2002). *Indigenous knowledge and pedagogy in First Nations education. A literature review with recommendations.* Ottawa, Ontario: Indian and Northern Affairs Canada (INAC). Retrieved from http://www.usask.ca/education/documents/profiles/battiste/ikp_e.pdf

Camosun College. (2018). *Whitehorse Field School.* Retrieved from http://camosun.ca/learn/programs/nursing/what-youll-learn/yukon-field-school.html.

Council of Yukon First Nations. (n.d.). *First nations' final agreements.* Retrieved from https://cyfn.ca/.

de Leeuw, S., Lindsay, N.L. & Greenwood, M. (2015). Rethinking determinants of Indigenous peoples' health in Canada. In M. Greenwood, S. de Leeuw, N. Lindsay & C. Reading (Eds.), *Determinants of Indigenous Peoples' health in Canada. Beyond the social.* Toronto, Ontario: Canadian Scholars' Press.

Hanson & Associates/Malloch Graham & Associates Management Consultants. (2001). *Nursing human resources demand and options for supply: phase two: nursing program feasibility study.* Whitehorse, YT: Yukon College.

Martin, D. H. (2012). Two-eyed seeing: a framework for understanding Indigenous and non-Indigenous approaches to Indigenous health research. *Canadian Journal of Nursing Research,* 44(2), 20-42. Retrieved from http://cjnr.archive.mcgill.ca/article/view/2348/2342

McGibbon, E., Mulaudzi, F.M., Didham, P., Barton, S. & Sochan, A. (2014). Toward decolonizing nursing: the colonization of nursing and strategies for increasing the counter-narrative. *Nursing Inquiry,* 21(3). Retrieved from https://repository.up.ac.za/dspace/bitstream/handle/2263/49265/McGibbon_Toward_2014.pdf?sequence=1

Pete, S., Schneider, B. & O'Reilly, K. (2013). Decolonizing our practice – indigenizing our teaching. *First Nations Perspectives,* 5(1). 99-115. Retrieved from http://www.mfnerc.org/wp-content/uploads/2013/04/Section6_Decolonizing-Our-Practice-Indigenizing-Our-Teaching.pdf

Pringle, D., Green, L. & Johnson, S. (2004). *Nursing education in Canada: historical review and current capacity.* Ottawa, Ontario: The Nursing Sector Study Corporation. Retrieved from https://www.nurseone.ca/~/media/nurseone/page-content/pdf-en/nursing_education_canada_e.pdf?la=en

Sidney, A. (2015). The Story of Kaax'achgook. *Northern Review* (2). Retrieved from http://journals.sfu.ca/nr/index.php/nr/article/view/335

The Council for Yukon Indians. (1973). *Together today for our children tomorrow.* Brampton, Ontario: Charters Publishing Company Limited

Truth and Reconciliation Commission of Canada. (2015). *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada.* Truth and Reconciliation Commission of Canada. Retrieved from

http://www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf

Yukon Bureau of Statistics. (2017). *Population report second quarter,* 2017. (Info sheet no. 60-October 2017). Retrieved from http://www.eco.gov.yk.ca/stats/pdf/populationJun_2017_R.pdf.

Yukon College. (n.d.). *Yukon First Nations Core Competency.* Retrieved from https://www.yukoncollege.yk.ca/yukon-first-nations-core-competency

Yukon College. (2016). *Institutional self-study submission to the campus Alberta quality council.* Whitehorse, YT: Yukon College.

Yukon College Act. (2002). Retrieved from http://www.education.gov.yk.ca/pdf/policies/yukon_college_act.pdf

40. Off-Campus Nurse Education – Education Model Impacting Regional Health Care Services in Finnish Lapland

SIRKKA SARANKI-RANTAKOKKO, EIJA JUMISKO, AND OUTI HYRY-HONKA

During the years 2015–2018, Lapland University of Applied Sciences executed a project called Off–Campus Nurse Education. The aim of the project was to experiment an education model that responds to the shortage of nurses and the need to develop nursing in sparsely populated areas of the Finnish Lapland. This article describes the regional impact of the project. The data was collected from students, working life representatives, teachers and the project coordinator, and the project manager. The project promoted reform of working life and the development of an education model integrated to working life. The project improved the career development opportunities of nursing staff and the availability of nurses in the region.

