Using Postcolonial Theory and a Cultural Safety Orientation to Understand Inuit Perspectives of Public Health TB Policy and Practice in Nunavut

by

Donna Beverly McKee

B.A., University of Guelph, 1986

B.N. University of New Brunswick, 1995

M.N., University of Victoria, 2005

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Supervisory Committee

Dr. Nancy Clark – Supervisor
Associate Professor,
School of Nursing, University of Victoria

Dr. Marjorie MacDonald – Departmental Member
Professor Emeritus and Adjunct Professor,
School of Nursing, University of Victoria

Dr. Catherine Worthington – External Member
Professor,
School of Public Health and Social Policy, University of Victoria

Abstract

This research sought to understand Inuit perspectives of culturally safe public health tuberculosis policy and practice in Nunavut, Canada. The legacies of colonialism in Canada's arctic north endure as harmful determinants of tuberculosis health, with Inuit of Nunavut continuing to experience inequitable rates of tuberculosis, up to three hundred times higher than Canadian-born non-Indigenous Canadians. Despite many studies investigating tuberculosis among Indigenous peoples, few studies have explored Inuit perspectives related to public health tuberculosis policy and practice. There is also lack of knowledge about what constitutes cultural safety related to TB policy and practice from Inuit perspectives, and thus the systemic issues that prevent Inuit from obtaining TB health services.

Given Canada's colonial history and its impact on Inuit health, a postcolonial theoretical perspective was applied in this research to understand the key research objectives: 1) the factors communicated by Inuit, that would promote culturally safe TB policy and practice with Inuit communities, 2) ways Inuit understand how TB-related stigma shapes Inuit perspectives of public health TB programs and limits their participation, and 3) how Inuit envision mobilizing Inuit knowledge to inform and democratize Government of Nunavut public health policy and programs. Principles of community based participatory action research made space for Inuit voices to be recognized as knowledge holders involved in shaping policy and practice. I applied Inuit Qaujimajatuqangit principles and Inuit Tapiriit Kanatami's research framework as a guide to promote culturally safe process and respect for Inuit self-determination.

Data were sourced from thirty conversational, semi-structured telephone interviews with twenty-five Inuit who were recognized as community knowledge holders, and five health care

professionals, three of whom were Inuit. Respondents were aged between 18-80 years of age, and self-identified as either men or women. Using Braun and Clarke's Reflexive Thematic Analysis, the data were then used to identify and analyze seven themes that Inuit described as necessary for culturally safe public health tuberculosis policy and programs. Recommendations for addressing culturally safe TB policy and programs for Inuit of Nunavut are that: 1) Kablunaaq, non-Inuit, develop trust and respect towards Inuit; 2) Inuit social determinants of health are addressed; 3) TB-related stigma is addressed; 4) Kablunaaq respect the importance of Inuit Shamanism and spirituality; 5) intergenerational trauma informed care is provided; 6) Inuit Qaujimajatuqangit principles are recognised and used to guide health care policy and programs; and 7) Inuktut language can be used in health care. A three member Inuit Research Advisory Committee supported the research process, and after identification of the seven themes in the data, individual discussions were held with the committee members to probe the meanings of the data and ways to use the information that had been shared.

Methodologically, this research demonstrates and advances understandings of the applicability and use of cultural safety as an orientation to guide and inform researchers' epistemological approaches to work with Indigenous peoples. In collaboration with Inuit, this research provides a pathway forward to improvement in the applicability of future public health TB policy and practice for Inuit.

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List of Acronyms

CBPAR	Community-based Participatory Action Research
ICPC	Inuit-Crown Partnership Committee
IQ	Inuit Qaujimajatuqangit
ITK	Inuit Tapiriit Kanatami
NTI	Nunavut Tunngavik Incorporated
OCAP	Ownership, control, access, and possession (First Nations Research Principles)
PHAC	Public Health Agency of Canada
RCMP	Royal Canadian Mounted Police
SDOH	Social Determinants of Health
TB	Tuberculosis
WHO	World Health Organization

Glossary of Terms

Many academic disciplines, including public health, afford critical attention to the impacts of colonization by western powers, and each discipline has its own nuanced definitions of the key terminologies used. To avoid confusion, in this dissertation the sense provided in each of the below definitions is used in discussing structures of social power and violence across the blurred historical periods: of European (predominantly British) colonization of the lands now known as Canada; its aftermath when Canada became an independent nation but continued to carry out practices of colonization of Indigenous lands and people; and the current period in which residues of colonial attitudes and beliefs not only endure but are actively strengthened in neocolonial actions, but only occasionally challenged and deconstructed in overt attempts at decolonization. The definitions endeavour to capture shifting conceptualizations which rightly centre the experiences of colonized peoples. Reflecting on my positionality as a Kablunaaq, I reflect here on the ways that I too am drawn within the words of thinker and racial equity advocate James Baldwin, who wrote of white people, "They[we] are, in effect, still trapped in a history which they[we] do not understand; and until they[we] understand it, we cannot be released from it" (Baldwin, 1963, p. 8). This research seeks to address some elements of white ignorance.

anti-colonialism	a term that describes resistance movements against colonial powers, which seek justice, equality, and self-determination. According to Fanon, anti-colonialism has emancipatory potential in which the colonized subject re-creates himself (1961).

colonization	a series of historical events that were inherently violent invasions, imposed western culture and values, and defined Indigenous peoples as savages who should be assimilated or eradicated as part of the colonial project. Colonization continues to structure and underpin injustices that manifest as inequities including social determinants of health (SDOH), and endures in attitudes and beliefs that devalue others as “less than human” (Allan & Smylie, 2015; Arboleda-Florez, 2002; Smith et al., 2021).
decolonialization	is not only about altering the content but also the terms of the conversation about colonial injustices and effects. It requires change at the epistemic and ontological levels which first requires acknowledging that there are many ways of being and doing and that Indigenous ways of knowing are valued as equal to western approaches to knowledge (Affun-Adegbulus & Adegbulu, 2020; Held, 2019)
distal social determinants of health	the most difficult social determinants of health to change, these are the contexts in which intermediate and proximal determinants are constructed. However, if reshaped they may result in significant changes to health inequities. These determinants encompass colonialism, racism, social exclusion, and self-determination (Greenwood & de Leeuw, 2012).
epistemic violence	as theorized by Gayatri Chakravorty Spivak, epistemic violence is the eradication of local or indigenous knowledge by dismissing, disrespecting, appropriating, or silencing them and instead privileging a more powerful alternative (1985). Building on Spivak, Kristie Dotson "offers an account of epistemic violence as the failure, owing to pernicious ignorance of hearers to meet the vulnerabilities of speakers in linguistic exchanges" (Dotson, 2011, p. 236).
intermediate social determinants of health	those social determinants of health that constitute the origin of proximal determinants and include community infrastructure, health care system and cultural continuity (Greenwood & de Leeuw, 2012).

knowledge holders	community members who offer insider perspectives on Inuit knowledge, Inuit ways of being, and community experience.
lifeways	is an anthropological term which in Indigenous studies conveys more than "worldview" as it also incorporates a sense of social, economic, and religious practices that are carried out in the present and which are consciously and profoundly influenced by the embodied cultural history and practices of ancestors/predecessors. It informs expressions of Indigenous understandings that human-earth-cosmos relationships are interactive and pervasive (Whalen et al., 2022). In many ways the concept of Indigenous lifeways resonates with IQ principles.
neocolonialism	is embodied in forms of ongoing unjust political, social, and economic systems established since colonisation. Considering neocolonialism in public health identifies and exposes the belief that the health concerns of those less economically developed can only be solved by those "white men" who have the required cultural and social assets of value to correct them (Perez-Escamilla & Desai, 2020).
othering/othered	is the Eurocentric conception that humanity is hierarchized and separated into "man" and "the other" with the other referring to racialized people (both men and women) and white women, who are automatically dehumanized and devalued as not fully women or men.
paternalism	occurs when an action is taken towards another individual or group and in which the action is intended by the initiator to benefit the recipient, however the recipient's consent or dissent, is not a relevant consideration for the initiator (Hershey, 1985).
postcolonialism	as espoused by scholars Gayatri Chakravorty Spivak (1985) and Edward Said (1978), postcolonialism is the stance that interrogates the lingering effects of colonialism after the colony has been formally dismantled, the colonizing powers have departed, and the territory is afforded self-governance. It challenges existing assumptions and power structures and seeks to intervene and amplify marginalized viewpoints in a new, independent, nation state (Drew, 2022). When considering Indigenous

	peoples, Indigenous scholar Aileen Moreton-Robinson (2011) highlights that the colonizing settlers did not “go home” and Indigenous peoples remained in a position of being subject to an occupying State. Moreton-Robinson therefore criticizes perspectives that identify postcoloniality as positive, by foregrounding Indigenous people’s enduring subjugation.
proximal social determinants of health	bear direct impact on emotional, spiritual, mental, and physical health of individuals. Included in these are education, employment, and income (Greenwood & de Leeuw, 2012).
syncretism	any attempt to blend or find a single clear system of meaning from distinct—even apparently incompatible—ideologies, epistemologies, and practices. When considered as a constructive, healing action, syncretism can be understood to enable unity in what otherwise appears to be multiplicity and diversity. When taken in the negative, syncretism often represents contamination, particularly by imposition of colonial attitudes or pollution of colonial “purity” by “savage” mysticism (Salamone, 2001). At its best, syncretism allows for harmonization between diverse world views that can allow people to find meaning in changing and challenging circumstances.

Glossary of Inuit Terms

Aajiiqatigiingniq	IQ principle: collaboratively confronting and seeking solutions to issues that threaten social harmony and balance
Angakkuit/Anatquq	is the term for Inuit spiritual leaders who are also seen as healers, and who possess superhuman, mystical abilities.
Apmasuviq	a new word in Inuktitut which is a descriptor that speaks to misconceptions about Inuit culture and the stigmas that are placed on Inuit
Avatimik Kamattairniq	IQ principle: observation, study of the land
Inuit	the people
Inuit Qaujimajatuqangit	IQ principles are reflected in language, values, and beliefs. They are often defined as Inuit knowledges, and encompass values, practices, and ways of being that assist Inuit in their conceptualization of the good life.
Inuk	one individual
Inuktitut	Inuit language
Inunnguiniq	the making of the human being – the period between birth and death
Inuuisqatiginniq	a holistic approach to health or "the way of being a person"
Kablunaaq	non-Inuit
Maligarjuat	big laws – the four laws that inform the IQ principles
Makavik	where you strip
Nuna	the land
Nanuq	polar bears
Nunavummiut	residents of Nunavut
Nunangat	the land of Inuit (in total)
Pijitsirniq	IQ principle: to be willing and able to serve others well
Pilimmaksarniq	IQ principle: building skills and knowledge to become capable

Piliriqatigiingniq	IQ principle: collaborative relationships or working together for a common purpose
Qanuqtuurungnarniq	IQ principle: protecting a child's mind, problem solving
Tuktu	caribou

This glossary is based on Karetak et al., (2017) and Inuktut Tusaalanga (n.d.).

Dedication

This work is dedicated to the memory of those who have suffered, and those who continue to suffer, from tuberculosis, a now preventable and treatable disease.

I especially remember Mary Elizabeth (Wilson) Forsythe and Florence Forsythe, my great-grandmother and aunt from Aghalee, County Antrim, Northern Ireland who died alone, far from family and home in a TB sanitorium.

Your short lives mattered.

You were so very loved.

You have never been forgotten.

And to my grannie, Doreen McKee (currently in her 104th year) and in loving memory of the late Ethan McKee, and the late Wm. James and Isobel Forsythe, I say thank you for teaching me that adversity can be overcome, that strength lies deep within us, and that family and faith are most important.

Acknowledgements

I wish to acknowledge Nunavut. I say thank you for the generosity, honesty, warmth, and laughter shared with me over many years. To those who have guided me and to those who participated in this research, I say with respect *Mat'na* and *Nakurmiik*.

I would like to express my absolute gratitude to my supervisory committee, without whom, I would not have been successful in completing this dissertation. To my committee members, Dr. Marjorie MacDonald and Dr. Catherine Worthington, I say thank you for your investment of time, direction, and support of me. And to my supervisor, Dr. Nancy Clark, I would like to say thank you for all of the time, effort, direction, support, your knowledge, and undoubtedly the stamina, it has taken to bring me to the finish line of my doctoral degree. A heartfelt thank you to you.

To those who have fiercely supported me, you know who you are, and in remembering those who now watch from above, I say a heartfelt thank you. Thank you for: believing in me, understanding my passion, encouraging me to be keep it authentic, laughing with me, praying with and for me, loving on me, teaching me that words hold power, and for pushing me up and over those proverbial and most unexpected mountains I had to climb during this PhD journey.

To my children Hayden, Moyrah, Rhonyn, Shayne, Broghyn, and Tara, the true Northern lights of my life, I say thank you for the privilege and honour of being your Mama. May each of you find your own true north.

And finally, to my parents Ronald and Florence McKee, there are no adequate words to say thank you for your unconditional love, your steadfast encouragement, your patience, your unrelenting support for the children and I, and for being our compass in this everchanging world.

Chapter One: Looking Northwards

1.1. Introduction

Inuit, like other Indigenous peoples globally, continue to be plagued with high a prevalence of TB (Alvarez et al., 2015; Kilabuk, 2019). This is particularly so for Inuit, who have the highest TB prevalence of any Indigenous[1] or non-Indigenous people in Canada, (Public Health Agency of Canada, 2023). In 2018, the rate of TB among Inuit, at 170.1 cases per 100,000, was 290 times higher than among Canadian-born non-Indigenous Canadians who had an incidence rate that year of 0.5 cases per 100,000, indicating that TB had almost been eradicated in the general population (Kilabuk, 2019; Patterson et al., 2018). One medical internist who provides care to the residents of Nunavut, often referred to as Nunavummiut, declared that "there is no clearer evidence of maldistribution of wealth and social services in Canada…than the TB epidemic in the Arctic" (Patterson, 2018). This inequity and the associated high prevalence of TB among Inuit are correlated with poverty, environmental changes, and other social determinants that impact Inuit health and are unambiguously an enduring effect of colonisation of Inuit lands. Colonialism was, and endures in, the imposition of policies and practices that sought to appropriate land and eradicate the cultures, values, traditions, knowledges, and skills that constituted Indigenous ways of being for thousands of thousands of years (Nowosad, 2023). Inuit remain collectively, a unique people living in a unique environment under unique situations.

[1] "Indigenous Peoples" is a collective term used to describe the original peoples of the world. There are three recognized groups of Indigenous Peoples in Canada: First Nations, Métis, and Inuit. Each group has their own distinct languages, cultures, customs, and beliefs (Inuit Tapiriit Kanatami [ITK], 2018b).

TB remains an ongoing global public health emergency despite more than a decade having passed since it was the first infectious disease that the World Health Organization (WHO) classified as a global health emergency (Rasanathan et al., 2011). In any context, efforts to eradicate TB are challenging because it is the "social disease, the disease of poverty, with medical consequences" (Jetty, 2020, p. 2). WHO reports that approximately 1.5 million deaths a year are attributed to TB, making it the 13th highest cause of death globally (WHO, 2021b). It was second only to the COVID-19 virus, in deaths attributed to infectious diseases in 2020, a year in which approximately ten million people contracted TB globally (WHO, 2021b). The burden and current state of TB found within Indigenous populations across more than 70 countries is not accurately known due to poor data collection practices on TB and Indigenous health (Halseth & Odulaja, 2018; Hargreaves et al., 2011; ITK, 2018b; Kim, 2019; Patterson et al., 2018).

For Inuit of Nunavut the medical consequences of TB can be framed within a Social Determinants of Health (SDOH) perspective which includes proximal factors (e.g., stigma, trauma, and mental or spiritual distress), medial factors (e.g., poor living conditions, food insecurity, and poor access to health care), and distal factors (e.g., colonialism, racism, social exclusion, self-determination) (Greenwood & de Leeuw, 2012; see also, Kulmann & Richmond, 2011; Mitrou et al., 2014 ; Patterson et al., 2018; Smith et al., 2021; Thomas & Stephen, 2020). These factors shape inequitable health outcomes for Inuit in Canada and inhabit social and political spaces outside an individual's or community's direct control (Adelson, 2005). As an infectious disease in which the individual has limited ability to affect factors attributed to SDOH, and where medical and public health practices often promote and encourage social exclusion, TB is often accompanied by stigma (Daftary et al., 2017; Pulerwitz, 2019). TB-related stigma is the

shame associated with having TB, of coming from a community where TB is rampant, and the fear of being excluded and isolated to limit the risks of infection or contamination. TB-related stigma impacts every element of the patient's illness, from avoidance of initial testing, through access to health care, screening, and treatment adherence; it therefore has serious implications for patient outcomes (Craig et al., 2017). Because of the social nature of TB-related stigma and its significant impacts, it is considered a key SDOH. TB and TB-related stigma continue to be experienced by Inuit of Nunavut.

1.2. Situating the Research

In Canada, the history of colonization of Indigenous Peoples and their lands continues to result in assaults on Indigenous' culture, family, community, identity, and relationships with Canada's health care system (Wilmot, 2021). While colonization is a matter of historical record, colonialism is a theoretical perspective that considers the process of dispossession and dysfunction which resulted in inequitable distributions of power, resources, and wealth and continues to directly affect Indigenous SDOH and well-being (Blakemore, 2019; Corntassel, 2012; Hudson & Vodden, 2020; Palmeter, 2014; Reading, 2009; Truth and Reconciliation Commission of Canada, 2015). The numerous policies and resultant actions enacted during colonization of Indigenous Peoples in Canada resulted in what is now referred to as cultural genocide (Matheson et al., 2022). Cultural genocide, a term first presented by Raphael Lemkin in 1946, refers to the purposeful committing of actions intended to destroy or obliterate a culture, tradition, or people e.g., killing, causing physical or mental harm, calculated destruction, or indirect acts such as poverty, hunger, trauma, and destruction of cultural values (Matheson et al., 2022; United Nations, 1948). For Inuit of Nunavut, the enforced disconnection from their ways of being, their lands, and their culture, brought about the marginalization of Inuit knowledges,

self, and community. These losses remain as the ever-present legacies of the colonial past. Inuit are a distinct Indigenous group in Canada with a unique history of colonization related to their northern geography and the complete government control of their public health and healthcare services.

The persistence of colonial social-structural dynamics which underpin health policy and programs, today results in inequitable health care policies and practices which determine or affect health outcomes (Browne et al., 2016). In Nunavut, the residues of colonialism and its enduring influence on postcolonial practices, attitudes, and assumptions continue to underpin negative SDOH for Inuit of Nunavut. I argue that these conditions stem from colonialism and continue to negatively shape Inuit lived experiences and Nunavut's public health TB policies and programs. This reality challenges public health officials' efforts to find pathways to secure health equity and impacts the nursing profession's ability to promote social justice in health (Griffiths et al., 2016).

Arising from anti-colonial and postcolonial rejection of colonial attitudes and practices, postcolonial theory is an extension of critical theoretical paradigms. Guided by postcolonial theory, researchers are positioned to uncover and expose the political and ideological thought structures in western society that result in inequalities (Wilmot, 2021). Specific to this research, using postcolonial theory advances serious engagement with Indigenous knowledge and philosophy, so that Indigenous people's perspectives and experiences can be used to reimagine and reconstruct the state of healthcare provision and policy. I draw on postcolonial theory to critique public health TB policy and practice that negatively affect Inuit, to offer recommendations that can be used to develop and implement a moral, just framework that can be

used by *Kablunaaq*[2] (non-Inuit) health care practitioners like myself. As both a critical theorist and a current senior program analyst with the Government of Nunavut, I am committed to listening to, learning from, and working with Inuit to address and act on the concerns they identify regarding current public health TB policy and practice; I am seeking improved Inuit health outcomes.

Extending the tenets of critical theory and postcolonial theory, cultural safety offers a complementary orientation from which to analyze the phenomenon of relationality between Kablunaaq society and Inuit experiences of receiving their health care. In this context, cultural safety exists when Inuit have the authority and power to determine what is and is not appropriate in a designated space, discourse, or institutional setting. This control ensures that, through self-management and self-determination, Inuit community relational needs are addressed (Deo, 2013). The concept of cultural safety can therefore be understood to function both as a process that is embedded as a guiding value, and an outcome of health care provision for Indigenous people (Provincial Health Services Authority, 2023). As a desired outcome, cultural safety can *only* be defined by those who are experiencing and receiving the care rather than those delivering it: it encompasses the ways social and historical contexts, and structural and interpersonal power imbalances, continue to shape health and health care experiences (Ramsden, 1992; Ward, 2017). Cultural safety as a process entails reflection by Kablunaaq individuals and service providers of their own cultural identity, and recognizing how that identity may impact professional practice in the delivery of care (Williams, 1999). Critical to this reflection is the willingness to receive and accept feedback and advice from Inuit, to continuously improve their actions in striving to foster a culturally safe environment. In the Canadian context, there is a dearth of knowledge about how

[2] Kablunaaq, is an Inuktitut term utilized in the Kivalliq region of Nunavut that refers to any non-Inuit.

cultural safety can be advanced and ultimately achieved for Inuit of Nunavut through changes to public health TB policy and practice. In this work I use cultural safety as both an ethical process toward addressing power relations with Inuit and as an orientation towards Inuit epistemology.