Key Terms: regional impact, nursing education, blended learning, distance education

Becoming a Nurse Outside the Campus Area – Impact of the Project

This article examines the impact of the *Becoming a Nurse Outside the Campus Area* project funded by the European Social Fund (ESF). The goal of the project was to experiment and investigate an education model created during a preliminary study (Mikkola, Saranki-Rantakokko & Paldanius, 2013). The model was created to respond to the shortage of nurses, and to conduct research and development pertaining to the needs of nursing. The education model differs from previously implemented nursing education in that the education was coordinated regionally by a teacher and implemented in local learning environments, where on-the-job learning was guided by trained mentors. Furthermore, the education was completed in constant dialogue with working life (Hyry-Honka, Jumisko & Saranki-Rantakokko, 2016; Mikkola et al., 2013). At the beginning of the chapter, we present the background for close cooperation with working life and methods for evaluating the impact of an education model. The results consist of a description of the experiences from students, working life representatives, teachers, the project coordinator, and the project manager concerning the students' bachelor theses and the education model as a whole.

Close Cooperation with Working Life

The mission of Universities of Applied Sciences (UAS) is to provide higher education for professionals, based on the requirements of working life and its development on the premises of academic research and education. The faculty members of UAS shall also carry out applied research, development, and innovation activities that serve education in UAS, promote industry, business, and regional development (Ministry of Education and Culture, 2014).

According to the government programme of Finland, the country's competitiveness is built on high expertise,

sustainable development, and open-minded reform. Learning environments have been modernized and the opportunities offered by digitalization and new pedagogical approaches are grasped. A further goal is to promote the dialogue between educational institutions and working life, and to improve the quality and impacts of research and development activities (Government Programme, 2015).

The main regional impact of the education provided by the Lapland UAS is the production of workforce required by the area's business and public sectors, and safeguarding and developing professional competence. This includes the development of education models that enable studying outside the campus area.

Impact of the Education Model

In the literature, the impact of education means the development of individuals or communities in a desired direction. It is learning outcomes and long-lasting effects of knowledge gained from training. Similarly, it is responding to the needs of communities and society. In addition, impact is about demonstrating how society utilizes the skills available (Aistrich, 2014; Raivola, 2000). The impact is measurable, for example, from employment or career prospects of the students or from the development of working life through the learning task.

According to Saari, Hyytinen, and Lähteenmäki-Smith (2008), new thinking models and (expansive) learning are at the core of evaluating impact. Completed projects are the targets of evaluation, and project researchers or operators act as the evaluators. Attention is focused on impacts from the perspective of the project's target group and societal interest groups (Norontaus, 2016; Rajahonka, 2013; Saari et al. 2008).

Discussions in the bachelor theses' presentation seminar and the students' written reports of their learning process were used in order to collect data for evaluation of the impacts of the bachelor theses to working life. Seven nursing students, who completed their studies in the autumn of 2017, participated in the seminar and reflected on their learning experiences in written reports. In addition, working life representatives (n=11), teachers (n=2), the project manager (n=1), and the project coordinator (n=1) participated in the seminar. The second author wrote notes about the discussions during the seminar. The first author interviewed the project manager and the project coordinator in order to collect data for evaluation of the project's impact as a whole. The project manager and the coordinator were interviewed together. The authors analyzed the seminar notes, students' written reflections, and the interview by inductive qualitative content analysis (cf. Tuomi & Sarajärvi, 2009).

Theses Focusing on Working Life

The students came up with the topics of their theses together with working life representatives, fellow students, teachers, the project coordinator, and the project manager. Some of the theses developed staff introduction processes and materials. A care plan process for a psychiatric client was also developed. One thesis investigated nurses' experiences on the reform of emergency nursing. The theses also included a study where the student created a plastering guide for bone fracture patients.

The students experienced that the thesis process improved their time management skills and their ability to withstand stress. In particular, students' skills in retrieving evidence-based information and its critical evaluation were improved. Working on their theses opened up new perspectives and expanded their understanding of continuous self-development. Similar student experiences on thesis projects have been described in various studies (Lundgren & Halvarsson, 2009; Lundgren & Robertsson, 2013).

The results of the theses were adopted at workplaces. More extensive utilization of the theses' results and new topics for development work were discussed. Coordinating development work groups promoted the students' professional growth. The theses had a positive effect on the students' employment.

Project Operators' Evaluation of the Project's Impact

The project manager and the coordinator operating in the area evaluated the impact of the project in December 2017. Processes and environments that support learning were created during the project. Students were guided based on their individual needs. Mentoring and learning tasks united the students and mentors into communities. The nurse training curriculum was supplemented with regional competence requirements, which were investigated in the health centres in Lapland in the preliminary study before the project (Mikkola & al., 2013). In practice, students together with the working life representatives and teachers defined their personal learning goals in the practical nursing context based on the general objectives of the nursing curriculum in the Lapland University of Applied Sciences (SoleOPS, 2018).

According to the project coordinator and manager, a new kind of connection was created between education and working life. The partnership and expertise between teachers, nursing staff, and students deepened when they reflected on connections between theory and nursing practice. Members of the Lapland Hospital District, local municipal actors and education representatives planned and built the new learning environments together. These actions contributed to mutual learning. All of the students who graduated were offered nursing jobs. Education led to the development of new thinking models and unified the practices of various units.

Conclusion

The *Becoming a Nurse Outside the Campus Area* education education model is an effective way of shifting the focus of education away from the institute and into working life. It produces new kinds of guidance models and learning environments and supports the reform of working life and education. The education model helps create an atmosphere that supports learning and activates professional discussion among staff, which promotes the development of practices. The education model ensures the availability of a workforce in the entire area and creates career opportunities for nursing staff. The education model support lifelong learning principals and can be transferred to various work communities and organizations.

References

Aistrich, M. (2014). *Kannattaako vaikuttavuutta yrittää mitata? (Is it worth trying to measure impact?)* Retrieved from https://www.sitra.fi/artikkelit/kannattaako-vaikuttavuutta-yrittaa-mitata/.

Government Programme (2015). *Finland, a land of solutions Strategic Programme of Prime Minister Juha Sipilä's Government 29 May 2015.* Government Publications 12/2015. Retrieved from http://valtioneuvosto.fi/documents/10184/1427398/Ratkaisujen+Suomi_EN_YHDISTETTY_netti.pdf/8d2e1a66-e24a-4073-8303-ee3127fbfcac

Hyry-Honka, O., Jumisko, E., & Saranki-Rantakokko, S. (2016). Off-Campus Nurse Education Supported by On Site Mentoring. *The Northern Review* 43, 23–38. Retrieved from http://journals.sfu.ca/nr/index.php/nr/article/view/589.

Lundgren, S.M., & Halvarsson, M. (2009). Students' Expectations, Concerns and Comprehensions when writing Theses as part of their Nursing Education. *Nurse Education Today* 29, 527–532.

Lundgren, S.M., & Robertsson, B. (2013). Writing a Bachelor Thesis generates Transferable Knowledge and Skills useable in Nursing Practice. *Nurse Education Today* 33, 1406–1410.

Mikkola, A., Saranki-Rantakokko, S., & Paldanius, A. (2013). *Sairaanhoitajaksi kampusalueen ulkopuolella (Becoming a nurse outside the campus area).* Kemi-Tornio University of Applied Sciences, Reports and publications 20/2013. Kopijyvä.

Ministry of Education and Culture (2014). *Universities of Applied Sciences Act 932/2014 (Amendments up to 563/*

2016 included). Translation from Finnish Legally binding only in Finnish and Swedish, Finland. Retrieved from https://www.finlex.fi/en/laki/kaannokset/2014/en20140932.pdf.

Norontaus, A. (2016). *Oppisopimuskoulutus yritysten tuottamana koulutuspalveluna: tavoitteista vaikutuksiin* (*Apprenticeship Training as a Training service provided by Companies: from goals to impacts.* Doctoral dissertation). Lappeenranta University of Technology. Juvenes Print Lappeenranta.

Raivola, R. (2000) Käsitteet, mallit ja indikaattorit koulutuksen tehokkuutta ja vaikuttavuutta arvioitaessa (Concepts, models and indicators in evaluation of education efficiency and impacts). In R. Raivola (Ed.), *Vaikuttavuutta koulutukseen Suomen Akatemian koulutuksen vaikuttavuusohjelman tutkimuksia (Impact for Education. Studies on the Effectiveness programme of the Academy of Finland*). Academy of Finland Publications 1/2000. Helsinki: Edita.

Rajahonka, M (2013). Hyvinvointipalveluiden vaikuttavuus–caseja ja keinoja. Impacts of wellness services – case studies and methods (a review). In Kolmas lähde (Ed.) *Vuorovaikuttamisesta vaikuttamiseen (From Interaction to making an Impact*). Aalto University, School of Business, Small Business Center. Retrieved from https://www.jamk.fi/globalassets/tutkimus-ja-kehitys–research-and-development/tki-projektien-lohkot-ja-tiedostot/kevat/ajankohtaista/41656_kolmas_lahde_vuorovaikutuksessa_vaikuttamiseen_2013.pdf

Saari, E., Hyytinen, K. & Lähteenmäki-Smith, K. (2008). Kehittävä vaikuttavuusarviointi menetelmänä tutkimus- ja kehitystoiminnan suuntaamisessa ja oppimisessa (Developmental Impact Evaluation as a Method of Facilitating R&D Operations and Learning). *Hallinnon tutkimus* 1, 35–48.