To be sensitive to power relations embedded in the long history of colonized policies and practice I used reflexivity throughout this research. Because my reflexivity was informed by my orientation towards cultural safety, I consciously sought to address the power dynamics inherent in my positionality as a Kablunaaq in Nunavut, a critical theorist, and a senior program analyst for the TB public health programs in Nunavut. I am cognizant of the deeply embedded inequitable power structures that position me to be able to conduct research with Inuit and "speak" on their behalf. I have therefore aimed in this work to embody and critically reflect upon my usage of a methodological framework that might advance critical thought and thereby disrupt my biases and potential impacts of my privilege (Anderson et al., 2003; Wilmot, 2021). Without critical reflection, these inequitable power dynamics are inevitably maintained and sustained by ongoing postcolonial or neocolonial narratives and actions which present as superficially inclusive and aware (Wilmont, 2021). When considering neocolonial actions, i.e., new policies or programs that are based in the tenets of colonialism, which impact Indigenous peoples globally, Perez-Escamilla and Desai (2020) highlighted occurrences where outsiders (colonizers) command the power to speak, act and implement new practices that nonetheless prioritize their own ontological perspective to the detriment of Indigenous recipients. In Nunavut, neocolonialism is evidenced in diverse policies and practices where top-down solutions are imposed without community consultation. This occurs, for example, when biomedical solutions based on clinical evidence and western priorities are implemented without addressing the root causes of social determinants of TB among Inuit. Even though they do not deliver improvements

in population health for the community, such solutions, which may be well intentioned, often remain unchallenged because they are established, generate economic gain, and present as generous in ways that garner political kudos. These types of actions inherently centre the outsider, privileging their agendas and knowledges to the exclusion of Inuit who are rendered "other" and thus belittled, demeaned, and dishonoured on their own lands.

The opportunity to do research with Inuit provides a privileged opportunity to uncover and unmask, to challenge and disrupt the inequitable power relations and dominant discourses of ongoing oppression found within TB policies and practices that impact Inuit. To accept this opportunity graciously, in this research I sought to create space to listen to Inuit community members, respectfully referred to as knowledge holders, and to participate in community dialogues and conversations when invited. Participating in such dialogues provided the opportunity to increase understanding of Inuit perspectives on the things that matter to them in bringing about positive change in TB public health policy and practice, and potentially improve TB outcomes (Holmes et al., 2008). These direct insights could then be aligned with the well known and documented root causes of TB in Inuit of Nunavut, such as low socioeconomic status, poor housing, food insecurity and malnutrition, and cultural barriers to health care access (Brown, 2012; Gibson et al., 2004; Greenwood et al., 2018; Hargreaves et al., 2011). The distal determinants of Inuit health must also be acknowledged and considered in attempting to address inequities within TB policies and practices. However, prior to this research there has been a paucity of information on Inuit perspectives of the day-to-day impacts of the historical and structural determinants on their health (Moller, 2010), and no reported assessments of what might promote culturally safe TB policies and practices for Inuit.

To affect change in TB outcomes for Inuit of Nunavut, it is vital that those who determine health care provision, policies, and practice not only acknowledge the harm of colonialism on Indigenous peoples, but also recognize that Inuit have a right to direct self-determination in health choices. Unlike other provinces in which health authorities and intermediary health departments provide diverse inputs, options for lessons learnt and opportunities, Nunavut is the only territory or province where the government's Department of Health continues to be responsible for directly delivering health care services (Office of the Auditor General, 2017). The Government of Nunavut's department of health is responsible for not only all health care services in Nunavut, but the development of all policies and legislation that govern the health care system. While the single point accountability in Nunavut results from the size of the population and budget constraints, it means that intermediary health providers are not present, and that government has complete control over the provision of public health programing and treatment of TB. This direct control has resulted in maintenance of the status quo, as existing health care systems, policies and practices endure without creating opportunities for deliberate reflection and change. While there are Inuit members of government, the lack of opportunity for thoughtful and dynamic engagement, particularly with the federally funded health care system itself, prevents Inuit community members from truly participating in democratic choices about their care. For Inuit of Nunavut new and enduring neocolonial impositions can be seen in poor SDOH and the continuance of forms of poverty that according to Haines et al., "diminish opportunities, limit choices, undermine hope and threaten health" (2000, p. 1).

By structuring the provision of health care through imposition rather than consultation, the Government of Nunavut is itself acting at odds with Inuit beliefs, values, and ways of being, as it is constrained by federal structures and requirements which mandate how relationships

between parties should operate. Inuit have a unique land-based relational and collective identity that is guided by Inuit Qaujimajatuqangit (IQ) principles[3] which inform an Inuit way of being and thinking about one's own reality within the context of how Inuit inhabit their collective space amidst ongoing experiences of disempowerment, discrimination, and disadvantage (Tester & Irniq, 2008). Intrinsic to IQ principles is the Inuit worldview which holds a mutually respectful relationship between living and non-living things, and understands that the physical environment plays a significant and active role in Inuit lives (Sheremata, 2018). Such a relational conceptualization encompasses an interconnected relationship that extends beyond humans to the land, the waters, and its animals, or mammals, and to non-living entities who, under Inuit Shamanism beliefs, possess spirits (Sansoulet et al., 2020; Tester & Irniq, 2008). It also situates all Inuit knowledge as relational (Sansoulet et al., 2020; Tester & Irniq, 2008). Privileging Inuit social and cultural contexts is necessary to mitigate and redress health care inequities, however the collaboration required to include Inuit in consultative development of culturally safe health care does not occur because of the enduring structural legacies of colonial paternalism.

To date there has been little research focused on Inuit perspectives of TB public health policies and practices that shape Inuit health. This research addresses this information gap by collating and presenting Inuit perspectives and knowledges of culturally safe public health TB policy and practice to inform government-run public health TB programming and state control over Inuit health and well-being in Nunavut.

[3] Inuit Qaujimajatuqangit is often defined as being Inuit knowledges. It is about values, practices, and ways of being that assist Inuit in living the good life (DeCouto, 2021).

1.3. Research Purpose, Objectives and Question

Given the impact of the legacy of colonialism on health determinants of Inuit TB, and the need for culturally safe TB public health programs, the purpose of this research is to understand Inuit perspectives of culturally safe public health TB policy and practice in Nunavut. The key objectives of this study are to identify and understand:

1. the factors communicated by Inuit, that would promote culturally safe TB policy and practice with Inuit communities
2. ways Inuit understand how TB-related stigma shapes Inuit perspectives of public health TB programs and limits their participation, and
3. how Inuit envision mobilizing Inuit knowledge to inform and democratize Government of Nunavut public health policy and programs.

To address these objectives, I critically explored Inuit history of colonization to identify harms in the past and present caused by power inequities. I critically engaged with the literature to identify the colonial and neocolonial origins of injustices that continue in public health in Nunavut. I listened to Inuit community knowledge holders as they shared their experiences with current public health TB policies and practices. I prioritized their perspectives. I gathered knowledge they shared about the social determinants of health that impact them, and what they identified as cultural safety and cultural un-safety in the context of TB health care. I analysed the insights Inuit shared to identify ways Inuit perspectives and goals for self-determination could be incorporated into TB public health policy, programs, and practices.

1.4. Structure of the Dissertation

In chapter one I have provided a brief overview of colonization, and the impact colonization has on the prevalence of TB among Inuit of Nunavut. I have specifically highlighted how colonization of Indigenous people in Canada continues to affect the root causes of TB in their communities, i.e., the social determinants of TB such as poverty, crowded and inadequate housing, food insecurity, and inequitable health care access (Jetty, 2020). I noted that enduring colonial attitudes embodied in neocolonial acts within public health systems perpetuates the legacy of social injustice which assumes that Inuit, like all other Indigenous peoples, do not have the cultural or social sophistication or knowledge assets of value, that can be brought to bear on their own public health concerns (Perez-Escamilla & Desai, 2020). I described the SDOH that impact Inuit and their causal relationship with TB and its outcomes. I highlighted that TB-related stigma is a distal social determinant of Inuit health which stems from systemic racism in public health policy and affects acceptance of public health programs (Thomas & Stephen, 2020). I further explained why I have utilized the tenets of a critical theory, postcolonialism, and a lens of cultural safety in this research to elicit critical insights into Inuit knowledge, perspectives, and experiences of TB public health policies and practice in Nunavut.

In chapter two I discuss the literature related to the history of Inuit TB and colonization in Canada. Carrying out a historical analysis is critical for postcolonial theory because it unmasks historical actions and provides a greater understanding of the power relationships that existed and continue to exist, between those in positions of power and those who are dominated (Fanon, 1961). I discuss Inuit population health disparities before turning to evidence from which to analyze what is known about TB as a global public health priority, and the root causes of TB amongst Inuit. I also discuss the SDOH and stigma, before outlining what is known about TB-

related stigma for Inuit. I then highlight public health approaches to TB and consider those carried out in Nunavut.

In chapter three, I discuss the methodological framework that guided my approach and analysis. I highlight my use of the critical theoretical tradition of postcolonial theory to identify the political, social, and historical impacts of colonialism on Inuit health today. Advancing relational aspects of Inuit knowledge, I discuss how I applied an orientation of cultural safety to redress power imbalances and to analyze findings related to understanding what constitutes culturally safe public health TB policy and practice for Inuit, *from* the perspectives of Inuit. Drawing from principles of Community-Based Participatory Action Research (CBPAR), I highlight the importance to this research of developing and maintaining relationships with community members that were based on trust, respect, and transparency. These relationships were foundational in ensuring that the research was structured to allow Inuit control, strength, and development of spaces that were safe for amplification of Inuit voices seeking change in Inuit TB health care. Finally, I discuss IQ, which frames Inuit ways of being, and the knowledge frameworks for Inuit health that have been developed by Inuit Tapiriit Kanatami (ITK), which is the National Representational Organization Protecting and Advancing the Rights and Interests of Inuit in Canada (ITK, 2018a).

In chapter four I discuss the qualitative methods used to understand Inuit perspectives of public health TB policy and practice in Nunavut. Methods included purposive sampling from two Inuit communities located in Nunavut. Inuit community knowledge holders were recruited through word of mouth, snowball sampling, recruitment posters and radio advertising. I also discuss the challenges and advantages of using conversational semi-structured telephone interviews in the context of COVID-19 and how I built trust with the community participants

involved. Having earned that trust, I emphasise the importance of ensuring Inuit specific ethical and political considerations are understood, acknowledged, and respected.

I describe my approach to thematic analysis using Braun and Clarke's (2022) Reflexive Thematic Analysis process. I situate myself by describing how I occupy a position of privilege in relation to my area of research and the community participants involved. I describe the advantages of this approach in relation to postcolonial theory, my adopted orientation of cultural safety, and the CBPAR framework. Using a process of reflexive thematic analysis allowed me to recognise and respect my subjectivity and relationships with the participants, while also drawing on complementary theories and frameworks such as postcolonial and critical theories, to deliver the research purpose and objectives (see chapter 1.3).

In chapter five, I present the research findings as seven interrelated themes which speak to the need for culturally safe practices in TB healthcare encounters. Because these findings are derived from Inuit perspectives, they are inherently relational and intrinsically encompass every aspect of Inuit lives. Based on the seven themes, the recommendations for addressing culturally safe TB policy and programs for Inuit of Nunavut are that: 1) Kablunaaq, non-Inuit, develop trust and respect towards Inuit; 2) Inuit social determinants of health are addressed; 3) TB-related stigma is addressed; 4) Kablunaaq respect the importance of Inuit Shamanism and spirituality; 5) intergenerational trauma informed care is provided; 6) Inuit Qaujimajatuqangit principles are recognised and used to guide health care policy and programs; and 7) Inuktut language can be used in health care. Each of these themes is highlighted and examined in the structural contexts that intersect with TB policy and practice, and Inuit health.

Finally, in chapter six I discuss how the findings obtained can improve Kablunaaq healthcare relations with Inuit, and TB public health policy and practice by the Nunavut

government. Drawing on cultural safety, I discuss: how existing power relationships influence one's own actions; the need for self-reflexivity to ensure the development and enhancement of trust relationships with Inuit; and ways that reflecting on these relationships can bring light to the continued oppression of Inuit (Anderson et al., 2003; Brascoupe & Waters, 2009). The utilization of a postcolonial theoretical approach is then highlighted in the implications for nursing research, training, and service delivery as a road map towards decolonizing health care (Beavis et al., 2015). The limitations and reflections on conducting research with Inuit communities are then discussed in detail. And in keeping with CBPAR and ITK research directions, so that Inuit voices would lead the direction of the research, I describe Inuit Research Advisory Committee suggestions regarding the next steps for use of the identified Inuit knowledge. A key element of the suggestions was preparation of an infographic suitable for sharing with the communities (see Appendix A). Following Bowen and Graham (2013), I then translate those directions in ways that can actuate tangible public health TB policy and practice changes that can improve TB health outcomes and disrupt TB stigma in Nunavut. I then conclude with my final thoughts on this research.

Inuit have a unique cultural history in the land now known as Canada and yet there is little knowledge about Inuit perspectives on their experiences of the enduring effects of colonialism on Inuit health which are experienced in the imposition of public health policy, practices and processes. This research aims to, at least in part, redress this gap.

Chapter Two: Literature Review

2.1. Introduction

In this chapter I frame TB as a global public health priority that affects Indigenous peoples worldwide. I present a detailed review of current literature related to Inuit of Nunavut's history of colonization, and the effect TB has had, and continues to have, on Inuit in Canada. I highlight the multiple pathways or trajectories, including neocolonial impositions of power and control, by which colonization continues to have detrimental impacts on social determinants of Inuit health, Inuit population health disparities, stigma, and public health. The consequences of these interwoven factors are explored as I focus on Inuit and their relationship with TB, and on TB-related stigma. Finally, culturally safe public health TB strategies found in Canada and Nunavut are discussed.

It has been necessary to provide an in-depth review of Inuit history to ensure a clearer understanding of the impacts of colonialism and TB on Inuit. Having a solid understanding of Inuit history is necessary when utilizing a postcolonial theoretical orientation, because it provides foundational data for identifying the ongoing marginalization and health inequities faced by Inuit today (Elam, 2019; Schultz et al., 2021). Inuit perspectives of living with TB and how this has affected Inuit singularly and collectively, are critical to understanding Inuit experiences of public health TB policy and practice in Nunavut. Having such knowledge will: provide a greater understanding of the factors that promote culturally safe TB policy and practice delivery for Inuit; highlight how TB stigma shapes Inuit perspectives of TB program participation and treatment; and make possible the mobilization of Inuit knowledge to inform and influence Government of Nunavut public health policy and program development and

delivery. Inuit perspectives on public health policy and programs can be used to promote activities that reduce the effects of colonization and lead to improved health outcomes.

2.2. Tuberculosis: A global public health priority

As noted in chapter one, TB is both a bacterial and social disease, and, when ranked against other infectious diseases, is today the second leading cause of infectious disease related mortality and disability for one-quarter of the world's population after COVID-19 (Devlin et al., 2019; WHO, 2021b). As such, TB remains a leading public health priority worldwide (Cogburn, 2019; Craig et al., 2017; Weiss et al., 2006). Despite TB being both preventable and curable, 10.6 million people globally contracted TB in 2021, while 1.5 million people died from TB (Acen et al., 2021; Vachon et al., 2018; WHO, 2021a, 2021b). TB is implicated in wider global health crises, for example it is the leading cause of death in people with HIV (WHO, 2021b). TB also impacts the global crisis of increasing antimicrobial drug resistance (WHO, 2021b). Half of all people with TB today are located in just eight countries: China, Bangladesh, India, Indonesia, Philippines, South Africa, Nigeria, and Pakistan (WHO, 2021b). That these countries were all to varying degrees impacted by colonialism, and today are all developing countries with high population densities, underscores the importance of post-colonial critiques to understanding social determinants of health, such as poverty, that are implicated in TB epidemics today.

Postcolonial critiques of colonization allow researchers to identify the structural conditions created by colonialism which continue to result in inequitable health outcomes for Indigenous peoples. By creating conditions in which Indigenous communities endure structural violence such as poverty and limited self-determination, colonization, "continues to impact health and well-being and must be remedied if health disadvantages of Indigenous peoples are to

be overcome” (Mowbray, 2007, p. 8). Relative to non-Indigenous people, Indigenous peoples globally experience a higher prevalence of proximal determinants of health such as food insecurity, poor housing, and malnutrition, which exacerbate TB (Cormier et al., 2019; Long et al., 2019). Through postcolonial critique, researchers have shown that negative SDOH such as these result from acts of colonisation including the possession of Indigenous lands, separation of Indigenous people from traditional food sources, and the prohibition and denial of Indigenous spiritual beliefs, land-based knowledges, and traditional ways of being (Cormier et al., 2019). For Inuit, such acts of colonization have imposed non-traditional and counter-cultural ways of living, which have in turn created social, educational, and health disparities and vulnerabilities. It is for these reasons that TB has been described as “quintessentially colonial” (Khan, 2021, p. 1). Data on the prevalence of TB among the world’s approximately 370 million Indigenous people is not known due to poor surveillance and data collection, and as a result of enduring colonial biases in all areas of TB including treatment modalities, policy, program monitoring, and delivery of care (Bloss et al., 2011; Khan, 2021). However, indications can be inferred from former British colonies Australia, New Zealand, and Canada, where it is known that TB rates are significantly “higher in Indigenous populations than in non-Indigenous” (Bloss et al., 2011, p. 677; see also Meumann et al., 2021; Mulholland et al., 2019, Patterson et al., 2018). For example, it was reported that in 2018, Indigenous Australians were four to five times more likely to be diagnosed with TB than Australian-born, non-Indigenous Australians (Bright et al., 2020). According to Brown et al. (2016), “TB mortality and morbidity patterns are strongly connected to histories of colonization, the dispossession of lands and cultural and economic resources, and the ongoing lack of access to the SDOH” (p. 35).

In 2015, the United Nations (UN) Global Sustainable Development Goals included the recommendation that by the year 2030, epidemics of TB and other diseases that interfere with "good health and well-being," should be ended (UN, 2022). The resulting Global Plan to End TB and the Stop TB initiatives were rolled out across the globe (Sachdeva, 2020). These initiatives included recommendations that Indigenous peoples be consulted in TB policy and practice before program development and implementation occurred (Basta & de Sousa Viana, 2019). However, for reasons including the enduring paternalistic legacy of colonialism, Indigenous people, and specifically Inuit, are typically not well represented in development of the public health policies that directly affect their communities (Black & McBean, 2016).

The root causes of TB today are particularly evident in Indigenous communities that endure colonization, such as Inuit. Bhargava et al., list these causes as food insecurity, low socioeconomic status, poor housing, lack of sufficient housing for Inuit population, food insecurity and malnutrition, and cultural barriers to health care access (2020). TB's prevalence among the poor means that in order to address inequities between population groups with respect to incidence, mortality, and morbidity of TB, both distal and proximate risk factors embedded in the SDOH must be addressed (Gibson et al., 2004; Rasanathan et al., 2011; Taha et al., 2011). A disease of poverty, TB thrives where socioeconomic inequity and health disparities exist, and where priority is given to business efficiency, cost imperatives, and the funding of social care, above the needs of the recipients, referred to as the neoliberal project (Browne et al., 2016; Devlin et al., 2019; Faust et al., 2020). Addressing Inuit SDOH therefore requires change at the territorial and federal government levels. Governing processes, referred to as structural determinants, can create and action economic and social policies, that decrease disadvantage and vulnerability stemming from inequitable SDOH and instead promote self-determination and

resilience with equitable SDOH (Lonroth et al., 2009; Reitmanova & Gustafson, 2012). However, SDOH are often overlooked in designing programs within public health models, this typically occurs when limited financial or human resources are instead prioritized to the provision of acute care. This means that even when it is acknowledged that SDOH are impacting health outcomes, activities targeting SDOH do not receive the support they need (Hargreaves et al., 2011; Orr, 2013; Raphael, 2011). Despite such challenges, addressing TB must remain a public health priority.

2.3. Tuberculosis and Indigenous Peoples

As noted above, TB is a significant health risk to Indigenous peoples worldwide with incidence rates significantly higher than for non-Indigenous peoples (Bright et al., 2020; Browne et al., 2016; Cormier et al., 2019; Feldman et al., 2022; Tollefson et al., 2013). Because of colonialism, and the reality of ongoing neocolonialism in the form of structures that result in a lack of agency or self-determination, many Indigenous peoples experience inequitable SDOH which has significant consequences that are apparent in health indicators such as TB prevalence (Basta & de Sousa Viani, 2019; ITK, 2018b). Researchers have shown that indigenous peoples struggle with social, economic, and health disadvantages related to TB, and yet few public health policies or programs have acted to address these ongoing systemic inequities and health disparities (Czyzewski, 2011; Devlin et al., 2019; Richmond, 2009). These reported experiences of TB from other Indigenous contexts are shared by Inuit of Nunavut, however the experiences of Inuit are compounded by their unique location, culture, languages, acts and patterns of colonization, by the fact that Inuit are not First Nations or Métis, and because of the challenges that result from all TB health care in Nunavut being provided by the Nunavut territorial government.

While recognising that issues facing Indigenous peoples are simultaneously common to multiple other groups and unique to their circumstances, the WHO's End TB Strategy highlights that urgent action on poverty alleviation and social protection of Indigenous peoples is required to decrease health inequalities and the burden of TB (2021b; Basta & de Sousa Viani, 2019). Although the rate of active TB in Canada is one of the lowest worldwide, the incidence rate remains high among Inuit of Nunavut with Inuit having a rate of 135.1 per 100,00 in comparison to First Nations with 16.1 per 100,00 and Métis with 2.1 per 100,000 (Government of Canada, 2021). Despite making up only five percent of Canada's population, Indigenous Peoples bear nineteen percent of all TB cases in Canada (Hick, 2019; Statistics Canada, 2016), with "Canada's indifference to TB has put [putting] Inuit at great risk" (Pai, 2018, p. 1).

2.4. History of Inuit Colonization and TB in Canada

Inuit traditional ways of living and being have been disrupted by colonially enforced paternalism, efforts at assimilation, and expansion of colonial market systems (Helin, 2008; ITK, 2018b). The disruptions began with first contact with European explorers, whalers, and missionaries in the sixteenth century, and accelerated to destruction of lifeways in the 1950s during formal colonization through the arrival of large numbers of settlers and imposition of Canadian government control (ITK, 2014). The structural control placed on Inuit have entrapped them in capitalist systems and imposed a dependence on colonial ways of existing that have led to Inuit impoverishment, despair, and disengagement from participation in traditional ways of being (ITK, 2018b; Nunavut Tunngavik Incorporated [NTI], n.d.). The Canadian Constitution of 1982 refers to "Aboriginal Peoples," a term which comprises Inuit, First Nations, and Métis peoples (Smylie & Firestone, 2015). Inuit prefer use of the interchangeable term "Indigenous", which also acknowledges the UN Declaration on the Rights of Indigenous peoples (Piita Irniq,

personal correspondence, November 21, 2021; UN General Assembly, 2007). However, even that term does not highlight that Inuit, First Nations, and Métis are not interchangeable terms, and that pan-Indigenous assumptions should be resisted (Smylie & Firestone, 2015). Inuit are a unique and distinctive population within Canada, occupying the most northern coastal regions of the world. Linguistically and culturally, Inuit have more in common with Indigenous Mongolians than with other Indigenous peoples in Canada (Zhou et al., 2019). The word "Inuit" in Inuktitut, the language of most Inuit, means "the people" whereas the word "Inuk" refers to one individual. It is correct to include Inuit when using the expression "Indigenous Peoples", however it is incorrect and a contradiction to say, "Inuit people" or "Inuit peoples". While this may appear a matter of semantics to Kablunaaq, it is important to Inuit in claiming their identity as unique and their experience of colonization as being different to that of both First Nations and Métis (Government of Canada, 2023). Inuit Elders remember the multiple, different acts of colonization that occurred in the 1950's; the trauma of colonization is an element of living memory. As elements of the diverse colonial acts are uncovered, those historical acts bring direct personal trauma that compounds the inherited intergenerational trauma. So for example, for young adults who have grown up listening to oral accounts of the events surrounding Residential Halls, that intergenerational trauma is reinforced in the present when graves of children who attended those facilities were recovered. Intergenerational trauma, loss of culture and language, and the shift from a hunter gatherer culture to a totally new paradigm of twentieth and twenty-first century technologies, values and intrusive modes of governance, has for Inuit resulted in disruption from their connections with the land, traditional ways of being and collective community autonomy (Cook, 2019).

Inuit have a long history of habitation of Arctic lands, however, European explorers relied on the principle as contained in the 1493 Papal Doctrine of Discovery which allowed any lands held by non-Christians to be declared uninhabited and ownership claimed for European powers. As a result, European explorers who arrived in 1579 claimed Inuit *Nunangat*[4] for England (Mundie, 2022). European explorers in search of the northwest passage including Martin Frobisher in 1576, John Davis in 1585, Henry Hudson in 1607, and William Baffin in 1616, sailed through Arctic waterways leaving a colonial legacy and imprinting their names across Arctic maps and European history, e.g., Frobisher Bay which is now re-named Iqaluit and is the capital of Nunavut, Baffin Island, waterways including Hudson Bay and the Davis Strait.

Post the early explorers and whalers who travelled through the Arctic, the next wave of colonization of Inuit was predominantly associated with European whalers establishing year-round settlements in the 1850's. Although these settlements were small, the increased presence of Europeans resulted in Inuit, not unlike other Indigenous peoples in Canada, having their lands pillaged for minerals, animal populations depleted for furs, and whale populations nearly eliminated due to over harvesting. These environmental impacts altered Inuit ways of life which were dependent on and sustained by hunting on the land and harvesting from the waterways. European colonization also meant that Inuit were introduced to communicable diseases, including TB (ITK, 2018b). Between the period of early Arctic explorations through until the early 1900s, and while these impacts were occurring and colonization continued, Inuit continued to live their nomadic lifeways, and little is known about the prevalence of TB among Inuit prior

[4] *Nunangat* is an Inuktut word derived from the root *nuna* meaning our land, the land of Inuit (Piita. Irniq, personal communication, April 10, 2018; Kerri Tattuinee, personal correspondence, April 27, 2022). Nunangat is a collective Inuit term used to describe the Inuit regions of *Nunatsiavut* (in northern region of Newfoundland and Labrador), *Nunavik*, (in Northern Quebec), *Inuvialuit* (in northern Northwest Territories), and the territory of Nunavut (see Appendix B).

to 1900. Records were not kept of the direct impact on Inuit of factors today understood as social determinants of health, which are understood in other contacted cultures to include racial violence, introduction of disease, and changes to housing and migration patterns. Furthermore, the specific incidence of introduced diseases such as TB among Inuit were not documented. That infection may have occurred among Inuit is indicated by data that in the late 1800s TB was the primary cause of morbidity and mortality in First Nations peoples in southern Canada (Daschuk et al., 2006).

In 1939, Inuit were classified by the Supreme Court of Canada as being "Indians" (like other First Nations peoples) under the British North American Act. The Court could have placed Inuit under administration by the Indian Act[5], however, Inuit were instead placed under the remit of Northern Affairs, who exercised complete colonial and patriarchal authority over Inuit (Qikiqtani Inuit Association, 2013). According to the Qikiqtani Truth Commission (2013), at this time Inuit were "viewed as British subjects and Canadian citizens requiring special protection" and while it is not stated who or what Inuit were to be protected from, a postcolonial critique shows that the language is paternalistic and belittling (p. 32).

The mandate of missionaries, Roman Catholic or Protestant, was to convert Inuit to Christianity and save them from their pagan beliefs, referred to as Shamanism. In some Inuit communities this resulted in hybridized religious practices, while in others Christianity replaced traditional spiritual practices entirely (van den Scott, 2017). In parts of Nunuvat, Shamanism and drum dancing were actively banned, and Shamans were forcibly coerced to convert to Christianity; as a result, this important element of Inuit culture which may have sustained Inuit

[5] The Indian Act, established in 1867, acknowledges the constitutional relationship between Aboriginal peoples and the Canadian crown. It distinguishes First Nations peoples from other Canadians and states the Government of Canada's obligations to them (Indigenous foundations.arts.ubc.ca).

healthy ways of living, was nearly eliminated. The reputations of individual Shamans were attacked leading to community suspicion of their own culture, and traditional beliefs becoming taboo (van den Scott, 2017). At the same time, the creation and establishment of residential halls in Nunavut in the 1950s furthered government and church supported efforts to "civilize" or assimilate Inuit. One such facility, "Turquetil Hall" was established in 1950 in the region now referred to as Nunavut, with the stated aim being to "complete the work of religious education of the Eskimos of Hudson Bay and raise their standard of education and civilization" (Bishop Marc Lacroix, 1954, as cited in Brandson, 1991). Residential halls, like residential schools for First Nations and Métis to the south, were institutions that attempted to eliminate diverse elements of Inuit languages, cultures, spirituality and Shamanic beliefs, and ways of being for Inuit, which were the SDOH that promoted Inuit health i.e., hunting and gathering, and living off the land in communal settings where each community member carried out a role and had value to the community as a whole. Colonization though Christianity and the creation of culturally unsafe government systems, policies, and laws, diminished Inuit self-determination in sustaining their positive SDOH by maintaining these traditional ways of living. The residential halls also harbored TB, and fostered sexual, physical, and mental abuse of Inuit children (Skura, 2019).

In the 1930s, Inuit were fingerprinted as a means of identification for access to health care that further demeaned and disempowered them. Such colonial actions were carried out to assist government agencies that found it too difficult to understand or pronounce Inuit names and did not understand syllabics[6] (ITK, 2018b; Roberts, 1975). In 1941, the practice of fingerprinting

[6] Syllabics is a writing system that was developed in the 1870s and is made up of characters that represent consonant sound followed by a vowel sound. Inuktitut has 14 consonants, each represented by a particular syllabic character (Inuktut Tussaalanga, n.d.)

Inuit for identification gave way to the initiation of E-discs "Eskimo tags"[7] as a means of standardizing Inuit "Eskimos": the change was implemented due to "increasing difficulty of identifying Eskimos and maintaining records of their hunting, education, hospitalizations, and relief because of the difference in spelling names" (R.A. Gibson, Deputy Commissioner of Northwest Territories, 1936, as cited in Roberts, 1975). It was thought that Inuit would accept the disc numbers into their daily lives using them as a means of confirmation of their identity, and where "the novelty of it would appeal to the natives" (Dr. A.G. Mackinnon, Medical Officer at Pangnirtung, Northwest Territories in 1935, as cited in Roberts, 1975). To aid uptake of the E-discs, Inuit were required to show their E-disc to access the government family allowance programs which were introduced for Canadian residents in 1945 (Roberts, 1975). This raises the question of whether Inuit chose to participate of their own volition or whether their participation in this program was another form of oppression wherein they feared further economic marginalization if refused to participate. The E-disc form of identification lasted into the early 1980s when it was replaced by "Operation Surname". Although before colonization Inuit did not commonly bear surnames (Piita Irniq, personal correspondence, December 6, 2021), Operation Surname was established in 1971, and while it afforded some Inuit a choice in establishing their own surnames, others had surnames imposed upon them. Of note, Inuit, who were referred to as "Eskimos" at that time, were the only Indigenous peoples in Canada to have been issued "dog tags" for the purposes of identification (Roberts, 1975). All other Indigenous peoples in Canada were referred to by their own names.

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[7] E-tags (Eskimo tags) were initiated in 1941 as a means to identify Inuit. The disc identified the region and the personal identification number of the person.

One of the many acts of colonization imposed on Inuit occurred following World War II and with the rise of the perceived communist threat, the government sought to assert Canadian Arctic sovereignty and enacted policies which relocated many Inuit to the High Arctic. In an ironic inversion of the 1576 declaration that Inuit lands were unoccupied, these policies used Inuit as "human flag poles" to demonstrate Canada's active occupation and were considered to be "a safety net for Canada at that time" (Friesen, 2014). As an incentive to relocate from their traditional lands, Inuit were offered increased education and hunting opportunities, and assured that they could return to their original communities after two years if they were not happy in their new locations (ITK, 2018b). Although many Inuit agreed to relocate, they were unaware of the hardships they would face in being taken from an area rich in hunting and vegetation, and instead living in an area of the Arctic that was barren and consisted of nothing more than rock and ice. The relocated Inuit arrived in the High Arctic to establish the new settlement in December when ice conditions prevented construction of igloos[8], with Inuit instead issued canvas tents to live in the 24-hour darkness and harsh freezing conditions. Many of the relocated Inuit starved or froze to death in the conditions (ITK, 2018b). The conditions were so harsh that those Inuit who had moved in good faith to help their colonizers, became increasingly and solely dependent on government welfare for survival. Those who requested their return passage home as promised, were refused and informed that they would have to pay their own passage, despite it being known that the relocated Inuit lived in abject poverty and had no means to do fund their own return (ITK, 2018b; Olofsson et al., 2009).

[8] An igloo is a shelter in the north, associated with Inuit, that incorporates principles of physics and thermodynamics to create an optimal form of shelter in the north (Craig, 2017).

Colonial policies of this kind continued to be used to dismantle Inuit ways of life. Another example of oppression rather than improvement took place in the 1950s when the Royal Canadian Mounted Police (RCMP) "and other persons in authority killed Inuit sled dogs systematically and determinedly" (Qikiqtani Inuit Association, 2006). This action resulted in Inuit being unable to hunt to provide food for their families or communities, or as a means to earn a living (ITK, 2018b). Without the ability to travel great distances after herds of *tuktu* (caribou) or to follow *nanuq* (polar bears), Inuit could not adequately feed themselves, provide for their community, or trade furs to earn needed supplies.

Far from being empty lands, Inuit Nunangat is home to three-quarters (72.8%) of the 65,030 Inuit in Canada, with 64% of Inuit living in the territory of Nunavut (Appendix B) (ITK, 2018b). Inuit are descendants of the Sivullirmiut and Thule peoples[9], who live on the same lands as their ancestors did 8,500 years ago. Inuit today, are only two generations removed from having lived off the land, experiencing an integrated way of life, and being self-governed (ITK, 2018b; Piita Irniq, personal correspondence, December 6, 2021).

2.4.1. Tuberculosis among Inuit

During the 1930s and 1940s, TB ran rampant across the Arctic and many Inuit perished (Olofsson et al., 2009). By the 1950s the annual incidence rate of TB among Inuit was 1500-2900 cases per 100,000 people (Orr, 2013). At this time Inuit suffered from poor SDOH with food insecurity, lack of access to health care, youth being forcibly removed from their families and placed in residential halls, relocation of communities to inhospitable lands, and people being

[9] Sivullirmiut, which means “First Peoples” in Inuktitut, and Thule peoples were early Indigenous peoples and are considered to be the earliest ancestors of present-day Inuit (Arnold, 2019).

taken from their land and forced to live year-round in established communities in poorly constructed “matchbox” houses.[10] Matchbox houses were 288 square feet (26.8m^2), made of plywood, insulated to southern regulations, overcrowded, and without any form of sanitation (Tester, 2009).

From the 1950s to the late 1960s, the Federal Government determined that mass screening of Inuit for TB would best address the TB epidemic. A vessel was sent from Montreal to the Arctic each summer to be used as a floating TB screening clinic. The clinic on board the *C. D. Howe* was made up of nurses, doctors, and dentists who were accompanied by the RCMP to ensure that Inuit attended the clinic. They utilized a helicopter stationed on board to seek out Inuit on the tundra and bring them in for screening.

Inuit referred to the C.D. Howe as the *Makavik,* which in Inuktut means “where you strip” (Meekitjuk Hanson, 2012). The RCMP brought Inuit on board, willing or otherwise, where they were assessed for TB (Smith, 2004). This testing involved Inuit of all ages having to strip off their clothing before receiving chest x-rays, physical assessments, and dental check-ups (Smith, 2004). If Inuit were found to have TB, the letters “TB” were written on their arms and then were forcibly prevented from leaving the vessel. People were not allowed to leave the vessel to say good-bye to their families, families were pulled apart with infants removed from their mothers, and mothers were separated from their children (Piita Irniq, personal correspondence, November 25, 2021). The removed Inuit were sent to TB sanitoriums located in the southern regions of Canada, far from Inuit lands, culture, foods, and languages. Many Inuit remained in

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[10] Matchbox houses were established in the 1950s when Inuit were forced off the land. These were part of the Eskimo Housing Loan Program. Rents and maintenance made them unaffordable to Inuit and eventually they were incorporated into the federal welfare program (Tester, 2009). It should be noted that this size and form of construction would, in other parts of Canada, typically be used to describe a 16 x 18 storage shed.

the sanitoriums for years before they returned to the Arctic; many more never returned and the locations of their graves are unknown.

The early 1970s saw a huge public health TB campaign established across the Arctic with testing and removals, which resulted in a 15% decrease in the incidence rate of TB (Orr, 2013). Even so, between the 1970s and 2017 there were numerous outbreaks of TB in Nunavut. In 2017, the community of Qikiqtarjuaq, located on Broughton Island which is north of the Arctic circle in the territory of Nunavut, was reported to have over 10% of its population of 600 people in treatment for either active or latent TB[11] (Pym, 2018). This community is located in an area that had previously been identified as being home to more than 90% of Nunavut's TB cases[12] (Murray, 2017).

Using postcolonial theory to analyse this timeline of colonization of Inuit and the associated impact of TB, brings attention to the historical impacts of colonization and how the acts of colonization remain in the foundations of the barriers to eradication of TB among Inuit today. For example, while the Federal Government moved Inuit into centralized communities to facilitate access to health and education services, relocations meant that many people lost traditional skills, culture, and connection to land ,which led to increasing food insecurity and reliance on welfare. The impacts of relocations remain in many ways, just one of which being today's chronic housing shortage which is shown (section 5.3.1) to be a major factor preventing eradication of TB among Inuit. In the era of Truth and Reconciliation where Truth comes before

[11] Individuals with latent TB carry the TB bacterium but are not infectious, and as a result it is often referred to as "sleeping TB". Latent TB is detected via a TB skin or blood test. A healthy immune system can prevent this form of TB from becoming active. It is treated with one or more medications over 3-9 months (TB Alert, n.d.)

[12] The community of Qikiqtarjuaq was invited to participate in this research, however circumstances within the community did not allow for participation.

Reconciliation it is critical to both recognize and acknowledge that unequal and unequitable power relations remain today and continue to create ongoing health injustices for Inuit (Beavis, 2015). Postcolonial theory offers insights into how colonial practices continue to be perpetuated as part of the neoliberal project, through ongoing acts of neocolonialism.

Neocolonialism is the term used to describe the reimagined, contemporary, and sometimes indirect methods used to control Indigenous people through ongoing unjust political, economic, and cultural means such as cultivating situations of Inuit dependency (Perez-Escamilla & Desai, 2020). Such economic dependency can be understood to be a part of neoliberalism which creates power differentials which lead to people being economically disempowered and can be understood to be "a form of structural violence affecting the most vulnerable" (Sakellariou & Rotarou, 2017, p. 177). Both processes contribute to structural violence which perpetuates health inequalities and the well-being of Inuit in Canada, including the lack of democratic opportunities to influence public health (Sakellariou & Rotarou, 2017). Examples of social and economic disempowerment that ultimately led to perpetuation of Inuit health inequalities include for example insufficient housing and employment inequities. My application of postcolonial theory attempts to disturb the established order, threatens colonially entrenched privilege and power in Nunavut, and demands that all human beings should have equality and well-being (Young, 2003). While complete decolonization is a practical impossibility given the historical reality of colonization, acts of decolonization begin with uncovering such colonial vestiges. The work of uncovering such remnants relies on postcolonial analysis, which in the context of public health would include interrogating historical trends and causalities, structural limitations to Inuit self-determination in health, and current manifestations of inequity in public health policy and programs.

2.5. Inuit Population and Health Disparities

Statistics and observations of the heinous impacts of TB on the Inuit population point to the need for change. On visiting Nunavut in 2017 and noting that 14 of the 25 Inuit communities of Nunavut had cases of active TB, former UN Special Envoy, global AIDS advocate and public health expert, Stephen Lewis described the region as the "epicenter for TB" (2017, p. 6). Lewis (2017) stated that "colonial inheritance… the fevered destruction of language and culture lies at the root of every contemporary Inuit struggle", and that TB in Nunavut was "inextricably held to a form of cultural genocide" (p. 6). According to ITK, the high rates of TB among Inuit are "one of the most long-standing social-inequity pieces with our society" (2018b, p. 18).