SoleOPS (2018). *Curricula: Lapland University of Applied Sciences 2015-2016.* Retrieved from https://soleops.lapinamk.fi/opsnet/disp/en/ops_KoulOhjSel/tab/tab/sea?koulohj_id=7198961&ryhmtyyp=1&lukuvuosi=4455279&stack=push.

Tuomi, J., & Sarajärvi, A. (2009). *Laadullinen tutkimus ja sisällönanalyysi (Qualitative research and content analysis*, 6th ed.) Helsinki: Tammi.

41. Health Research and Health Professional Education in Greenland

GERT MULVAD

Communities in Greenland continue to encounter significant challenges in healthcare, including a critical shortage of health professionals (nurses, doctors, etc.), a lack of well-trained health workers from the North, recruitment problems, unfilled positions, continuity and responsibility, and cultural barriers. Building local capacity through the University of Greenland is an important step to addressing these challenges. In response, higher education has been actively developing programs over the past decade to address these challenges, of which three are demonstrating notable success: 1) specialist education for Medical Doctors, 2) nursing education, and 3) the creation of the Greenland Centre for Health Research. In this chapter, I will describe each of the programs, outline their successes, and the future direction for these programs in order to continue build capacity.

First, doctors working in northern hospitals and health centers are regularly confronted with problems and situations that are not a part of their university medical education. The *Specialist Education for Medical Doctors in Greenland as General Practice* is a supplementary educational program that focuses on the health and wellbeing of residents in the circumpolar region, health culture, and the delivery of health care and wellbeing services in the North to strengthen the skills of physicians wishing to work in Arctic hospitals. The program is offered at the Nuuk hospital and provides doctors an additional five years in specialized training to become doctors with a specialty in family medicine. Specifically, medical doctors have to stay 2½ years at two different District Centre in Greenland, and 2½ years in different specialist departments at the National Hospital in Nuuk. More than 30 doctors have had a five-year contract with the Greenland Health System for training as specialists in General Practice. Around 50% of the Medical Doctors in Greenland with a permanent employment are educated under this program.

Greenland is further using a novel approach to keep — and educate — doctors in Greenland. Specifically, the specialist training program offers students an opportunity to study with specialists at the Nuuk hospital, instead of remaining in Denmark. Greenlandic medical students study at universities in Denmark. After those students finish their eight years of studies, they are encouraged to return to Nuuk to continue their specialized training, instead of receiving their training in Denmark. This has been helpful to combat brain drain and to provide better mental health services to Greenland's residents. In particular, it has been observed that after Greendlandic medical students spend six months of their five-year training program in the mental health unit, they provide better mental health services to patients.

The University of Greenland has also offered a nursing education program for many years. The nursing program constitutes a four-year bachelor's degree and it alternates between theoretical and practical studies, where practical and clinical education accounts for approximately 1/3 of the content. The main subject in the theoretical part is nursing. In addition, there are subjects from health, natural, human, and social sciences. The clinical studies are a long-term course in health care in Greenland. Nursing students gain experience at Queen Ingrid Hospital in Nuuk, in the hospitals and health centers, and in villages at nursing homes on the coast around Greenland. Nurses are recruited from the high schools in Greenland with a possible uptake of 14 students. Every year, 8-10 nursing students graduate. Since the start of the of the Nursing education program in Greenland, more than 150 have graduated and more than 90% of the nurses are still working in Greenland.

Finally, the University of Greenland is increasingly approaching research as a means to building capacity. The Greenland Centre for Health Research was established in 2008 and became connected to University of Greenland in 2013. The vision for the Centre is to improve the health status in Greenland through initiation and coordination of health research; facilitate exchanges; disseminate and apply scientific knowledge; create national and international networks; build local capacity through mentoring and PhD programs; and improve community involvement and local partnerships. PhD courses have been completed from Greenland Centre for Health Research include: 1. Research and Communication; 2. Health, Society and Environment in Relation to Large-Scale Industrial; 3. Ethics in small population; 4. Research

method in small population; and 5. Research Cohort, Reproduction and Environmental Health, Community Involvement, Population Trends across the Arctic, Multidisciplinary Research.

Moreover, the Greenland Centre for Health Research has agreements with 7 professors, which all have been involved with health research in Greenland for more than 10 years and their research cover a broad perspective of health research, including: infectious diseases, diabetes, environmental medicine, health and population survey, health cohort, patients with chronic disease and their relatives in relation to their everyday life and rehabilitation, and ear diseases and hearing problem among children. At the moment, five PhD students are enrolled at the Centre and they have a network and collaboration with PhD students at Universities in Denmark working with Health Research in Arctic.