What Lewis observed was the manifestation of colonization's acts of attempted genocide and cultural eradication through; imposition of sedentary communities comprised of matchbox housing, lack of culturally relevant education, removal from hunting lands and slaughter of sled dogs. These manifestations are also seen in social statistics describing Nunavut today. Statistics Canada reports that 52% of Inuit live in overcrowded housing compared with 9% of non-Indigenous Canadians; 34% of Inuit youth graduate with their high school diploma in comparison to 86% of non-Indigenous Canadians; and 70% of Inuit are food insecure compared to 18% of non-Indigenous Canadians (Food Insecurity Policy Research, 2023). Inuit infant mortality is at 8% or 12.3 per 1,000 compared to 4.4 per 1,000 for non-Indigenous Canadians; and 63% of Inuit adults smoke daily compared to 16% of non-Indigenous Canadians. The life expectancy of Inuit men is 70 years, some 11.4 years less than non-Indigenous Canadian men, while for Inuit women life expectancy is 76.1 years which is 11.2 years less than for non-Indigenous Canadian women. (ITK, 2018b). Inuit population is the youngest of all Indigenous peoples in Canada, with a median age of 20.6 years of age; in comparison to non-Indigenous

Canadians at 37 years, and where one in three Inuit are under 15 years of age (Statistics Canada, 2022). The spread of such discrepancies across so many social measures, and their normalization as part of Inuit life, has generated an environment in which stigma thrives.

2.6. Constructions and Models of Stigma

Before considering the causes, mitigating factors, and effects of stigma among Inuit, it is important to understand theories and models regarding the construction and operation of stigma on individuals and social groups. In sociological terms, stigma is broadly defined as a social and culturally constructed process in which a person is first labelled as different and then devalued, resulting in status loss and discrimination (Goffman, 1963). Following Goffman's overarching description of stigma, much attention has been given to the dynamics of stigma (Bos et al., 2013; Earnshaw & Chaudoir, 2009; Link & Phelan, 2001; Pachankis, 2007; Phelan et al., 2008). Stigma is "shaped and promulgated by institutional and community norms and interpersonal attitudes" (Thomas & Stephen, 2020, p. 859). Because of the entanglement of social norms and values in its construction, stigma has been referred to as a social sickness (Lafferty, 2021). Mobilized as a form of structural violence, the power of stigma can be used to exploit, control, and create an environment of exclusion (Link & Phelan, 2014). Not always blatant in nature, stigma can be insidious and multi-layered, often misrecognized or intertwined with other elements of inequity, especially in the context of a disease, such as TB (Baral et al., 2007; Link & Phelan, 2014; Thomas & Stephen, 2020). For example, stigma, or even the perception of stigma, is known to influence or interfere with the decisions individuals and communities make when accessing TB screening and treatment (Jetty, 2020; Courtright & Turner, 2010). This means that stigma which differs across contexts can be "both a determinant of and determined by other forms of discrimination" (Smith et al., 2021, p. 1).

Given the multiplicity of social factors that contribute to construction of stigma, many different forms have been theorized. One model delineates four stigma categories, the first two of which operate at intra or interpersonal levels: (a) Self-stigma which sees the individual internalize the social construct and develop self-blame as they appropriate, both cognitively and emotionally, the negative stereotypes and behaviours, and normalize them as appropriate to themselves (Corrigan & Rao, 2012; David & Derthick, 2014). (b) Public stigma is experienced as social ostracization, critique, exclusion, and, at times, stigma by association. For example, exercised in the social domain as discrimination and prejudice of those who contract TB, public stigma is the most easily recognized and commonly reported form of stigma (Corrigan & Rao, 2012; David & Derthick, 2014). In the case of an infectious diseases, fear of infection is often deployed as justification for declaring individual(s) as being contaminated and therefore worthy of being rejected and avoided; this is seen among Inuit who avoid those with active TB in a form of socially constructed public stigma.

The third and fourth categories address the normalization of the role of stigma into the operation of inequitable social structures: (c) Institutional or structural stigma sees domination and paternalism incorporated into social constructions of exclusion and shame. Structural stigma refers to inequities displayed in policies and programs within organizations and society in general (Klein et al., 2022). Breaking down structural stigma involves acknowledging the existence of embedded stigma in government institutions and programs. A postcolonial lens allows for greater critical reflection on past and present structural health care policies and practices that create an environment of fear and stigmatize disease, and reinforce government and institutional power over Inuit without their consent. Reflecting on the timeline of colonization acts above shows that government policies and practices that reinforced control over

Inuit and fostered stigma included stripping down Inuit onboard the Makavik boat, finger printing Inuit as a requirement for access to health care services, insisting that Eskimo dog tags be worn to access funding when no other citizens were required to wear ID to access their entitlements, and more recently, challenging Inuit self-determination attempts i.e., the failure of recent federal health care budgets to deliver funding that would be specifically used for TB elimination. This critical analysis raises the question of why embedded stigma is allowed to remain entrenched in the current health care system processes and practices, and facilitates recognition of ongoing colonialism with its hierarchical and patriarchal systems of inequity. The fourth form of stigma is (d) professional stigma which comes to characterize the culture and practices of services accessed by the stigmatized group as stigma contaminates and taints the very services such as health care that are supposed to provide aid (Pryor & Reeder, 2011). Manifestations of professional stigma can be found in the way health care practitioners perform their roles and the language that is mobilized. Health care practitioners hold an unequal power advantage in health care relationships with patients/clients. They have the knowledge that patients and carers need to manage the illness, and can act in paternalistic ways when they frame or withhold information such that patients are retarded in managing their own condition. Furthermore, the beliefs, attitudes, and actions of health care practitioners towards TB as a communicable disease, can also serve to reinforce wider societal stigmas (Dodor et al., 2009).

All four elements of stigma operate collectively as a social determinant of health that is a key factor contributing to the critical TB health burden in Nunavut (Grant, 2022; Thomas & Stephen, 2020). Stigma has specific relevance to Inuit and their colonial history of TB, because it often exists when “harmful and untrue stereotypes are anchored in colonial views and reinforced” through racialization (Greenwood et al., 2018; see also Craig et al., 2017; First

Nations Health Authority; 2019 Smith et al., 2021; Turner-Musa et al., 2020). Structural, institutional, and professional constructions of stigma then operate on the racially devalued population to reinforce colonial power inequities and interweave with other SDOH to add to the burden of illness (Cogburn, 2019; Craig et al., 2017; Weiss et al., 2006). For example, the practice of forcibly sending Inuit away to sanitoriums reinforced TB stigma and located the cause for devaluing and isolating Inuit within Inuit bodies thus deflecting the blame away from the colonial practices that created the stigma. This is compounded on an individual level by relational and self stigma, because being stigmatized leads to isolation, feeling othered or defined as an outsider or outcast, and feeling uncomfortable in seeking health services (First Nations Health Authority, 2019). TB-related stigma therefore encompasses all aspects of devaluing and shaming of a person because they have contracted TB. For Inuit, both cultural and systemic value systems influence the power imbalances which contextualize their multiple experiences of TB-related stigma (Nyblade et al., 2019; Subu et al., 2021). TB-related stigma undermines and becomes a barrier to health care access, diagnosis, and treatment, blocking positive public health outcomes (Nyblade et al., 2019). Before health inequities in Nunavut can be addressed, acts of colonialism that have perpetuated TB among Inuit and TB-related stigma must be recognized from the perspective of Inuit. This is a priority because, according to Dr. Jetty,[13] "reducing stigma and discrimination around TB will ultimately help improve TB treatment and prevention" (2020, p. 1).

[13] At the time of publication, Dr Radha Jetty was Chair of the First Nations, Inuit and Métis Health Committee in collaboration with the Assembly of First Nations, Inuit Tapiriit Kanatami, and Métis National Council (Jetty, 2020).

2.7. Inuit Tuberculosis Stigma and Social Determinants of Health in Nunavut

The acts of colonization imposed on Inuit and the resulting stigmatization of Inuit, created highly injurious SDOH in Inuit Nunangat and support the assertion by Smith et al., that "stigma is part of Canada's legacy of colonial TB policy…" (2021, p. 7). It is also a reflection of Canada's contemptible history of neglect of Indigenous Peoples which has resulted in severe health inequities (Brown, 2012; Orr, 2013; Picard, 2018; Vachon et al., 2018). The consequences of stigma are understood to be fundamental drivers of population health disparities and negatively impact the effectiveness of public health programs, and individual and community health outcomes (Clair, 2018; Van Brakel, 2007). The ways stigma is understood to bring about these consequences are related to its entanglement with SDOH in ways that strengthen barriers that prevent Inuit accessing health care, diagnosis, treatment, and complying with TB care (Cremers et al., 2015; Woodgate et al., 2017). One example of where this entanglement creates barriers that prevent Inuit from accessing health care occurs when the health care treatment the person has struggled to arrange is delivered by newly arrived, southern trained nurses. Since these nurses have often been taught that TB is a contagious disease that has been eradicated, they may react with varying amounts of concern, even at time extreme caution; at worst Inuit patients are stigmatized. Because of the high turn-over of nursing personnel in Nunavut, encounters such as these are frequent experiences for Inuit who have active TB and intensify already chronic stigma. Social stigma surrounding diagnosis and treatment of TB has been identified by Inuit of Nunavut (Frizzell & Oudshoorn, 2018). By understanding stigma and how it interferes with Inuit access to and adherence to TB treatment, and through considering the ways historic and systemic racism intersect with stigma to impact TB policy and practice in Nunavut today, it becomes clear

that the root causes of health inequities must be addressed before TB can be eradicated (Craig et al., 2017, also chapter 2.10.3).

Inuit, like other Indigenous peoples, are not inherently predisposed to poor health, however the reality is that today, being Indigenous is considered a SDOH. TB-related stigma as a SDOH among Inuit is insidious and affects all dimensions of individual and community health; the stigma that Inuit experience related to TB does not exist in isolation. This is in part because "historical traumas have created a justifiable distrust in colonial structures, including institutions of health", which leaves a legacy of colonialism wherein Inuit report feeling disrespected, isolated, and stigmatized (Loppie, 2017, pg.187). By contrast, for Inuit, primary dimensions of health and well-being exist in the realms of physical, emotional, spiritual, mental, and social health, in which health is viewed holistically as *Inuuisqatiginniq* meaning "the way of being a person" (Healy, 2017; see also ITK, 2018b; Stoewen, 2017). This viewpoint considers that all dimensions of health and well-being are directly affected by numerous relational contexts, which today necessarily include the overwhelmingly negative SDOH experienced by Inuit (Healy, 2017). Importantly, this holistic view of one's being, or community's being can have significant implications for stigma associated with TB which results in isolation and separation. The utilization of a postcolonial theoretical lens in addressing this concern reveals a larger picture that reflects how TB-related stigma compounds both distal and proximal SDOH, including poverty, marginalization, prejudice, oppression, racism, discrimination, and ongoing systemic colonialism found in public health policies and practices that Inuit of Nunavut experience (Turan, et al., 2019).

2.8. Stigma as a Legacy of Colonization in Nunavut

Critically examining the role of racism in the construction of TB-related stigma using a postcolonial perspective, illuminates the remnants of colonization in the ways the state conceptualizes Inuit (Macq et al., 2006; Williams et al., 2008). Racialization introduces many intersecting forms of oppression, discrimination, and social inequality which influence not only how society conceptualizes stigma but also how individuals experience or adopt dimensions of stigma themselves (Lutz et al., 2011). Societal conceptualizations of TB-related stigma as envisaged both by those with TB and those without, combined with ongoing colonial practices of structural racism, clearly illuminate enduring, revived, and accepted power differentials (Bailey et al., 2017; Earnshaw & Chaudoir, 2009; Stangl et al., 2019; Turan et al., 2019). For example, the social taboo associated with TB originated with colonizers who believed TB growth and transmission was related to contact with soil/dirt which meant that “TB reshaped people’s morality, sociability, and daily habits” (Mason et al., 2015, p. 2). Inuit, at the time of initial colonization and up to 55 years ago, lived on the land in animal hide tents or in igloos, depending on the season, and did not subscribe to the hygiene habits imposed by Europeans who associated dirt with the transmission of disease. Colonizers, who already devalued Inuit as other and less-than-human, compounded their prejudice by interpreting the lack of European-style personal hygiene practices as being “dirty”. One way in which these presumptions continue to directly impact Inuit health is because, when Nunavut became a territory on April 1, 1999, the new Government of Nunavut maintained use of existing policy systems and programs, including health policy, with the intention of revising them over time. However, the practicalities of administering the territory meant that substantial revision or rework was often not undertaken, and only imperative updates were made. As a result, current public health policies, practices, and

procedures continue to carry colonial, paternalistic and judgemental attitudes and beliefs about Inuit. Without deliberate change informed by postcolonialism, such entrenched systems continue to resist Inuit self-determination in health, dehumanize Inuit, and maintain discriminatory SDOH (Harris et al., 2015; Kulmann & Richmond, 2011; NTI, 2021). Many Inuit consider these practices to be both active and oppressive in Nunavut today.

In Nunavut today, TB-related stigma remains a valid concern with entire communities facing potential discrimination if their TB status were to be disclosed (Grant, 2022). Whether TB-related stigma results from an internalised fear of discrimination or is enacted by acts of discrimination, it remains a socially constructed, racialized, and relational entity with respect to Inuit (Scambler & Hopkins, 1986). TB-related stigma strategically positioned could be likened to a socially produced "tool" for justification of ongoing colonial domination against Inuit (Parker & Aggleton, 2003). That Canadian governments and the general Canadian population appear indifferent to Inuit TB rates, health inequity, and social injustice, speaks to ongoing colonialism and subjugation of Inuit. The interconnecting political, cultural, and health care structures that have and continue to impact Inuit health, including public health policies and practices, inevitably influence how Inuit experience and manage TB and TB-related stigma (Heijnders & Van Der Meij, 2007). Past TB care and treatment continues to influence Inuit attitudes towards and participation in current public health care services related to TB.

Unequal power dynamics, evident in the Government of Nunavut's colonial and neocolonial health system, are drivers of stigma which subsequently shape the structure of public health policy and practices, and influence community attitudes to public health care (Public Health Agency of Canada, 2023). It is therefore key to determine, from Inuit perspectives, exactly what defines culturally safe public health policy and practices, and in identifying what

actions can be taken in public health policies and practices to mitigate TB-related stigma experienced by Inuit.

2.9. Tuberculosis and Public Health

In 1882, Dr. Robert Koch identified *mycobacterium tuberculosis* as the bacteria that causes TB, for which he was awarded the Nobel Prize in 1905 (Centers for Disease Control and Prevention, 2023). In 1921, the attenuated strain of *mycobacterium bovis* was used by Dr.'s Calmette and Guerin, in what became known as the Bacille Calmette-Guerin TB vaccine (Centers for Disease Control and Prevention, 2023). This vaccination continues to be given in high-burden countries, primarily to small infants and young children; it is not a vaccination that prevents TB in adults. The vaccine is not commonly administered in low incidence or developed nations such as Canada; however, it was routinely given to Indigenous children in Canada until 2006 and today remains an accepted and common vaccination administered to Inuit infants and young children (National Advisory Committee on Immunization, 2021; Faust et al., 2020).

Since the mid twentieth century, curing TB has relied on "a cocktail of antibiotics" (Centers for Disease Control and Prevention, 2023) and was once a lengthy process. However, with the development of TB drugs such as Rifampin, treatment periods have been shortened to approximately nine months (Murray et al., 2015). Targeted pharmaceutical advancements have resulted in noted declines in TB morbidity and mortality in advanced nations (Faust et al., 2020). However, such successes have not been reported globally in high-TB-burden countries nor in low-TB-burden countries with high-burden populations such as Indigenous Peoples in Canada (Faust et al., 2020; Seaworth et al., 2013). As TB has killed more people on an annual basis than any other infectious disease the WHO maintains that public health mandates must remain

focused towards the goal of TB elimination (Basta & de Sousa Viana, 2019; Brown, 2012; WHO, 2021b).

Canada's Public Health Agency has a mandate to promote and protect citizens through leadership, partnership, innovation, and action in public health (Public Health Agency of Canada, 2023). Within that remit, the Public Health Agency of Canada's TB programs, like most worldwide, are focused on biomedical screening and treatments that aim to control the immediate TB disease process rather than seeking to end the epidemic (WHO, 2021b). Certainly, screening and treatment programs have resulted in lessening TB numbers, however, these programs focus on short term results, (e.g., TB control via attempting to break the chain of transmission), but do not achieve long term elimination of the disease. This is because screening and treatment activities do not always identify the latent TB infections from which cases of active TB can develop. (Matteelli et al., 2018). Instead, progress in long-term TB control requires undertaking primordial prevention activities, which means "not only investment in strengthening TB control programs, diagnostics, and treatment but also action on the social determinants of TB" (Hargreaves et al., 2011, p. 1). To address systemic and endemic TB, it is necessary that public health policies and practices in Nunavut address the root causes of inequities associated with TB by advancing culturally safe and decolonizing frameworks in the distribution of programs (Richardson & Crawford, 2020).

Inuit suffer from unprecedented TB rates, ongoing TB epidemics, and TB-related stigma in the year 2023; a fact which highlights that despite political posturing and "woke" illusions that suggest the contrary, Canada's health care system is neither free nor equal nor equitable for all its citizens, (Courtright & Turner, 2010; Government of Canada, 2022a; Hick, 2019). To make systemic change and influence policy, it is critical that this research obtains insight into Inuit

perspectives on ongoing constraints and opportunities to improved public health care programs, policies, and practices (Oliver, 2006; Richmond & Cook, 2016; Stover, 2009). It is only once policy makers recognise that TB policies and programs contribute to the alarming inequities faced by Inuit related to TB, that Indigenous reconciliation and decolonization of health care systems can occur. All health care in Canada is a product of the nation's colonial past and is situated within political and social contexts of historical trauma. Nunavut's most recent TB outbreaks are not merely avoidable tragedies, but sound clear warnings, highlighting the need to critically address the social determinants of Inuit TB health.

2.10. Nunavut's Public Health Approach to Tuberculosis

Nunavut public health TB programs are focused on a multifaceted approach to TB prevention and control; they are in keeping with all other public health approaches to TB across Canada (NTI, 2021). This includes management of active TB cases, contact tracing and outbreak management, screening for latent and active TB, surveillance and data management, laboratory diagnostics, education and training of health care professionals, community-based awareness, monitoring, and evaluation (NTI, 2021). As noted elsewhere, vaccination is not applicable to adults and is therefore not included in these comprehensive programs. While these multidimensional initiatives have resulted in the number of active cases reported among Inuit of Nunavut dropping from over 300 per 100,000 (0.3%) in 2010, to approximately 200 per 100,000 (0.2%) in 2021, an incidence rate that must however be compared with the national rate among the overall Canadian population of 4.6 per 100,000 (0.005%) in 2017 (ITK, 2018; Grant, 2022). TB rates remain high and ongoing outbreaks continue to challenge the ability of Nunavut public health to control TB in the area (Orr, 2013; Patterson et al., 2018). In 2022 the worst TB outbreak to have been reported across Nunavut in five years occurred in the northern Baffin

Island community of Pangnirtung, a community of 1500 Inuit (Grant, 2022). More than 160 cases of TB were recorded, equating to 10.6% of Pangnirtung (Grant, 2022). Of those, 35 cases (21.8% of total cases, or 2.3% of the population) were identified as having active TB disease, that is, individuals displayed symptoms and were highly contagious (Grant, 2022). This equates to ten times the rate among Inuit, and 460 times the overall rate in Canada. Such ongoing outbreaks of TB in Inuit communities threaten Inuit human rights to health, security, and self-governance (UN, 1948, 2007, 2022).

The Government of Nunavut has articulated its commitment to address TB policy challenges in Nunavut. Firstly, it has expanded the territorial TB program for individuals with latent TB infection by investing in new treatment programs known as 3HP. These programs involve treatment once weekly for 12 weeks with rifapentine and isoniazid (Alvarez et al., 2020). Secondly, it has established in Nunavut a first of its kind memorandum of understanding which allows sharing of TB-related information between Nunavut Tunngavik Incorporated[14] (NTI) and the Government of Nunavut. The memorandum is seen as a “first step toward better co-operation on eliminating TB in Inuit communities” (Grant, 2022, p. 1). The Government of Nunavut and NTI have previously worked in parallel, both with stated commitments to eliminating TB; however, information sharing between the organizations has not been easy given the mistrust which has shadowed the relationship since the creation of Nunavut in 1999 (Grant, 2022). In my research I worked to establish relationships with both agencies to ensure respectful communications.