In addition, the Greenland Centre for Health Research focuses on network-building between universities in the Arctic region through UArctic Thematic Networks. The mission of the Network on Health and Well-being in the Arctic is to improve the sustainable development of health and wellbeing in circumpolar regions by promoting research projects on health people, and by organizing research training and distributing scientific information. The main task of the network is to increase the quantity and quality of scientific research carried out at the circumpolar area by the means of the graduate school, and the international Master and PhD programs for Circumpolar Health and Wellbeing.

In conclusion, education for all levels of personnel working in the health system have been given high priority. Living in a country with 56,000 inhabitants, we still have to recruit personnel from abroad, especially highly educated personnel. To also focus on the attainment of high education by our own citizens will have a huge impact at the development of the health system and the development of society over time.

42. Northern Partnership between Two Schools of Nursing in Norway and Canada: A Historical Perspective

PERTICE MOFFITT AND GRETE MEHUS

In nursing curricula around the world, educators are recognizing the need to develop undergraduate nurses as global citizens. This occurs in both developed and developing countries in a milieu of collaboration, partnership, and relationship between institutions offering undergraduate programs. The aim of this chapter is to highlight a partnership between two schools of nursing in northern regions of Norway and Canada. This partnership is unique because of the circumpolar locations of each school and their rural and remote practice setting. This chapter will highlight the journey of two nurse educators as they engage and develop a collegial relationship between their two facilities. The narrative begins with an initial student exchange from northern Canada to northern Norway, continues with shared lecturing and/or presentations in the host country, and carries on with scholarship and research activities. The benefits of the collaboration and partnership are a shared understanding of what it means to live and work in rural and northern locations. Working together for innovative education and nursing practices enhances global citizenship for both students and faculty. The informal partnerships are as beneficial as formal partnership. This chapter shares some living conditions and histories of colonization of Indigenous peoples. Through our understandings of these histories, we can create meaningful ways to reframe past grievances towards more positive and equitable negotiations.

Key Terms: partnership, collaboration, rural and remote, circumpolar, nursing education

Introduction

In 2009, a nurse educator and an international liaison of Finnmark University College, Norway travelled to northern areas of Canada in search of exchange opportunities for their students. One of the sites they selected was Aurora College in Yellowknife, Northwest Territories. Interest in student exchange in a circumpolar setting was appealing to faculty in both schools. Our collaboration, beginning almost a decade ago, started with an undergraduate student exchange, then continued with graduate rural and remote education, and has culminated to an evolving shared research partnership. Each of these initiatives will be described briefly in this chapter ending with benefits and challenges within the partnership.

Background

Aurora College School of Nursing

Aurora College is a decentralized postsecondary institution located in the Northwest Territories (NWT), Canada. The college has three campuses located in Inuvik, Fort Smith, and Yellowknife, and 23 Learning Centres scattered in communities across the North. The nursing program is located in Yellowknife at the Yellowknife/North Slave Campus. The program began in 1994 as a three-year diploma nursing program and was enhanced to an undergraduate university program with intake beginning in 2002. The annual intake of students is approximately 30 and there are approximately 80 to 100 full-time students on campus. The Bachelor of Science in Nursing (BSN) curriculum was developed in collaboration with several schools of nursing from British Columbia. Aurora College was part of the Collaborative Nursing Program (CNP), which was later renamed the Collaboration for Academic Education in Nursing (CAEN) Program, from 2001 to 2012. When the collaboration dissolved, three colleges from British Columbia and Aurora College remained in partnership with the University of Victoria and continued to share a concept-based curriculum. All four years of the nursing program are taught on site in Yellowknife.

Students in the nursing program attend classes on campus and complete practicums in local agencies (hospital acute and chronic care, home care, public health). The majority of their clinical experience is acquired at a 100-bed regional hospital in Yellowknife. Because nurses provide care to a diverse population with a major Indigenous component, students are provided with a course about Indigenous People of the NWT and attend cultural camps where they learn about Indigenous beliefs and practices. Theoretical perspectives and philosophies are geared to rural and remote, Indigenous, and contemporary ontologies, and are conceptually threaded throughout the curriculum.

The Arctic University of Norway, School of Nursing in Hammerfest

The school of nursing in Hammerfest was established in 1960. During a period of 53 years, it has expanded and merged twice. First, it merged with the Finnmark University College in 1994, and then with the University of Tromsø, The Arctic University of Norway (UiT), in 2013. This university's main site is located in Tromsø, which entails approximately a 40-minute flight from Hammerfest. The school of nursing is now merged with the Department of Health and Care Sciences, Faculty of Health.

The university has ten campuses located in the three most northern counties in Norway and Svalbard, which is an archipelago north of Norway. Four of the campuses deliver nurse education; two of them use the same three-year bachelor program and curriculum. In 1960, the school had approximately 20 students each year. Today, the annual intake of students is 80 each year. In addition, the school has approximately 25 students in a decentralized nursing program every second year, located outside the campus. Internet and skype are used for educational purposes and meetings. Fifty percent of the program is practice. Students have to travel and stay outside the campus for six to ten weeks, practicing both in local hospitals in Hammerfest and Kirkenes, Finnmark (approximately 53 and 85 beds), and in homecare and elderly centers in the municipalities. Many of the students stay in Finnmark after their graduation, despite the fact that it is located in a remote and rural area (Nilsen, Eriksen & Huemer, 2012). Our theoretical perspectives today were not mirroring rural aspects of nursing or the fact that Norway has a Sámi population (approximately 40,000 – 60,000 people). The school has started to integrate Sami perspectives in the bachelor curricula since the inclusion was random in the past (Eriksen, Bongo & Mehus, 2017). Rural nursing perspectives, inspired by the colleagues in Yellowknife, Canada, have been included as well. In 2015, the school started the first specialization in Rural Nursing in Norway (which has a yearly intake) as a component of the Master of Science in nursing program. Thus far, twenty-five students have passed with this distinction.

Nursing Student Exchange and Global Citizenship

Burgess, Reimer-Kirkham and Astle (2014) described global citizenship with student exchange to low income countries as a means of social responsibility and social justice. They explicated themes of global awareness, global engagement, and global citizenship and social justice that explained student motivation for the international exchange in low income countries. Although we are discussing student exchange in developed countries, both Norway and Canada share a history of colonization of Indigenous people living in our circumpolar regions. Social responsibility and social justice expressed through awareness, engagement, and social justice are significant principles for both Canada and Norway, as we begin our processes of peace and reconciliation for equitable and reciprocal relationships with Indigenous people. We contend that student exchange between our schools provides students with insights and knowledge leading to cultural safe practices.

Nursing student exchanges between developed countries are an opportunity for personal and professional development (Button et al., 2005; Kent-Wilkinson et al, 2012) In particular, nurses learn about diversity, and cultural similarities and differences. They learn about values and beliefs that inform health care delivery systems and broaden their knowledge of nursing practice approaches. Intercultural sensitivity is also learned by faculty who become tutors for students from away (Koskinen & Tossavianen, 2003).

Undergraduate Student Placement and Exchange

Although Finnmark College was placing students in Russia, Scandinavia, and other parts of Canada, student exchange and placement was a new initiative for Aurora College. There were no international department at the school, or existing policies or procedures, resulting in a limited sense of what a nursing student exchange entailed. The Arctic University of Norway, School of Nursing in Hammerfest did have a circumpolar connection as a member of the University of the Arctic, which is an education network for northern regions of the world.

The nursing programs did not align in terms of student placement. In the Northwest Territories, theory is integrated with practice, so students spend two days a week in nursing practicum and the other three days in class. At the end of each year, there is a consolidated practice that is 6 weeks in duration. In Finnmark County, the students have theory front-loaded, then a blocked approach to nursing practice is used. For the Canadian students, the time of year that best accommodated Norwegian student needs was the spring consolidated practice (May/June).

Planning between the two schools began; and after many online meetings, a memorandum of understanding was created and implemented. Aurora College developed a selection process for students going abroad. Specifically, at the beginning of the school year, Aurora College nursing students were informed of the opportunity and were advised of the application process. Students interested in international placement were required to submit a formal request to the International Placement Coordinator in Yellowknife; write a letter of interest; submit their academic transcript; and provide names of references. A selection committee was struck and six applications were received. Four students were selected to go to Norway with the first author accompanying the students. The Aurora College School of Nursing then began to fundraise in earnest. It also approached the Institute for Circumpolar Health Research for funding assistance and they provided the students with travel bursaries.

Prior to the travel to Norway, students participated in a week of orientation and preparation. Karen Binder, a graduate from the Beaufort Delta region, had an important Sami connection. Her mother was Sami from Kautokeino, Norway. She came to Canada with her father when reindeer herds were introduced to the Canadian Arctic and today, her brother manages a reindeer herd in Inuvik. Reindeer herding is a way of life in Northern Norway. She presented to students about northern Norway, Sami people, and her perspectives of how to prepare for their travels.