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[14] Nunavut Tunngavik Incorporated (NTI) is the Inuit organization that ensures the provisions under the Nunavut Land Claims Agreement are carried out.

Current TB public health policy initiatives and dominant policy narratives are often constrained or dictated by factors that are outside the control of Nunavut's TB public health officials. This lack of control is a result of the territorial government's dependency on federal government funding and program supports, which are structures of power derived from colonization and therefore are colonial by nature. The continuance of TB in Nunavut is yet another symptom of a greater systemic problem, with TB being but a contemporary manifestation of the enduring colonial project[15]. There are many reasons why the Government of Nunavut has struggled in its attempts to eliminate TB from Nunavut including:

1. The Government of Nunavut is a new organization, it is only twenty-five years young[16], and therefore it is in its infancy with respect to creating and putting its own "made in Nunavut" stamp on policy and programs.
2. The Government of Nunavut's ability to source health care professionals is undermined by a shortage of health care professionals in Canada, especially registered nurses, and the challenges of attracting staff to remote and isolated locations. This results in high turn-over of front-line staff, who are often referred to as being little more than "warm bodies". This colloquial term is used to indicate that while staff are physically present, they are considered to be of little use since they are inadequately trained to work in remote Arctic communities or with TB. Inuit care is negatively impacted by the lack of clinical understanding of TB, and even less awareness or understanding of Inuit colonization and culture. Compounded by rapid

[15] The "colonial project" is a term that is used with respect to the maintenance of unequal relationships between Indigenous peoples and non-Indigenous peoples/government systems that keep Indigenous peoples in a state of dependence.

[16] The territory of Nunavut was established on April 1, 1999.

staff rotations and scarcity, those warm bodies are unaware of Inuit cultural ways, or the need for cultural sensitivity and cultural safety in the delivery of care (Cherba et al., 2019).

3. The Government of Nunavut is grossly underfunded by the Federal Government in terms of the requirements of the territory, which directly impacts the funding that can be made available to make TB elimination a priority. Recently John Main, Minister of Health with the Government of Nunavut, shared that although the recent federal funding initiative to channel 381 million over 10 years to improve Nunavut's health services was significant, the size of the Federal Government's commitment could be put into context by sharing that the Government of Nunavut's annual operating budget for the health department is 470 million (Lochead, 2023a). Without federal political will to increase funding and take tangible steps towards improving Inuit SDOH (e.g., building housing units to alleviate overcrowding and thus curbing the spread of TB pathogens, and making nutritious foods available in Nunavut at a price that Inuit can afford in the absence of traditional foods sourced from the land and waterways) the Government of Nunavut's public health TB program is simply placed in a position where, as mentioned above, they are "putting out proverbial fires" (Dr. Patterson, CPHO of Nunavut, personal correspondence, Dec., 23, 2022).
4. Because of its inheritance and maintenance of pre-existing TB public health policies and practices, the Government of Nunavut's systems retain embedded systemic colonialism, for example, in the form of paternalism. Despite their well-intentioned delivery of TB care, public health staff may unwittingly perpetuate colonialism in their practice and in the development of policies through entrenched racialized

> attitudes, perspectives, and assumptions (Orlowski & Cotterell, 2019). Unless Inuit are specifically writing TB policy, delivering TB programming, and sitting in the chair of the Chief Public Health Officer, the reality is that all created and delivered TB public health policy or practice comes from a colonial interpretation and paternalistic attitudes towards Inuit health. Inuit do not gain from the delivery of health care that is embedded in colonialism because it is extractive by nature. In this context, health care delivery is extractive in that Kablunaaq who choose employment delivering health care in Nunavut are well paid and provided with housing that is both above that achievable by Inuit and often empty due to high levels of personnel turnover. Furthermore, the employment aids the individual Kablunaaq's standard of living, but statistically appears to have little benefit to Inuit health and no benefit to Inuit improving their own quality of life on their traditional lands.

The Canadian Federal Government, which takes such pride in leading TB elimination globally, as evidenced by committing 1.2 billion dollars to the Global Fund to fight TB, HIV/AIDS, and malaria, has yet to critically invest in and take immediate actions towards addressing Inuit SDOH that expediate the continuance of TB in Canada (Government of Canada, 2022a). Despite Canadian Federal Minister of International Development Harjit Sajjan stating that Canada is “committed to leaving no one behind” with reference to TB, clearly Inuit continue to be left behind in efforts to mitigate, let alone eradicate, TB in Canada (Government of Canada, 2022a). The challenge, even if increased funding were made available for TB eradication among Inuit, is that it would need to be matched by spending across all the SDOH to affect real change. That this challenge must still be met is highlighted by the abovementioned Nunavut’s 2022 TB

outbreak, which sounds a dire warning, of the need to critically address the social determinants of Inuit TB health.

To achieve a social determinant of health perspective in TB policy and practice, requires a change in the thought processes that allows conceptualization both of what constitutes successful target attainment in TB control (Hargreaves et al., 2011). This means considering that in addition to biomedical targets, targets are required that consider the root causes of TB, e.g., elimination of poor housing and food insecurity in actions which are referred to by Hargreaves et al., as “structural interventions” (2011). Structural interventions are the kind of public health interventions that “promote health by altering the structural context within which health is produced and reproduced” (Blankenship et al., 2006, p. 1). To make such systemic changes and address human rights violations requires that accountability and resources be drawn from wider than the Government of Nunavut's limited public health apparatus and funding. Innovative approaches would require the collaboration and commitment of Canada's Federal Government and corporations who profit from the region such as the extractive mining corporations for example. With sufficient political will, desire, intensive public scrutiny, and demand for accountability towards the elimination of TB, policies that adopt a SDOH lens are possible in Nunavut. That said, such policies and practices should not continue colonialism’s history of imposition on Inuit, but rather be created with and delivered through a lens of cultural safety. An example of such an approach is the Canadian Paediatric Society’s TB Strategy which identifies the necessity for health care professionals to understand the social factors, not just the biological or medical factors, which contribute to TB in Indigenous populations in Canada. To improve the health care strategies in Nunavut, it will be important to draw on lessons learnt in many of the public health TB strategies in Canada that also attempt to promote and ensure cultural safety.

One example is the British Columbia Centre for Disease Control's TB strategy, which is committed to cultural safety and humility, and seeks to remove barriers to care by fostering a culture of cultural safety (Provincial Health Services Authority, 2023). Until TB is eradicated from Nunavut, there exists a pressing need for all public health strategies to be created with and delivered through an orientation informed by cultural safety.

2.11. Public Health Tuberculosis Strategies Across Canada

Health Canada, in collaboration with the Public Health Agency of Canada (PHAC), developed the Federal Framework for Action on TB Prevention and Control based on best practices (2014). The national framework also promoted increased partnerships and relationships with people and governments at every level (PHAC, 2014). Not unlike PHAC's updated 2018 document The Time is Now: Chief Public Health Officer Spot Light on Eliminating TB in Canada, this framework focused on practice, process, and partnerships highlighting: 1) prevention, diagnosis, and management of TB through actions such as primary prevention, case finding, treatment, and evaluation; 2) targeting populations at greatest risk for TB and working with these communities to ensure TB programming; and 3) developing and maintaining relationships via public health education, messaging, and linking public health programs to promote optimal health outcomes (PHAC, 2014, 2018). When critically reviewing a bureaucratic framework such as this by using postcolonial critical perspective, it becomes clear that there are unanswered questions. For example, "whose best practices has the strategy considered," "are those best practices suitable for Inuit?" and "were Inuit invited to sit at the 'proverbial' table and be heard?" If postcolonial questions such as these are not considered, it is unlikely that Inuit TB health needs and preferences can have been fully considered.

The Canadian National TB strategy, in keeping with the UN Global Strategy to Stop TB, follows the Canadian Thoracic TB Standards and adheres to public health principles of human rights (Government of Canada, 2018a). The National TB Strategy targets populations at greatest risk for TB in Canada, such as Indigenous Canadians and foreign-born peoples within Canada. The strategy asserts the nation's commitment to decreasing TB by: 1) utilizing evidence-based best practices in TB care; 2) promoting Indigenous involvement in TB policy development to ensure cultural safety; 3) ensuring that TB program evaluations are completed in a timely fashion; and 4) working to ensure cooperation, communication, and commitment to the eradication of TB is recognised as fundamental by all rights holders (Government of Canada, 2020).

The Government of Canada supports the WHO's End TB Strategy with its aim to reduce global TB incidence to ten cases per 100,000 of population by 2025, and with a further reduction goal of fifty percent by 2035 (WHO, 2021b). According to the Director General of WHO, Tedros Adhanom Ghebreyesus, "the success of TB elimination rests on unwavering support and high-level political commitment" (p. 1). Canada, a fervent supporter of TB eradication strategies globally pledged its financial support to the WHO strategy. Despite this laudable rhetoric and the numerous frameworks, standards, and plans proposed by the Canadian Federal Government, the funding support for TB "elimination", even within its own country, is miserly. Canada, a founding member of REACH TB, an organization supporting global TB "detection programs", contributed $85 million across the years between 2017-2021 (Government of Canada, 2022a). Within Canada, in 2018, the prevalence rate of TB in Nunavut rose to 300 times that of all other Canadian-born Canadians, and yet the Government of Canada pledged a mere $27.5 million over five years (i.e., $5.5 million a year) to TB prevention and control strategies in Inuit Nunangat

(Government of Nunavut, 2018). Furthermore, in global TB "elimination" (rather than detection), in 2019 Canada gave only seventy-six percent (i.e., $19.3 million) of its previously committed annual contribution of ($25 million) for global TB elimination research (Faust & Zimmer, 2021). While estimating a funding level that might constitute an adequate response to TB can only be hypothetical, it is clear that spending on Inuit is inadequate as it represents 0.003% of a 2018 Canada-wide health spending budget of approximately CAD 175 billion (Canadian Institute for Health Information, 2018). Further, contemplating such a figure raises questions about human rights, appropriate reparations for cultural genocide, and the value of human life. It must also be acknowledged that decolonization is a perspective, and that physical eradication of colonial legacies is impossible – even when Inuit voices are heard, the injustices of colonial acts remain a fact of history which have indelible impacts. Yet, in contemplating these kinds of questions, it is also important to recognize federal government statements such as the statement by the Department of Finance Canada in the context of the 2021 budget, that "No relationship is more important to the Federal Government that the relationship with Indigenous peoples" (Government of Canada, 2021). Taken together, such words and inadequate financial pledges, could be perceived as mere tokens that reflect poorly on the Government of Canada's true commitment to eradicating TB and its ongoing deprioritization of Inuit of Nunavut.

Past public health programs attempted to identify, trace, and treat TB from a colonial, paternalistic, and biomedical perspective. These programs did not achieve eradication of TB, instead they left a legacy of Inuit mistrust of the health care system, fear of being sent away from Nunavut without hope of return, and stigma related to being diagnosed with TB; the impact of these programs thus endures and interferes with efforts to encourage Inuit to seek diagnosis and treatment for TB (ITK, 2018b). That such public health TB strategies were oblivious to a need

for cultural safety, a commitment to social justice or the need for health equity for Inuit, meant the incorporation of initiatives such as removal from traditional lands to sanatoriums that became virtual incarceration (Browne et al., 2016). In seeking to avoid repeating the injustices of the past, working to ensure cultural safety in the context of TB public health in Nunavut means raising awareness that it is Inuit who must hold the power to make (democratic) choices that determine the health care strategies affecting them and their communities.

It has only been in the last fifteen years that Inuit-specific and Inuit-led TB strategies and frameworks have been developed. The documents developed in that time address a variety of issues facing Inuit including food security, housing, education, and of direct relevance here, TB health (ITK, 2018b). In 2013 for example, ITK developed an Inuit-specific TB strategy as TB prevalence rates started to rise across Inuit Nunangat (ITK, 2013). The Inuit-specific TB Strategy was created to increase awareness of the need for effective Inuit-focused TB initiatives related to the prevention and control of TB, and to bring together stakeholders to try to decrease the incidence of TB by using an Inuit-specific TB action plan (ITK, 2018b). ITK recognized that eliminating TB from Nunavut would mean finding a means to deliver the actions and strategies that Inuit identified would be culturally safe (ITK, 2018b). It was further argued that social and behavioral factors that impact TB prevalence in Nunavut must be given the same investment of energy, time, and money as biomedical and environmental factors related to TB (Uppal et al., 2021).

In response to ITK's strategy, in 2017 the Government of Canada entered into an Inuit-Crown Partnership Committee (ICPC). The ICPC would support a “whole of government approach” to address issues such as TB, which were identified as needing attention that was beyond the capacities of specific departments or agencies. This approach was not unlike the

"permanent bilateral mechanisms" that the Government of Canada has in place with Métis and First Nations peoples which identify joint initiatives and monitor government progress (Government of Canada, 2022b). The ICPC had four initial objectives including the: identification of shared priorities; development of structured partnerships and actions for shared priorities; creation of accountability metrics, and publication of progress (Government of Canada, 2023). Since its inception in 2017, the ICPC has focused on numerous priorities including health and wellness (including food security and TB elimination), housing, education, land claims and climate change. Research both in 2017 and since, indicates that to decrease TB mortality and morbidity among Inuit, social factors including food insecurity and poor housing require direct mitigation strategies (Bougie & Kohen, 2018; N'Diaye et al., 2019; Uppal et al., 2021).

Strategies identified by ICPC to address social factors impacting TB in Nunavut have included the Makimaniq Plan: Territorial Food Security Strategy (food insecurity), Nunavut Housing Strategy (housing crisis), and the Nunavut TB Elimination Action Plan Strategy (public health). These strategies highlight the attempts by the Government of Nunavut, ICPC, NTI, ITK and Pauktuutit Inuit Women[17] in collaboration with the Government of Canada, to address ongoing inequities in the social determinants of Inuit health that result in the continuing presence of TB among Inuit. The three strategies are discussed below with the aim of showing the concerted efforts made, the challenges addressed, and the limitations faced.

[17] Pauktuutit is the national representative organization of Inuit women in Canada and is governed by a 15-member Board of Directors from across Canada (Pauktuutit Inuit Women of Canada, 2023).

2.11.1. Makimaniq Plan: Territorial Food Security Strategy

Food insecurity remains an ongoing reality in Nunavut and is a SDOH that introduces additional negative consequences in the context of TB (St-Germain et al., 2019). For those experiencing TB, poor nutrition equates to increased risk of disease severity, reduced compliance with treatment modalities, and reduced effectiveness of medications (Uppal et al., 2021). In 2010, a territorial poverty reduction strategy referred to as the Makimaniq Plan was created in Nunavut (NTI, 2011). From this territorial strategy, the Nunavut Food Security Strategy and Action Plan 2014-2016, was created (Nunavut Food Security Coalition, 2014). Action plans focus on food security by ensuring Inuit have access to country food (traditional food sourced from the land, lakes and ocean) and that there is a balance between Inuit hunting rights and principles of wildlife conservation (Nunavut Food Security Strategy, 2014). The initial plan was then updated when the Makimaniq Plan 2: A Shared Approach to Poverty Reductions, 2017-22 was developed (Nunavut Round Table for Poverty Reduction, 2016). In 2018, Inuit households with children had 62.4 % food insecure adults and 42.7 % food insecure children (Statistics Canada, 2018). In 2021, ITK developed the Inuit Nunangat Food Security Strategy (ITK, 2021). This Inuit developed strategy clearly identifies the numerous and interrelated drivers of food insecurity, including poverty, climate change, and a lack of governance over Inuit food systems (ITK, 2021). It also identifies the actions necessary to provide Inuit with greater control over their food systems via policies, programs and initiatives that put Inuit well being at the centre of all food security initiatives (ITK, 2021). However, according to Natan Obed, ITK's President, *food security* still does not exist in Nunavut and in fact, the level of food insecurity that Inuit experience is a "human rights violation" (ITK, 2021, p. 2). COVID-19 exacerbated Inuit already disastrous food insecurity as shipping costs increased and were passed on to Inuit consumers

through increasing food costs (Wirzba, 2021). Food insecurity in Nunavut remains a critical public health crisis.

2.11.2. Nunavut Housing Strategy

When Nunavut was established in 1999 the Government of Nunavut inherited the social housing programs from the Northwest Territories; according to Tester (2009) the housing that was existing was in poor repair. Today in 2023, there is a severe shortage of both social and private housing. In Iqaluit, the capital of Nunavut, private rental accommodation fetches prices of $2785 a month, for a small two-bedroom apartment and has a vacancy rate of 0.07%. In the public housing sector, the reality is that the 5,955 public housing units available, are home to 22,831 occupants (Venn, 2023). Thus, it is not surprising that one in every five homes across Nunavut shelters unhoused community members (ITK, 2022). Currently, 52% of Nunavut residents live in substandard housing provided by the Government of Nunavut (Nunavut Housing Corporation, 2016). This demand is increasing, as 33% of Inuit in Nunavut are under 15 years of age, and that segment of the population is increasing (Government of Canada, 2019b; ITK, 2018b; Statistics Canada, 2022). In 2019, ITK and the Government of Canada co-developed a National Housing Strategy for Inuit Nunangat through the ICPC that sought to: 1) address the effectiveness of recent investments in housing; 2) develop long-term plans to address the housing crisis; 3) target funding to Inuit communities in greatest need; 4) reduce overcrowding and increase affordable housing, 5) develop Inuit labor skills, and 6) enhance intergovernmental collaboration (Government of Canada, 2022a; ITK, 2019).

In 2019, ITK reported that Nunavut was 3800 housing units short of meeting housing supply needs. Such gaps in housing supply are meant to be addressed by federal funding from

the Canada Mortgage and Housing Corporation National Housing Agency that is then directed to the Nunavut Housing Corporation which oversees all public housing in Nunavut (Nunavut Housing Corporation, 2016). In 2021, the Government of Canada announced a further $45 million was to be put towards a Nunavut Housing Corporation housing project referred to as the Rapid Housing Initiative that is proposed to build 101 affordable and permanent housing structures (Canada Mortgage and Housing Corporation, 2021). Nunavut's' Housing Corporation is further looking to retrofit existing housing to increase energy efficiency and decrease environmental concerns such as the presence of black mold (Frizzell, 2018; Government of Canada, 2018a). Mold caused by improper insulation and ventilation creates an environment for respiratory health concerns and is not conducive to TB elimination (ITK, 2019). Furthermore, overcrowded and poorly ventilated housing leads to increased spread of TB bacteria, increases respiratory conditions such as pneumonia and asthma, which make individuals more susceptible to contracting TB, and increases mental health concerns leading to increased non-compliance in completing TB treatments (Canada Mortgage and Housing Corporation, 2022; Uppal et al., 2021).

Nunavut's housing crises remains despite the numerous ongoing housing initiatives, including Nunavut 3000, a plan to build 3000 houses by the year 2030 when it is hoped that TB will be eradicated in Nunavut (Iigluliuqatigiingniq, 2023). When analyzing why the numerous initiatives undertaken to date have not met the growing housing needs of the growing Inuit population, it is Inuit themselves who provide the clear answer to the ongoing dilemma. Inuit have expressed community concerns that federal commitments of $1.3 billion towards housing that have been made since 2016 have failed to meet, and in fact do not meet even half of what is required to ensure basic Inuit regional housing objectives for the next 10 years (ITK, 2019). Such

funding disparities and deficiencies are evident when considering that in the fiscal year 2022, 175 individual housing units were built by Nunavut Housing Corporation at a per unit cost of $923,447, totally over 161 million dollars (Venn, 2023). Thus 3000 units would equate to approximately $3 billion: Nunavut's housing shortage equates to a critical public health crisis in Nunavut.

2.11.3. Nunavut TB Elimination Action Plan Strategy

In addition to these diverse housing strategies, in 2020, the Nunavut Tuberculosis Elimination Action Plan, 2020-2023 was created by NTI in partnership with the territorial Government of Nunavut (NTI, 2021). The plan commits both NTI and the Government of Nunavut to working to eliminate TB from Nunavut by 2030 (NTI, 2021). The following specific and culturally safe actions have been identified by both parties as being necessary to achieve the goal of TB elimination in Nunavut. These actions are (NTI, 2021);

1. promoting advocacy and partnerships
2. strengthening the health care system
3. improving food security
4. strengthening families and communities
5. eliminating TB-related stigma
6. strengthening Nunavut's TB program
7. supporting Community TB screening
8. promoting education and employment for Inuit, and
9. promoting Inuit-governed research.

This partnership is a positive step on the path to TB elimination as previous researchers and experience have shown that TB public health cannot be viewed in isolation from the diverse

economic, political, cultural, and social factors that shape its presence and continuance in Nunavut (Daschuk et al., 2006). Attempting to address each of these strategic actions will require both time and, according to Dr. Michael Patterson past Chief Public Health Officer of Nunavut, an increased and sustained financial investment by the Canadian Federal Government. Additional funds will be required to adequately support and invest in the actions Inuit have outlined in the strategy, in ways that will eliminate the inequities in the social determinants of Inuit health and facilitate improved health, and health outcomes (Dr. Michael Patterson, A/CPHO of Nunavut, personal correspondence, July 3, 2023). Many of the actions proposed in this strategy are achievable, however without adequate and sustained funding, the Government of Nunavut and its numerous partners will be unable to maintain the impetus that is required to address these actions and eliminate TB in Nunavut.

In this chapter I have presented a literature review that places my research within the historical trajectory of knowledge about colonialism in Canada and its ongoing effects on Inuit of Nunavut. The review identified the absence of Inuit voices and perspectives in the narratives that construct current understandings of Inuit health inequities and limit self-determination. Despite the absence of Inuit accounts, the literature review highlighted the atrocities carried out in the name of colonialism. Furthermore, colonialism and neocolonialism continue to impact Inuit lifeways and contribute to the unjust and inequitable TB crisis that has become synonymous with Inuit of Nunavut. In the next chapter I explore research theory and perspectives, demonstrating how I use each to address my research objectives: identifying the nature of cultural safety in Inuit communities; understanding how TB-related stigma shapes TB in Nunavut; and contemplating ways Inuit knowledge can be used to increase self-determination in health care related to Government of Nunavut Inuit TB public health policy and programs.

Chapter Three: Research Theory and Methodological Underpinnings

3.1. Introduction

In this chapter I introduce and discuss the theory that grounded my methodology (chapter four) in engaging with Inuit and working with the knowledge they shared about experiences and perspectives of TB public health policy and practice in Nunavut. In all elements of my research, I took a critical stance. The theory, orientation, and frameworks that I used in the research, informed, and were interconnected and interrelated with, the methods used for both data collection and analysis. The theory and interconnected frameworks utilized to inform my research are shown in Figure 1.

I first outline below postcolonial theory and the concept of cultural safety, to indicate why they are vital to and prioritised in my research; these theories oriented and focused my thinking, and I used them to ensure that I critically examined the structural inequities and ongoing power relationships between Inuit and the Government of Nunavut around TB public health. Cultural safety also became a fundamental element of my research practice and values which allowed me to reflect on ways that my research would advance Inuit perspectives instead of perpetuating epistemic violence against Inuit.

I next discuss the approaches I used: CBPAR (community based participatory action research), and an ITK research strategy (Inuit Tapiriit Kanatami). I explore how their principles and their logics position my thinking and inform my methods for engaging with Inuit specific knowledge and to derive recommended actions based on Inuit perspectives. Although CBPAR focuses researchers on addressing and neutralizing inequitable power relationships in research,

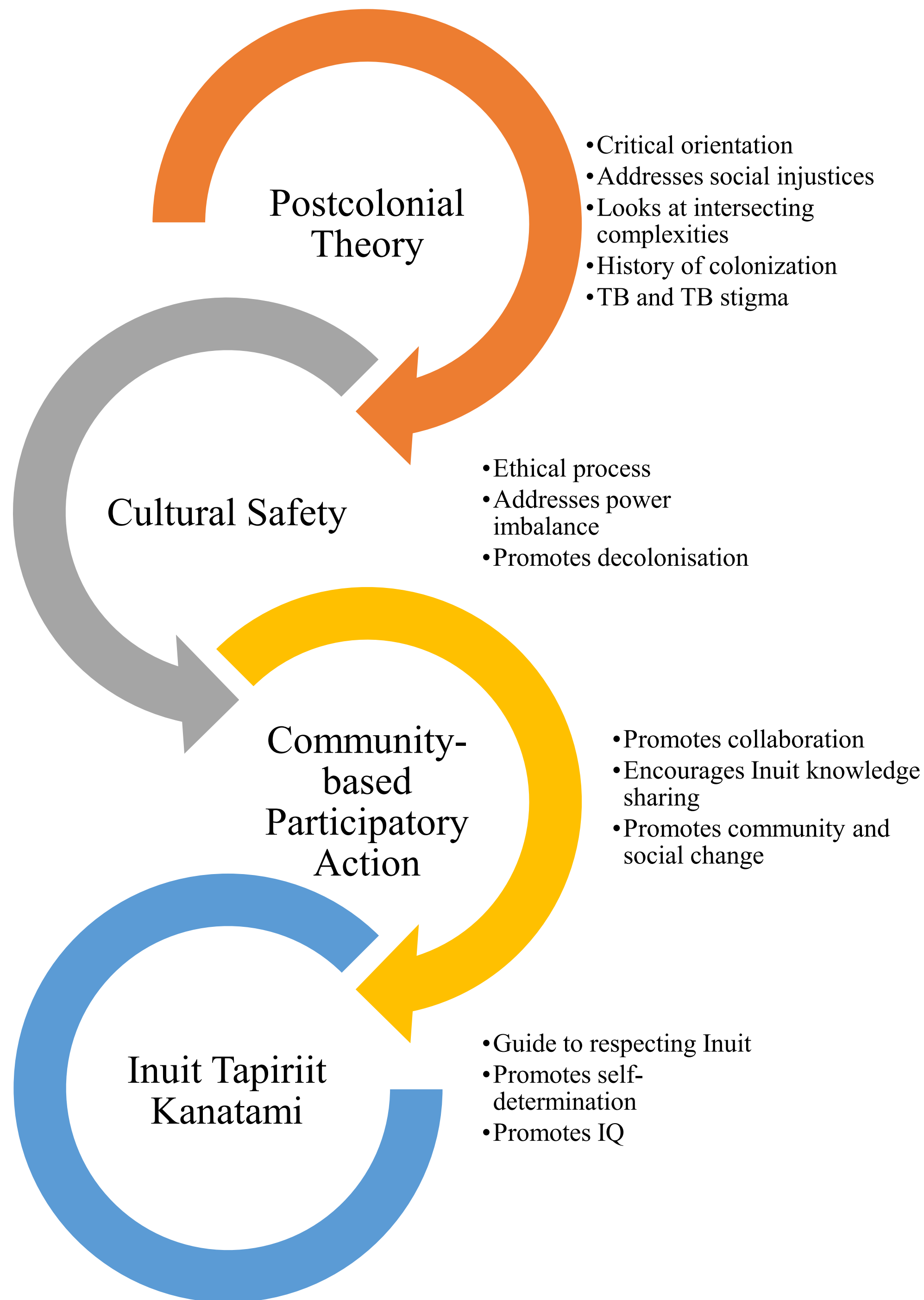

Figure 1: Research Theory and Frameworks

it has been created and adopted within western contexts and therefore inevitably retains western and postcolonial perspectives (Lenette, 2022). I discuss how, to ensure that I complemented these western models with Inuit knowledge, and foregrounded that Inuit knowledge, epistemology, and ontology, I used the ITK Research Strategy (ITK, 2018a). Including the ITK strategy allowed me to deepen my understanding of Inuit ways of being, knowing, and doing. I also describe that I included an Inuit Research Advisory Committee to guide and inform my research. Members of the committee represented the two regions where the research was carried out and assisted me to understand and apply cultural and community information that facilitated my research.

3.2. Postcolonial Theory

I used postcolonial theory to examine how postcolonial relations between the Canadian nation-state and Inuit continue to oppress and negatively impact Inuit health outcomes. I also used it to identify opportunities to address ongoing colonial power inequities. Using postcolonial theory, researchers question the status quo, confront injustices, and interrogate the consequences of colonialism and the continuance of colonial power inequities in the postcolonial era (Getty, 2010; Holmes, et al., 2008). It is a theoretical approach which was developed by numerous postcolonial scholars and so reflects their differing experiences and perspectives, while continuing to evolve in this current neocolonial era.

An early postcolonial theorist, Franz Fanon (1925-1961), wrote of the experiences of the colonized in north Africa, in his 1952 foundational work Black Skin, White Masks. Analysing the domination of white men over black men, Fanon identified that ongoing colonial power relationships defined colonized people as inferior; a label that was internalised in ways that led to

assimilation of the culture of the colonizer and loss of pre-colonial ways. Also focused on the effects of colonization in North Africa, Edward Said's (1935-2003) groundbreaking publication Orientalism formalized the concept of postcolonialism and became a foundational work for the discipline. Said critiques power relations and the imposition by the colonial west of demeaning and simultaneously romanticized stereotypes which belittle, exclude and other the "Oriental" (Said, 1978). Said argued that the consequences of orientalism continue into the postcolonial era, with the colonizer continuing to impose expectations e.g., language and cultural performance, at the expense of the ignored, overpowered and socially othered colonized peoples (1978). For Inuit, the ongoing consequences of colonialism that impact health can be see for example in the imposition of the English language in health care provision. Homi Bhabha (1949-) built upon Said and Fanon's works but focused on the relationship between the colonial and colonized in the postcolonial period. Bhabha's work theorizes that in the postcolonial period, when the colonized region gains political independence, the subjective identity of the new nation will emerge out of the struggle to reconcile diverse trajectories (Bhabha, 1995; Byrne, 2009). Nunavut was created as a new territory in only 1999 and its subjective identity remains entangled with the historical colonial and contemporary neocolonial Federal Government. In the arena of TB health this results in Federal Government statements and national positioning regarding Indigenous peoples, which have little overlap with Inuit needs and cultural safety.

Fanon, Said, and Bhabha worked in Egypt/Palestine, Algeria, and India respectively, and wrote about the experiences of postcolonialism in modern nation states where the colonising power had left, governance was independent, and citizens struggled to formulate new postcolonial identities and ways of life. However, that is not the experience of Indigenous peoples, as highlighted by Indigenous postcolonial theorists such as Aileen Moreton-Robinson

(2011). Moreton-Robinson highlights that even after the formal end of colonization, e.g., after the end of British rule, Indigenous peoples continue to experience colonization. Colonization did not disappear for Indigenous peoples when formal colonization by European powers ended and local state autonomy was granted; for Indigenous people the colonizing state did not leave, Indigenous self-determination was not afforded, and Indigenous people's subjective position as citizens connected by ancestry to the land was not recognized or valued (Moreton-Robinson, 2011). Research using postcolonial theory in Indigenous contexts must therefore critically engage with the ongoing causes and effects of Indigenous people being outsiders in their own land.

Within postcolonial theory literature there are two distinctive ways of writing the term "postcolonial": the hyphenated version "post-colonial" and the non-hyphenated "postcolonial". The hyphenated version implies that colonialism is of the past and that the present is post (after) the colonial experience has ended. The use of the hyphen adds a visual cue separating the period of colonialism from its aftermath (Gandhi, 2019). In recognizing that colonialism persists without temporal interruption, I instead utilize the unbroken, unhyphenated choice of "postcolonial". This is representative of the need to both remember and revisit the colonial past, and to be cognizant of the enduring legacy of health inequities and disparities which continue to be shaped by ongoing practices of neocolonialism. Neocolonialism, according to leading postcolonial theorist Gayatri Chakravorty Spivak (1942-), is "what happened after the beginning of the dismantling of colonial power" (Spivak & Young, 1991, p. 220). It is a form of colonialism that continues to hold power and control over Inuit from a socio-economic and political standpoint. One example of this is seen in Federal Government regulation of Nunavut's community fishing programs, where Inuit knowledge of sustainable use of waterways is

devalued (Bernauer, 2022). Postcolonial theory provides insight into such ongoing manifestations of false colonial narratives, and the constructed "conceptualizations of race, racialization, and culture within neocolonial contexts" (Browne et al, 2005, p. 20).

Examining the diverse tensions and interconnections that become obvious during a critique of postcolonial social and power structures, brings to light colonial impacts on Indigenous people including enduring social injustices, language loss, identity loss, structural and direct racism, and implicit and explicit biases (Reimer-Kirkham & Anderson, 2002). Among the concepts that are positioned in and stem from postcolonial theory, the most relevant to the study of inequities in health and health care are identified as including racism, othering, paternalism, stigma, and loss of both knowledge and voice (Browne et al., 2005). Spivak again provides insight in this context through her identification of "epistemic violence," which she theorized as the "disappearing" of knowledge when local or Indigenous knowledge is dismissed, disrespected, appropriated or silenced due to the privileging of more powerful, colonial alternatives (Dotson, 2011). When considering these negative and limiting impacts on communities and individuals, it is clear that use of a postcolonial lens is "congruent with nursing's mandate for social justice and [offers a] context for analysis of social inequities [that] is committed to action" (Bickford, 2014, p. 215).

Postcolonial theory provides a critical lens through which to examine how Indigenous-colonial relations continue to have negative impacts and influence the health and well-being of Inuit. That these impacts endure for Inuit and not simply all Indigenous people in Canada, was evidenced in 2016 in what was known as the Jordan's Principle – A Child First Initiative (Government of Canada, 2018b). This well-meaning initiative was led by the Canadian Federal Government and aimed to clarify funding ambiguities and address special service requests for

chronically ill or terminally ill Indigenous children (Government of Canada, 2018b). However, despite being deliberately established to aid Indigenous children, Inuit children were omitted from this initiative. That is, while other First Nations children were eligible, Inuit children were denied access to the program simply because they were Inuit. According to Natan Obed president of ITK, Inuit children were excluded "*solely* on the type of Indigenous person we are" (2018b, emphasis in original). Although the policy has since been rectified, that Inuit were ever excluded indicates the deficiencies in the very systems that are supposed to advocate for and protect Inuit health.

As this example demonstrates, the colonial power inequities and biases that are embedded in Canadian government bureaucracies, policies and process continue to oppress Inuit. Impacts on Inuit communities and governance are dominated by ongoing and historical processes, such that Inuit experience "marginalization, racialization, and oppression by both structural and historical politically and socially entrenched powers" (McGibbon et al., 2014, p. 180). These impacts have fostered relationships of dependency whereby the majority of Inuit are forced to rely on mandated external, government systems to access the routine needs of daily life that are enjoyed by other Canadian citizens. From a postcolonial position, relationships of dependency are understood to be created when the postcolonial structure is predicated on the assumption that Indigenous people are incompetent to navigate the complexities of the "modern" world and must rely on their colonizers for paternalistic support (Browne et al., 2005; Jensen, 2009; Spivak, 1985; Thomas & Stephen, 2020).

In the context of Inuit TB health, relationships of dependency emerge from two specific Kablunaaq failings. First being the widespread Kablunaaq stereotype that Inuit are complacent and disengaged from efforts to address their own health. The second being that Kablunaaq had

failed to understand Inuit ways or communicate in respectful terms that Inuit could engage with. Both these Kablunaaq failings meant that, over time, Inuit internalized their supposed inadequacies (Alexander & McKee, 2021). Having come to believe themselves incapable of managing their own health, many Inuit disengage and become dependent on paternalistic health care (Alexander & McKee, 2021). Spivak argues that the normalization of a place of inferiority was how people came to understand and internalize their position in the world as necessarily lesser and dependent on the colonizers (1985). In countering such paternalistic impositions and disempowerment, the idea of cultural safety was developed.

3.3. Cultural Safety

The concept of Cultural Safety was developed by Irihapeti Ramsden (1946-2003) and Māori nurses in Aotearoa New Zealand out of a deep concern that a lack of self-determination was causing inequities in Indigenous peoples' health (Papps & Ramsden, 1996). Inspired by the principles of protection, participation, and partnership, the idea at the core of cultural safety was that health professionals should seek to identify practical ways to address the social, economic, political, historical, and often emotional reasons for the increased incidence of chronic health conditions faced by Māori (Papps & Ramsden, 1996). Cultural safety is known as *Kawa Whakaruruhau* in the Māori language (Papps & Ramsden, 1996).

Extended outside Aotearoa New Zealand, Cultural Safety in health care literature today is diversely understood and applied. Advocates of cultural safety have evolved terminology when probing theoretical consequences and identifying cultural safety's essential elements, diverse ideas, contributions, usages, and contexts. However, wrestling with taking the concept out of its initial context has obscured Ramsden's focused clear objective of delivering care that is

determined to be safe from the perspective of the Indigenous recipient (for example, Ball & Beazley, 2017; Brascoupe & Waters, 2009; Ramsden, 1992; Smye et al., 2010). One example of this loss of focus is highlighted by Anderson et al., who identify that cultural safety has in some instances been reduced to a checklist (2003). Anderson et al., argue that such a simplification grossly undermines the value of cultural safety and Ramsden's objectives that cultural safety centres the Indigenous community in their own words, and must offer "a process of growth that occurs at personal and organization levels… not [be used] as a lens to look through at 'another' who is or has the problem" (Anderson et al., 2003, p. 199). Even here, the use of the word "lens" may create confusion; while Anderson et al., write to resist cultural safety being used as a means to put the issue onto an "other," the term "lens" can in other contexts be used as a positive metaphor for a useful way to look at or approach a topic. A further example of misuse of the concept of cultural safety, is the erroneous understanding that cultural safety can be viewed as being on a continuum with the concepts of cultural sensitivity, cultural awareness, and cultural competency. However, as a critical orientation, cultural safety extends beyond such a continuum to include analysis of power differentials, colonization, institution discrimination, and colonial relationships, with particular focus as Ramsden envisaged to the realm of Indigenous health care (Curtis et al., 2019).

Despite these differences, usages of the core principle of cultural safety, and its antithesis, cultural un-safety[18], are characterised by the recognition of the consequences of Indigenous people being prevented from exercising self-determination in health care choices. Applying a postcolonial critique, complements the project of identifying specific factors of un-safety and

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[18] Note that in the context of culturally safe health care, "un-safety" is deliberately hyphenated to emphasise the separation between Indigenous peoples and safe health care.

seeks to highlight the causes of un-safety in the colonial record. In the context of culturally un-safe health care, a lack of self-determination is understood to mean that Indigenous people do not have the power to choose from appropriate health care options that are suitable for meeting their needs. Researchers and advocates of health equity have argued that there is a need to adopt and apply cultural safety principles in order to first identify the factors contributing to cultural un-safety, before critiquing, seeking to mitigate the effects of, and ultimately deconstructing, colonial health care systems that limit Indigenous self-determination (Browne et al., 2005).

Focusing on cultural safety means prioritizing, appreciating, and valuing the positionality and subjectivity of the Indigenous group who needs that cultural safety in order to attain the appropriate health care required to thrive (Smye et al., 2010). As a result, there is a need to consider what cultural safety means in relation to the intersecting dimensions of power relationships, such as social disadvantage and explicit racism, which ultimately affects the provision of services, such as health care and access to health care services (Polaschek, 1998). In this research, I therefore use cultural safety to orient the critical theoretical analysis, and allow power imbalances, and misuses and abuses of power, to be identified. When transfers of power within diverse relational contexts are examined, underlying assumptions are also uncovered which creates the opportunity for safe environments that achieve health equity to be created (Brascoupe & Waters, 2009; Curtis et al., 2019; Milne et al., 2016; Richardson et al., 2017). Examining existing health care systems in this way shows that health care equity can only be achieved when the receiver of the care, the cultural knowledge holder, holds the power to determine policy, procedures, processes, and actions that create the care options from which they can select. According to Papps and Ramsden, use of cultural safety advances equitable health

care relationships by highlighting that patients may hold different worldviews to their healthcare providers (1995).

In this research I therefore use cultural safety as an "orientation" that informs and shapes every aspect of the research in ways that are illustrated in Figure 2. My use of the term orientation is because it conveys my deliberate choice to orient myself with the values of cultural safety in every element of my critical positioning, methodology, reflexive practice, interviews, analysis, and outcomes; cultural safety is the underlying logic that orients my research.