Since the Aurora College School of Nursing was the new partner in the process, it relied on their Norwegian colleagues to advise on the model that should be used. Both parties agreed upon a Canadian student being buddied with a

Norwegian student and supervised by a Registered Nurse at the hospital in Hammerfest. This preceptor and buddy model worked very well. The students provided care in the hospital on the medical and surgical units. They did not document their nursing care since charting was in Norwegian and record keeping was electronic. Instead, they reported their care to the RN. Faculty member, Pertice Moffitt, visited the first group of students in the hospital and found that the scope of practice, in terms of physical assessment was quite different. Norwegian students were focused on patient symptomology, while in Canada, students learned and practiced physical assessment. The second group of students who went to Norway were connected to the Canadian liaison via skype, rather than in person.

In Hammerfest, both students and faculty were introduced to the Norwegian health care system whereby similarities and differences were highlighted, in terms of nursing care, hospital policies and procedures, the community and its history, and the culture of the people. Students listened to lectures and visited facilities. Norwegian faculty provided a guided tour through northern Norway where students learned of the effects of WWII, saw remnants of a hospital built by the Germans, and learned of the evacuation of the community when the community was burned to the ground, the animals were killed, and the people were deported to the south.

Two groups of students travelled to Norway, with the first four visiting in 2010 and the next four visiting in 2012. Then there was a lapse in exchange, while both schools transitioned into new collaborations. When the School of Nursing in Hammerfest became affiliated with UiT, an international liaison in Tromsø assumed responsibility for all four sites in Northern Norway. In 2016, the first three students from Norway experienced placement in Yellowknife at Aurora College. Each semester since that time, Aurora College has accepted exchange students and there are plans in place in 2018 for Canadian students to go to Tromsø, Norway. In Canada, the second year Norwegian students were oriented to the Canadian health care system, the integrated nursing programme, and the hospital. Before beginning their practicum, they were given a one-day physical assessment review. They were set up in a preceptorship with RNs and under the supervision of Aurora College's International Student Coordinator. They toured two remote communities, visited nursing stations, and then were able to spend a few days in a remote community.

Graduate Rural and Remote Education

Scholarship was integral to the collegiality between the two schools. The schools took every opportunity to network both personally and professionally, support each other, build the relationship, and together create and enhance new programs in each other's institution. When Norwegian faculty came to Yellowknife, they were introduced to the NWT health delivery system, Aurora College's nursing curricula, and the culture of the Canadian North. In Hammerfest, Canadian faculty was similarly introduced to Norway.

While in Yellowknife, the second author shared her doctoral research on snowmobiling safety in northern Norway with a lecture open to the public at the Prince of Wales Museum (Mehus, Germenten & Henriksen, 2012). There was a great deal of interest in her topic as snowmobiling is a way of life in both jurisdictions. In a similar fashion, with the establishment of the rural and remote master's program in Norway, the first author provided lectures to the students. Most of the lectures occurred over skype and were provided in English; however, the guest lecturer role began for the Canadian faculty with a road trip from Oulu Finland to Hammerfest Norway. When the International Circumpolar Health Conference was held in Oulu Finland in June 2015, both authors attended and gave oral presentations. The Canadian faculty extended their visit to Europe and travelled by car with their Norwegian colleagues back to Hammerfest. A professional development excursion was planned to London, England. The first author provided a lecture on rural and remote nursing practice in Canada to the group of Norwegian nurse educators in Hyde Park. In addition, both authors, along with Norwegian graduate students and faculty, conducted an educational retreat on a remote Island in northern Norway, Rolvsøy. We read each other's papers and provided feedback. Thus, the relationship building so important to collegiality and international exchange was created (Ryan-Krause, 2016; Sochan, 2008).

Shared Research Interests and Activities

Throughout our meetings and gatherings, we shared our research interests in Indigenous, circumpolar and rural and remote health. We collaborated on a research project about Sami experience of the Norwegian healthcare system, highlighting principles of cultural safety (paper was accepted July, 2018 and will be published in Spring, 2019). We met for data analysis in Guovdageaidnu (Sami name for Kautokeino), Norway in the home of our research team member, Berit Andersdatter Bongo. On her kitchen table, we conducted a thematic analysis reviewing documents that were translated first in Sami, then in Norwegian and English. We attended the Arctic Indigenous Education Conference (AIEC) held during that time March 2016 where the focus was on language revitalization. Furthermore, we are writing research grants together to continue our partnership and enhance our schools' global citizenship.