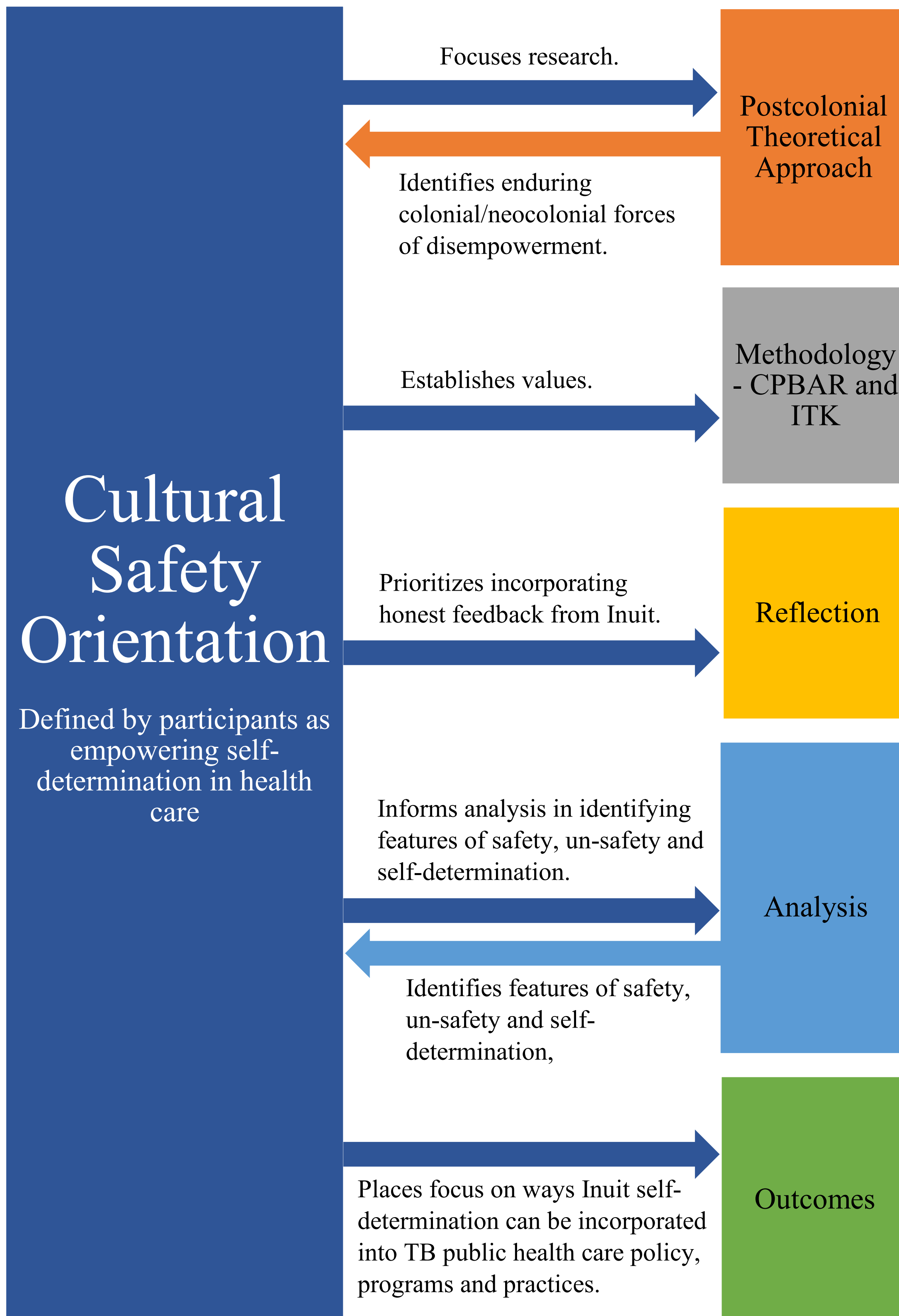

Figure 2: Cultural Safety Orientation

The following list describes my orientation towards cultural safety as an approach to conducting research with Inuit. In choosing to operationalize cultural safety as an orientation, I:

1. Concentrate my postcolonial critical engagement and critiques of the history of colonization of Inuit, to make sure that I focus on identifying enduring colonial and neocolonial sources and forces that disempower Inuit self-determination.
2. Prioritize the cultural safety of my research participants in my methodology, to make sure that I do not perpetuate epistemic violence.
3. Draw on the open and honest support and feedback of my Inuit Research Advisory Committee members and participants in order to reflect on my behaviour and research, so that I address my inevitable mistakes as a Kablunaaq, nurse researcher and as a clinician and senior program analyst to the Government of Nunavut.
4. Focus my analysis to be aware of data that points towards and highlights Inuit knowledge about what they identify as culturally safe and un-safe.
5. Extract knowledge from my findings to share ways that Inuit self-determination might be incorporated into future decisions about the development, implementation and goals of health care policy, programs, and practices.

In considering this list it is clear that cultural safety is vitally concerned with every element of my research.

3.4. Cultural Safety and Postcolonial Theory

The application of cultural safety that is informed by a focused critique based on postcolonial theory, fosters deep introspection and critical reflexivity which allows for the questioning of assumptions, situatedness, and power relations of both researchers and health care

professionals (Thambinathan & Kinsella, 2021). Using postcolonial theory to critique colonization, attempts at decolonization, enduring colonial legacies and neocolonial structures that limit Indigenous self-determination "addresses the multiple facets of disconnect between health care and Indigenous health outcomes and the root of perpetual inequity itself" (Eni et al., 2021p. 2). This compatibility is also noted by Alexander, who has argued that "cultural safety is a mode of policy resistance against neocolonialism with the goal of achieving a postcolonial reality" (Personal communication, May 6, 2020).

Using cultural safety as an orientation, provides the underlying rationale and logic for this research, and complements the use of postcolonial theory to highlight enduring colonial inequities that are resulting in cultural un-safety. Both postcolonial theory and cultural safety position researchers to interrogate injustices and oppression from the perspective of those oppressed (Keikelame & Swartz, 2019). Using postcolonial critique to understand the reasons and mechanisms by which Indigenous people are disempowered is important if spaces for safe discourse are to be created so that Indigenous perspectives can be shared in a manner that transforms the researcher; this process of transforming the researcher involves a sort of decolonization of the self (Keikelame & Swartz, 2019; Nair, 2017; Smith, 2012). Critical reflexivity or decolonization of the self is an unsettling process. de Leeuw and Greenwood suggest that engaging in research to uncover the causes of un-safety and the requirements of cultural safety as a step towards reconciliation, involves "unsettling comfortable ignorance and reorienting awareness that one's comfort is built on colonial violence towards Indigenous peoples" (2017, p. 144). In the Truth and Reconciliation Commission of Canada: Calls to Action report, reconciliation was defined as "an ongoing process of establishing and maintaining respectful relationships" (Truth and Reconciliation Commission of Canada, 2015). According to

de Leeuw and Greenwood, this process opens new space for "innovative even creative means for non-Indigenous settler-colonial subjects to reform [their] knowledges about colonial violence of the past, present and future; to behave, in essence in more culturally safe and attuned ways that put decolonizing theories and practices into action" (2017, p. 144).

Undertaking a critique using the tenets of postcolonial theory advances contextual understandings of the realities and social histories of people who are marginalized in and by health care (Reimer-Kirkham et al., 2002). The insights from critiques based on postcolonial theory therefore inform understandings of the ever-changing and persistent causes of cultural un-safety. Part of the importance of undertaking such a critique is that it shows that cultural safety is not static and can be multidirectional; it can only be determined by Inuit in each situation. As social, economic, and political factors change with time, so too do the elements that limit Indigenous self-determination. Smye et al., identified that while settlers cannot determine what is culturally safe or culturally un-safe for Indigenous peoples as individuals, communities, or nations, they must develop "a critical consciousness towards power differentials inherent in health care" and the skills to assist in making cultural safety a reality in their particular situations (2010, p. 6). Competencies that advance cultural safety include developing an understanding of colonization, a commitment to key principles in indigenous health, the utilization of culturally safe communications and language, and the recognition of Indigenous knowledges (Reimer-Kirkham et al., 2002; Richardson & Williams, 2007).

As a Kablunaaq researcher conducting research on Inuit homelands and with Inuit, it was of tantamount importance that I approached this research in a manner that put decolonizing practices into action. I needed to ensure my research activities were at all times culturally appropriate, respectful, and did not further harms caused by systemic oppression, epistemic

violence or cultural un-safety towards Inuit (Datta, 2017; Kovach, 2010; Tuhiwai-Smith, 2012; Wilson, 2008). I sought direction from my Inuit Research Advisory Committee members throughout the research when concerns arose regarding the cultural appropriateness of my actions. For example, the Inuit Research Advisory Committee reviewed my research questions and advised on their applicability and nuances of meaning; the ongoing specific advice and direction obtained from the committee is discussed in detail in chapter 4.2. I took full responsibility for my own actions ensuring that I met the cultural safety competencies, and I held up community research participants as "knowledge holders," always centering them in the research (Tuhiwai-Smith, 2012). While focusing on Inuit health care and health care outcomes in Nunavut, I further ensured I had a solid understanding of what colonization has done to Inuit and what neocolonial forces continue to do to Inuit as a collective (Smith, 2012). I also contemplated my own responses to and feelings about Inuit and TB, colonialism, and addressed how my own situatedness, as researcher and program policy analyst working with TB policy and practice, impacted my thoughts and actions so that I could be aware of the potential for bias in the research findings (de Leeuw & Greenwood, 2017).

Postcolonial theory-based critiques identify that current health practices and policies continue to represent Indigenous peoples negatively by continuing to support colonializing, objectifying, and racializing discourses upon which institutions were built; this is especially evident in northern health systems (Anderson et al., 2003). Systemic racism, political correctness, human rights abuses, implicit and explicit bias are a few of the uncomfortable topics that efforts at decolonization need to address to improve Inuit health care. In order to empower Indigenous people and ensure TB public health policies and practices facilitate health care

relationships based on respect and agency, it is vital that spaces are created which are both safe and brave, where dialogues can be held in an ethically responsible way (Latimer et al., 2018).

3.5. Culturally Safe Communication and Language

Language represents power, and as a result, “talk is central to the experience of [equitable] health care” (Jennings et al., 2018, p. 109). Dialogue can make one feel valued, or it can reinforce powerlessness. Professional conversations can leave a client or patient with a range of responses including a sense of being dismissed, being judged, or feeling ignored when information is withheld (Jennings et al., 2018). Language can be used to connect people or as a barrier to separate. One principle of cultural safety is to promote awareness and respect in communications, both spoken and un-voiced, between people of different cultures (Hurn & Tomalin, 2013; Manchester, 2013). Of particular relevance to this research is the principle that culturally safe communication (ideally) constitutes Inuit as holding social power, exercising their own self-determination in speaking with their own voices, rather than being treated paternalistically, spoken down to, or ignored. This is critical in research with all Indigenous peoples where the semantics of language and communication play a major a role in the shaping of thought, identity, and culture (Kovach, 2009).

Language also has a major role in the binary of othering, demeaning and excluding. Indigenous knowledge has an “interrelationship between language structure and worldviews, and … colonialism has interfered with this” (Kovach, 2009, p. 59). Dominant colonial Eurocentric knowledge systems privilege specific modes of communication such as writing. However, many Indigenous forms of knowing, and specifically Inuit knowing, are primarily dependent on Oral Traditions. In Nunavut, colonizers displaced, disrespected, dismissed, and banned Inuit Oral

Traditions (van den Scott, 2017). Approaching this research with an awareness of the need to privilege Inuit oral communications meant that I knew it was important that Inuit community knowledge holders were given the opportunity, space, and time to share their knowledge with me. I aimed to communicate respect by actively listening and providing feedback that I had learnt from knowledge Inuit shared.

There is no one common universal Indigenous language or means of communication. However, for Indigenous peoples there is a common shared Indigenous experience of not being heard and being forced to participate in health systems that promote ongoing colonization and oppresses Indigenous peoples and their languages (Jennings et al., 2018). Language can exclude, other, and essentialize. Language can harm. Adopting cultural safety as an orientation increases one's awareness that power imbalances are evident in language usage such as "Indigenous Canadians" or "Inuit of Canada" that is, language that imposes and is mediated by power differentials that force Inuit into a place of inferiority (Jennings et al., 2018). However, if the utilization of language is informed by cultural safety, it can also be used by both researchers and health care professionals to acknowledge Inuit voices. Even when language usage is encouraged, healing can only occur when an awareness of power differentials and resulting inequities are critically examined. Self-reflexivity, key to cultural safety, promotes examination of the interconnectedness of our roles in relation to those who have been othered under the ongoing assumptions and practices of colonialism.

3.6. Locating Myself in this Research: My Story, My Direction

I am without a doubt a person of privilege. I am a white immigrant, the invisible immigrant, a new settler in Canada, and a Kablunaaq when in Nunavut. I did not grow up

knowing the privilege of wealth but I have also never suffered for having white skin, and while I have had to work for everything that I have attained, I recognize that others have not had the opportunity to work, study or achieve due to implicit or explicit bias, discrimination, and outright racism: by virtue of not being white they have been denied the chance to acquire the opportunities that I attained.

I occupy a position of privilege in relation to my topic as well. I have had the incredible privilege of working with Inuit in many Inuit communities across Nunavut. As a nurse, I have held positions of power and control over community members' health and well-being. I am Kablunaaq and so I should be considered to be an outsider, however I am uniquely positioned in a space that places me as an "insider of sorts" in this research. As the research process has evolved, I have come to realize that this is not an easy position to exist within. It is also a lonely space to exist within. In addition, as the mother of Indigenous children including those who are Inuit, I recognize that the space in which I am positioned has definitely shaped my relationships with research participants.

I am privileged to have a personal understanding of Inuit ways and worldviews that many researchers do not, nor ever will, have access to. I have been warmly welcomed in carrying out my research in Nunavut. I have not been met with any degree of mistrust, or distrust. I have had Inuit call to ask if they can help me in any way with my research. I am quite sure that this is a privilege that few researchers experience when carrying out research across Nunavut. Such relationships have benefitted me when accessing and recruiting participants, in gaining Inuit input during the creation of and in asking research questions, and in reviewing findings with Inuit who could give greater historical and IQ context to findings. All of this assisted me in gleaning a greater understanding of Inuit lived experiences with ongoing colonialism. I recognize

that my longstanding relationships, many built over decades, have created a safe space for me to carry out this research.

At the same time there have been disadvantages in occupying this space. There has been the personal fear of letting community members down by not successfully completing this research. The intensity with which some Inuit have wanted me to succeed has added to my fear of not retelling Inuit perspectives as they deserved to be. I also found that when listening to Inuit share their stories I was overcome with emotion and a kind of guilt: here I was as a Kablunaaq being supported and cared for in my research by Inuit, and yet, it was people visually like myself that have and continue to cause such harm to Inuit. I had not considered that in having such close relationships with many Inuit, I was also more vulnerable to the emotions they would share. This was insightful learning for me.

Coming from this trajectory only increased my commitment to my research obligation and priority which was to ensure the utilization of cultural safety as an ethical approach. In so doing I sought to create an ethical safe research space in which worldviews could meet and open and honest dialogue occur (Ermine, 2007; Sasakamoose et al., 2017). I committed myself to be accountable, to seek feedback from Inuit to address my inevitable biases, and to deliberately ensure that my work advanced the purposeful decolonization of TB public health policies, practices, and procedures to which I am fortunate to have any contribution.

I bring who I am to my research, and who I am is more than a body of Celtic descent who has a history of employment in a neocolonial health care system; understanding that positionality requires more than simply applying an insider-outsider binary, I, like all people, am "multiply positioned in relation to power and privilege" (Fox & Ore, 2010, 631-632). I have had the incredibly good fortune of being able to live in Nunavut, where every day I learnt from Inuit

about Inuit ways, perspectives, and outlooks on life, living, and death. This sharing of wisdom and lifeways is something I never take for granted and which I treasure very much.

From an academic perspective, I am privileged by having had the opportunity to access education and to hold the power of knowledge. I have consciously and reflexively endeavoured to use this knowledge to empower and uplift others, and to resist it being seen as a barrier to others or as a status symbol for myself. As I have journeyed towards the completion of my doctoral research, I have also been benefited through my participation in the creation of an applied human-rights theoretical framework, referred to as D2 Framework (Default to Deliberative Framework; see Appendix C). This framework was created for settlers as a road map per se towards one's own decolonization and as an attempt to support others in their journey towards reconciliation (Alexander & McKee, 2021). This evolving framework has not been directly utilized in my research as a formal methodology since this research uses postcolonial theory, is oriented by cultural safety, and uses the CBPAR framework and ITK strategy. However, the D2 Framework concepts are of personal value to me and inform my own ability to reflect, recognize, and embrace with a heightened awareness, my own default modes of racism and neocolonialism. I had assumed I was "woke" and anti-racist, working the good-fight against colonialism and its inherent stereotypes, racism, stigmas, and oppressions. It is always humbling to recognise (or be told) that you have so much more to learn. For me, the D2 Framework allows me to reflect on my journey away from the dominant colonial narratives and from the ongoing structural/systemic racisms and oppressions occurring in Canada today. The D2 Framework motivates me as a human being to take a deliberative and self-reflexive look at what I need to do to personally, socially, and even politically move away from neocolonialism, and towards reconciliation with Indigenous peoples.

As I carried out my research, and especially when carrying out my analysis utilizing Braun and Clarke's Reflexive Thematic Analysis, I recognized the need to be critically self-reflexive of my relational interests, and what tensions I, in simply being myself, brought to this research (2022). I am aware of the potential for tensions to arise between my desires to be an advocate alongside Inuit and in taking on the role of objective analyst in my research (Reimer-Kirkham & Anderson, 2002). I used a self-reflexive journal as a means by which to examine my experiences, privileges, thoughts, and power throughout the research (see Appendix D). Being self-reflexive assisted me in being able to ensure my actions and interactions were carried out in a responsible manner that was true to my aim to be oriented by cultural safety. I furthermore recognized that as an outsider, my position may have unwittingly disempowered the participatory and respectful foundational objectives of this research. I am a privileged person. In being self-reflexive, I challenged myself to question my own actions and interactions with Inuit. In utilizing a cultural safety orientation, as the outsider researcher I tried to position myself as a respectful learner in all my interactions with Inuit; I rejected any instances where I could be interpreted as presenting as someone who holds superior knowledge or authority to Inuit (First Nations Health Authority, 2019). It is from my unusual and privileged position that I have carried out my research.

By constantly orienting myself and my research towards cultural safety, I have been able to seriously question the past and present impacts of colonial systems on Inuit. Staying oriented towards cultural safety helped me to analyze how power is operationalized in public health policies, programs, and practice. This gave me a conceptual framework from which to glean an understanding of how the purposeful creation and continued perseverance of TB-related stigma decreases Inuit power and how the presence of cultural safety reclaims that power for Inuit. Inuit

are the only stakeholders who should hold power in determining how safe and or un-safe public health nursing care and public health programs have been for Inuit, both emotionally and intellectually (Ball, 2017). Orienting myself to cultural safety has highlighted the need to develop a critical consciousness of all intersecting power differentials in public health policy and practice, especially those at the micro level of analysis which is integral to trying to decolonize a postcolonial health care context (Smye et al., 2010). Cultural safety and interwoven postcolonial informed acts of decolonization is promoted by ITK in their research strategy framework to eliminate TB across Inuit Nunangat. A recommendation under this strategy is the recognition of Indigenous knowledges as valuable, and to no longer be subjected to epistemic violence.

3.7. Indigenous Knowledges

As Indigenous people, Inuit knowledge shares many epistemological principles with other Indigenous knowledges and worldviews around the world. One experience common to Indigenous knowledges is that they are questioned and disrespected in ongoing neocolonial epistemic violence. Indigenous peoples globally have and continue to resist this violence. For a Kablunaaq to seek to understand Indigenous knowledges means stepping away from western epistemologies and being open to Indigenous epistemologies and ontologies. One element of Indigenous knowledge that requires a shift for the Kablunaaq is that Indigenous knowledge is relational (Hart, 2010). For the Kablunaaq to understand this concept means allowing that all knowledge, objects, humans, and environments exist in relationship; nothing can be viewed in isolation. Stansfield and Brown explain that an Indigenous worldview sees life as "being lived not according to universal, abstract theories about the way things work, but as an interactive relationship in a particular time and place" (2013, p. 27). It also means that since people, objects and environment are all interconnected, relationships and harmony are prioritized over self

advancement. Little Bear echoes this sentiment stating that Indigenous knowledges are the "sum total of what is known by an individual, group, community, society, nation and humanity" (2009, p. 17).

It is these relational underpinnings of Indigenous knowledges that often challenge western worldviews and make it difficult for those who are enculturated in the western world to understand Indigenous perspectives. For those enculturated in western ontologies, it is often easier to attempt to define, adapt, and even contain, that which their own knowledge and thinking cannot comprehend, rather than contemplating their place within a greater, relational whole, (Hart, 2010). According to Indigenous knowledge, thinking about reality makes that thinking real (Kovach, 2012). This ability to change and influence reality imposes responsibility on the individual, community, and nation; a responsibility that westerners are often oblivious to.