Conclusion

This chapter highlights the journey of two nurse educators from different circumpolar countries with a common goal to create opportunities for faculty and students to enhance their knowledge, skills and capabilities as global citizens. As global citizens and nurses, we shared our knowledge to learn from each other about health care issues in our countries, our cultures, and our personal and professional lives. These activities afforded us professional development, enhanced our capacities in international scholarship, and generated global nursing knowledge and curricula for both schools. We experienced many similarities related to rural nursing practice, teaching practices in rural communities, Indigenous people's challenges, rurality and "small place's sociology." For nursing students, a circumpolar exchange enhances their cultural awareness of peoples who live in the most northerly countries of our world; they expand their knowledge of social, political, and historical contexts that exist in other circumpolar countries; and, they appreciate the differences and similarities of health care delivery systems. Students and faculty develop cross-cultural communication skills and abilities that are an important asset for future international work. Despite the fact, that we are living on two different continents, it is like coming home when we visit each other's places. We recommend that other education institutions across the circumpolar world connect through research, visiting lecturing and student exchange to further global citizenship within their education programs.

Additional Exercises

Immonen, I., Anderssen, N., & Lvova, M. (2008). Project work across borders in the arctic Barents region: practical challenges for project members. *Nurse Education Today*, 28(7), 841-848. doi:10.1016/j.nedt.2008.02.01

Leh, S.K., Robb, W.J.W., & Albin, B. (2004). The student/faculty international exchange: responding to the challenge of developing a global perspective in nursing education. *Nursing Education Perspectives*, 25(2), 86-90.

Kokko, R.(2011). Future nurses' cultural competencies: what are their learning experiences during exchange and study abroad? A systematic literature review. *Journal of Nursing Management*. doi: 10.1111/j.1365-2834.2011.01221.x

References

Burgess, C.A., Reimer-Kirkham, S., & Astle, B. (2014). Motivation and international clinical placement: shifting nursing students to a global citizenship perspective. International Journal of *Nursing Education Scholarship*, 11(1), 75-82.

Button, L., Green, B., Tengnah, C., Johansson, I., & Baker, C. (2005). The impact of international placement on nurses' personal and professional lives: a literature review. *Journal of Advanced Nursing*,50(3), 315-324.

Eriksen, L., Bongo, B.A., & Mehus, G. (2017). Urfolksperspektiv I utdanning. Sykepleierutdanninger I Norge uten urfolkskunnskap? [Indigenous perspectives in education. Nurse education in Norway without knowledge about indigenous peoples?] *Nordisk sygeplejeforskning [Nordic Nursing Research]*7(4). Retrieved 22.1.18 http://www.idunn.np/nsf/2017/03/urfolksperspektiv_i_utdanning

Kent-Wilkinson, A., Starr, L., Dumanski, S., Fleck, J., LeFebre, A., & Child, A. (2010). International nursing student exchange: rural and remote experiences in Australia. *Journal of Agromedicine*, 15, 58-65. doi:10.1080/ 10599240903389672

Koskinen, L., & Tossavainen, K. (2003). Relationships with undergraduate nursing students. *Journal of Advanced Nursing*, 41(5), 499-508.

Mehus, G., Germeten, S., & Henriksen, N. (2012). How young people communicate risks of snowmobiling in northern Norway: a focus group study. *International Journal of Circumpolar Health*, 70, 205-214.

Mill, J.E., Younge, O.J, & Cameron, B.L.(2005). Challenges and opportunities of international clinical practica. *International Journal of Nursing Education Scholarship*, 2, Article 18. Retrieved from ttps://www-degruyter-com.ezproxy.library.uvic.ca/downloadpdf/j/ijnes.2005.2.1/ijnes.2005.2.1.1119/ijnes.2005 .2.1.1119.pdf.

Nilsen, F., Huemer, J., & Eriksen, L. (2012). Bachelor studies for nurses organized in rural contexts- a tool for improving health care services in circumpolar region? *International Journal of Circumpolar Health*, 7(1). doi: 10.3402/ ijch.v71iO.17902

Ryan-Krause, P. (2016). Short term global experiences: reflections, themes and implications. *Journal of Nursing Education*, 55(7), 379-384.

Sochan, A. (2008). Relationship building through the development of international nursing curriculum: a literature review. *International Nursing Review*, 55(2), 192-204. Doi : 10.1111/j.1466-7657.2007.00595.x

43. Theme V Reflection Questions

1. How do nursing and other health providers' roles differ in rural northern communities compared to southern and urban contexts?
2. Imagine you have accepted a health care position in a northern or Indigenous community that you are not from. What steps might you take to become familiar with community practices and expectations? What will you do if they are different from your own?
3. What precautions should you take to ensure your own safety while practicing under the unique conditions of rural or remote health care delivery? What precautions should you take to ensure your clients' safety?

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