Indigenous knowledges also require a fluid way of knowing that is derived from teachings transmitted from one generation to the next. Knowledge is an experience in context, where the context is the self, in connection to experiences, and the findings from such exploration is knowledge (Kovach, 2012). Furthermore, Indigenous epistemology recognizes and values interconnections between the realms of the human world, the spirit world, and inanimate entities (Battiste & Henderson, 2000; Kovach, 2012; Turner, 2006). This can mean that Indigenous epistemology "is simultaneously elusive and ubiquitous, woven tightly with a personal identity that shifts over a life span and is thought to be holistic" (Kovach, 2012, p. 55). In my research I have acknowledged, sought to respect, and, with Inuit guidance, taken up to the best of my ability Inuit epistemology and IQ principles. I have done this by attempting to situate my findings in a shared relational context with Inuit who embody IQ, which is intrinsic and central to Inuit well-being.

3.8. Inuit Qaujimajatuqangit: A Way of Being

Inuit Qaujimajatuqangit[19] (IQ) is knowledge that Inuit have always known (Karetak et al., 2017). Like other Indigenous knowledges, IQ is grounded in relational ways of knowing and cannot be separated from the land (Karetak et al., 2017). IQ is a contextualized knowledge system that is place-based, tied to the land, to the ancestors, to animals, to other human beings and more than humans (Karetak et al., 2017). Inuit knowing and ways of being is "individual or collectively unique, where identity is not perceived as a label nor does it encompass an identity based on traits whether that is behavioural, artefacts or exclusive worldviews" (Dorais & Searles, 2001, p. 26).

In exploring what IQ means, Bennet and Rowley note that IQ is "the knowledge that was passed down by ancestors, things that we have always known, things crucial to our survival-patience and resourcefulness" (2008, p. 21). Marchildon and Torgerson described Nunavut as being the only substate in Canada in which an Indigenous group makes up the majority of the population and where IQ is the cultural context of Nunavummiut (2013). According to Greenwood et al., "Inuit knowledge is holistic with its core concepts of connectedness and belonging, based on respectful relationship building that are essential to living a good life" (2018, p. 25). Grounded in a wholly Inuit worldview, IQ represents all Inuit cultural knowledge (Ferrazzi et al., 2019). Inuit epistemology is thought to be the theory of knowledge, the questioning of what knowledge is, and how it is acquired (Thayer-Bacon, 2003). Inuit epistemology is a starting point for a researcher seeking to understand IQ. Questions such as "what do we know and how do we know it?" "Do we know it individually or collectively?", and

[19] Inuit Qaujimajatuqangit (IQ) is Inuit knowledge, a relational way of knowing that is intrinsically interwoven with the land. It is the Inuit way of doing, thinking, perceiving, and being perceived (Karetak et al., 2017).

"how is knowledge possessed and how can it be engaged with?" are all addressed by Inuit in IQ (Healy, 2017). IQ principles are not a collection of rules; they are reflected in language, values, and beliefs (Healy, 2014). Guided by IQ, Inuit have learnt to be patient, resilient, and innovative to survive and thrive in the Arctic.

Underlying Inuit knowledge are four main laws referred to as *Maligarjuat* in Inuktitut, meaning the "big laws." Upon these four firmly adhered to laws, all other principles are built. These four cornerstones to living the good life are "working for the common good and not being motivated by personal interest or gain, living in respectful relationships with every person and thing they encounter, maintaining harmony, and planning and preparing for the future" (Kalluak, 2017, as cited in Karetak et al., 2017, p. 221). These laws are to be followed from birth until death with the period in-between being referred to as *Inunnguiniq* which translates to "the making of the being, the human being" (Karetak et al., 2017).

In addition to *Maligarjuat*, there are six guiding principles that tell Inuit how to live in a relationship affirmed by balance, harmony, and peace. These principles are: *Pijitsirniq*, to be willing and able to serve others well; *Pilimmaksarniq* building skills and knowledge to become capable; *Qanuqtuurungnarniq* protecting a child's mind, problem solving; *Avatimik Kamattairniq* observation, study of the land; *Aajiiqatigiingniq* collaboratively confronting and seeking solutions to issues that threaten social harmony and balance; *Piliriqatigiingniq* collaborative relationships or working together for a common purpose (Greenwood, 2017, as cited in Karetak et al., 2017, p. 222). Taken together, the laws and principles are recognized as the compass for Inuit to live the good life, based on respectful contribution to the wider community (Tagalik, 2011). For many Inuit, IQ provides a sense of self, belonging, and direction in life, which together builds a strong cultural identity that connects Inuit with the legacy of their

ancestors (Tagalik, 2011). IQ principles guide Inuit towards the pursuit of truth with the goal of ensuring a balanced life, one that is based on the adherence to that which is true (Karetak et al., 2017). For Inuit, that truth is their way of being, their way of knowing, and it is what they call IQ. IQ is therefore more than a philosophy, it is an ethical framework, a detailed plan to adhere to and follow through on, and a means to transform the self as a part of a greater collective (Karetak et al., 2017; Stern & Stevenson, 2006). It is a way of thinking, a way of being, and a way of journeying through life.

3.9. Inuit Tapiriit Kanatami Research Framework

According to Inuit Tapiriit Kanatami (ITK), Inuit are known to be amongst the most researched Indigenous people on the globe (ITK, 2018a). Until recently, most research endeavours were carried out on Inuit rather than with Inuit. Such a research approach others Inuit on their own homelands and places Inuit under the proverbial microscope of colonial voyeurism which results from a western assumption of superiority. Such colonial approaches can still be found whether they are implicit or explicit in their form.

As an organization, ITK is built on privileging and promoting IQ. ITK developed the National Inuit Strategy on Research in 2018 to ensure that “research governance bodies, policies, and practices must be transformed to respect Inuit self-determination in Inuit Nunangat” (ITK, 2018a, p. 4). Over many years, Inuit have been continually excluded from federal research funding eligibility criteria, which speaks to Inuit voices being silenced, Inuit access to research being denied, and Inuit knowledge being ignored (ITK, 2018a). Colonial and patriarchal influences controlling research in Inuit Nunangat, have led to distrust of western researchers. Inuit know what Inuit need and the acceptance of Kablunaaq determining what Inuit need via

research has long passed. To that end, ITK in collaboration with Inuit across Inuit Nunangat have developed a vision for research that includes their desire to produce knowledge that will work alongside Inuit to mitigate historical power imbalances and promote self-determination (ITK, 2018a).

In keeping with the National Inuit Strategy on Research, I utilized ITK's Inuit Tuberculosis Elimination Framework which promotes enhancing TB care and prevention programming via Inuit specific solutions to ensure meaningful involvement of Inuit and their communities in my research (ITK, 2018b). Use of this resource allowed me to meaningfully engage with Inuit research and access Inuit insights for improving TB public health care policy and practice. In addition to utilizing the ITK research strategy in the research process, I drew on CBPAR methods based on principles considered acceptable to Indigenous research (Drawson et al., 2017). In carrying out my research with Inuit it is critical that I chose to engage with research frameworks, such as CBPAR, that complement and move IQ from knowledge to action leading to the promotion of social justice and equity in health care for Inuit.

3.10. Community-Based Participatory Action Research (CBPAR)

CBPAR originated from the Northern pragmatic tradition of Kurt Lewin who focused on fact-finding action and reflection, and from the Southern traditions of emancipation, coming from Paulo Freire's liberty and popular education movement of the 1970s in Latin America (De Chesnay, 2014; Holkup et al., 2009; Leung & Minkler, 2004; Wallerstein et al., 2018). The practice of CBPAR incorporating these two historic traditions possesses a distinctive range of "action-oriented intentions, participation and collaborative partnerships" (Stewart & Draper, 2009, p. 30). Both traditions stem from the same ontological paradigm and both rely on an

"experiential and participative knowing informed by critical subjectivity and participatory transaction" (Holkup et al., 2004, p. 164).

According to Grimwood et al., CBPAR has three specific aims "to balance research power relations by sharing control of research processes and outcomes; to foster trust though transparent, reciprocal, and interactive relationships; and to support community ownership or research priorities, decision making and knowledge" (2012, p. 215). To achieve these aims, Barbara Israel developed nine guiding principles to assist researchers utilizing a CBPAR approach and to promote partnered research (Israel et al., 1998). These nine principles were (Israel et al., 1998; Minkler et al., 2012):

1. seeing the community as one unit of identity
2. building on strength and resources in community
3. facilitating collaboration and equitable partnerships in all stages of research
4. promoting co-learning and capacity building
5. integrating research and action
6. emphasizing local relevance of public health problems that attend to multiple determinants
7. involving a cyclical process
8. disseminating findings to all
9. engaging in a long-term commitment.

In 2008, Minkler and Wallerstein added two additional principles (see also Yonas et al., 2006):

10. committing researchers to openly address issues of race, ethnicity, and social class in ways that embody cultural humility
11. encouraging workers to ensure rigor and validity.

These comprehensive principles reflect CBPAR's focus on participation and action, and their benefit to public health research by translating research to practice and thereby impacting health status (Burke et al., 2013; Izumi et al., 2010).

CBPAR, like the ITK research principles, prioritizes respectful relationships with community partners who are best positioned to support and elevate Indigenous knowledges, methodologies, and voices (Vukic et al., 2011). Principles of CBPAR also focus on action and the use of research outcomes to inform and shift policy. This includes diverse ways of representing community knowledge including individual and community expressions, ranging from carvings, sewing, songs, dances, ceremonies, stories and from exploring the land. CBPAR is a collaborative approach to recognizing and building upon community strengths that promote trust between me, as a Kablunaaq nurse-researcher, and Inuit (Freeman et al., 2006).

CBPAR focuses the researcher's attention on Inuit voices and knowledge forms (Mitchell, 2018). It supports the promotion of community relevant insights into the research with the goal of unsettling and displacing ongoing colonial narratives and both actions and inactions (Caxaj, 2015). I used principles of CBPAR to uphold Inuit knowledge in a respectful way, privilege Inuit culture, and maintain my commitment as the researcher to embodying accountability and reciprocity with community (Caxaj, 2015; Charania & Tsuji, 2013; Gaudet, 2014). Further, CBPAR promotes the reciprocal, relational, and respectful establishment of trust and meaningful relations that are central to ensuring cultural safety for community members in research, and, through its commitment to equal community partnerships, also better supports the return of research findings and shared community knowledge to the community (Elder & Odoyo, 2018; Jull et al., 2017; Ka'opua et al., 2017).

The work of Charania and Tsuji shows that CBPAR is successful in helping researchers engage Indigenous peoples in community-based and community-driven initiatives (2013). CBPAR is a collaborative approach that values community rights holders as being equal contributors and where Inuit community knowledge holders are equal in redressing health policy and practice inequities towards positive TB health outcomes (Leung & Minkler, 2004; Wallerstein et al., 2018; Wilson et al., 2019). CBPAR can also be seen as a means to build community capacity and a research tool for change (Jernigan, 2009). Freeman et al. conceptualized that CBPAR would offer a collaborative approach that has researchers recognizing and building upon community strengths that promote trust between researchers and communities (2006).

3.11. Community-Based Participatory Action Research and Inuit Principles

The principles of CBPAR are distinct from Inuit IQ principles because that they come from different cultural and epistemic paradigms. However, because of their shared commitment to equitable relationships, many CBPAR principles are complementary to IQ principles that promote (Alexander & McKee, 2021, see also Glossary of Inuit Terms):

- *Pijitsirarniq*, the serving and valuing of each community member.
- *Aajiiqatigiingniq*, the fostering of consensus decision making with shared goals.
- *Pilimmaksarniq*, promoting skill and knowledge acquisitions and capacity building.
- *Qanuqtuurungnarniq*, promoting the need to be resourceful to solve problems which required adaptability and flexibility in response to a rapidly changing world.
- *Piliriqatigiingniq*, promoting collaborative relationships, working together for the common good, and stressing the importance of community over the individual.

- *Avatimik Kamattiarniq*, supporting environmental stewardship, fostering respect for a mutually interdependent relationship and seeking to improve and protect the relationship.

Taken together, IQ principles and CBPAR can foster and promote increased accountability and validity of evidence-based knowledge.

Use of CBPAR focuses the researcher on respecting Indigenous methodologies and attempting to address the power imbalances often found between Indigenous and non-Indigenous researchers (Darroch & Giles, 2014; Lenette, 2022; Vukic et al., 2011). It is the quality of such participation that is key to addressing the difference between whether the research is community-based, community led, or community requested. CBPAR, unlike traditional research, values Indigenous community knowledges, experiences, and the community's need for more equitable research partnerships and collaboration (Lencucha et al., 2010; Mitchell, 2018). The utilization of a participatory approach to research with Indigenous communities is considered to be both "positive and constructive" (Nakamura, 2015, p. 165). Within Indigenous methodology and CBPAR, truths can be viewed as being experiences and perceptions (Fraser, 2018). Tuhiwai-Smith suggests that when researchers are working within an Indigenous context, research is required to keep Indigenous peoples at its very center (2012). Indigenous peoples must be central to every stage of the research process, from setting of research priorities to the construction of the research questions right through to the end stages of the entire research process, including the final written reports.

In this chapter I have discussed the theoretical underpinnings of postcolonial theory, and how culturally safety is an appropriate orientation for research focused on decolonizing public health TB strategies, policies, and program delivery practices in keeping with Inuit ways of

knowing (Eni et al., 2022). The process of decolonizing means looking at, acknowledging, promoting, and taking action based on Inuit systems of knowledge, not attempting to adapt western knowledge to fit Inuit reality (Foster-Boucher & Thirsk, 2021). Ensuring cultural safety is about improving health outcomes for Indigenous peoples and can be used as an orientation in analyzing Inuit experiences of TB and TB-related stigma in Canada. Choosing respectful and appropriate methodology to successfully address the objectives of this research is key to gaining such perspectives.

Chapter Four: Methods

4.1. Introduction

In this chapter I discuss the qualitative research methods utilized to elicit, and, as stated in my research purpose, to ultimately gain a greater understanding of, Inuit perspectives of culturally safe public health TB policy and practice in Nunavut. I call attention to and emphasize the critical need I had for Inuit support in order to carry out all aspects of this research. I then outline the purposeful sampling used to obtain participants from two communities in the Kivalliq and Qikiqtani regions of Nunavut. I discuss the multiple recruitment strategies utilized and expound upon the recruitment process addressing both challenges and advantages. Data collection using conversational, semi-structured telephone interviews is discussed. I then describe the vital importance of the ethical and political considerations that were met, emphasising the need to establish trust-based relationships and to make certain that I did not assume a pan-Indigenous (i.e., generic rather than Inuit specific) approach in the research. I explain the need for confidentiality and why such levels of confidentiality were warranted. I describe how I prepared for any potential alignment or contradiction between the knowledge shared in the interviews, by reviewing four applicable strategy and framework documents.

Turning next to my analysis of the data, I describe my utilization of Braun and Clarke's Reflexive Thematic Analysis process, detailing how I became familiar with the specifics and nuances of my data, how I then coded the data, looked for themes, and the final development and review of the themes (2022). I describe the advantages of this approach in relation to postcolonial theory, my orientation of cultural safety, and the CBPAR framework. I finally bring

attention to how remaining flexible in the analysis process allowed me to apply my chosen complementary approaches and frameworks and to address the research question and meet the research purpose and objectives (chapter 1.3).

4.2. Inuit Community Research Supports

Critical to the success of this research was the participation of the Inuit Research Advisory Committee and the community youth champions. The Inuit Research Advisory Committee was made up of three Inuit professionals, two Elders and one community member who all work in health-related capacities in Nunavut; they each provided invaluable support throughout the research process. Their support included: providing Inuit knowledge perspectives; sharing their working understandings of IQ principles; offering communication supports; making introductions to community members and leaders; and, suggesting ways to best translate newfound knowledge findings into actions that can inform public health policy design and delivery. The Inuit Research Advisory Committee also gave recommendations and direction on: developing communication strategies when speaking with Inuit community knowledge holders; offering suggestions for the development of culturally safe research interview questions; providing insights into the historical context around Inuit and TB and health care access in Nunavut; and identifying potential community youth champions. Two community youth champions were identified, and each one supported the research process in their communities.

In research undertaken in rural and remote regions, community youth champions are understood to be “community members who draw on their local community and cultural knowledge, skills, and life experiences to promote community well-being” (Pelletier et al., 2020). In this research, community youth champions were more than just volunteer community

members. These young adults embraced their role and actively shared their knowledge about their specific communities. They provided key linkages to community knowledge holders and critically assisted me, as the researcher, in building and establishing trust relationships with community members (Carter et al., 2019). Involvement of the community youth champions provided me with the opportunity to connect with Inuit whose voices would never have otherwise been heard; their perspectives remaining unvoiced and unknown. The community youth champions were first point of contact for interested community members as described in section 4.4. Equally important, the community youth champions made certain that I gleaned an awareness of community context (e.g., culture, history, current community issues and challenges) before engaging with community knowledge holders (Pinsoneault et al., 2019).

In this way, the community youth champions became community knowledge holders, storytellers, and community advocates (Carter et al., 2019). Their experiential and relational knowledge of their community and community members was critical to ensuring my engagement were carried out in a culturally safe manner. With support and direction from both the Inuit Research Advisory Committee members and the community youth champions, I was confident that I acted in culturally safe manner in my approaches to the research i.e., community communications, building respect, carrying out recruitment calls, carrying out the interviews, and in following up with community members. The community youth champions were chosen in part because of their bilingual abilities, Inuktut /English, to provide any translation services that might be needed during the recruitment process. The community youth champions were never intended to provide translation services for interviews as that would have created an ethical concern regarding the confidentiality of interview content. Instead, a separate Inuit translator was identified to provide any translation services for the interviews. As it turned out, translators were

not required for interviews as every community knowledge holder chose to rely on their own English capability in their interviews.

Working with community youth champions is in keeping with ITK's research and TB elimination strategies, which value youth perspectives and recommend inclusion of Inuit youth in research opportunities wherever possible (ITK, 2018a). The community youth champions received an honorarium in the form of a monetary gift, which is congruent with Inuit cultural practice. Participating as a community youth champion in this research gave Inuit youth an opportunity to gain knowledge and a new skill set (e.g., knowledge on how research processes work, the importance of consent and confidentiality in research, and diverse forms of data collection methods), which will facilitate their participation and employment in future research opportunities. The community youth champions and I exchanged numerous telephone calls to discuss the intentions of my research, emphasizing the purpose, the objectives, and the questions the research may answer. A confidentiality form was a signed by each of the community youth champions upon agreement to participate in the research (see Appendix E).

4.3. Recruitment Strategies

Many recruitment strategies have been shown to be successful in reaching hard to reach populations in remote communities (Rasmus, 2014). In this research "snowball sampling," which was started by the community youth champions, was utilized to spread awareness of this research study and the need for community knowledge holders (Polit & Beck, 2018). As is the intention of the metaphor of a snowball, each community member told additional community members about the research and the opportunity to participate, adding another layer of potential community knowledge holders. The community youth champions also hung recruitment posters

(see Appendices F and G) throughout the community (e.g., the grocery store, RCMP office, town hall offices, schools, health centre, airport and on many telephone poles throughout the community) and had the research study included on the local radio announcement board. Recruiting Inuit community members through radio announcements was necessary given the remote and isolated nature of the communities and became more vital due to the constraints of the COVID-19 pandemic. The recruitment posters were created with direction from the Inuit Research Advisory Committee and used culturally appropriate language specific to Inuit needs written at basic literacy levels. They were produced in Inuktut syllabics and English. All written materials were translated for the regions in which the communities were located; the two regions required different materials as linguistic differences are found in the regions of Nunavut. Facebook advertising was also utilized with limited success which was explained as resulting from severe weather and a general lack of internet connectivity.

In conjunction with the community youth champions, I made numerous telephone calls to local hamlet staff, the mayors' office, community wellness staff, and to the grocery store managers in both communities; all to raise awareness of the research. I engaged with these community leaders and sought to establish rapport, if possible, before but especially during data collection. Adopting a cultural safety orientation meant that I wanted these prior engagements to "show" community knowledge holders that they were the priority in the interviews, they could speak their minds, and that I hoped we could move towards establishing trust. Because of the COVID-19 pandemic and associated lockdown restrictions, these conversations were all held by telephone. Feedback from members of the community indicated that my engagement and research were welcomed and seen as a sign of respect for leadership and the community members. As these conversations were in support of, but not part of addressing the research, they

were not documented in detail. I had initially hoped to recruit community knowledge holders from three communities, however one community experienced unforeseen circumstances involving community deaths, a TB outbreak, and a community-wide COVID-19 screening and immunization clinic, which meant that it was not appropriate for me to carry out my research in that community.

All the above recruitment strategies were used with the aim of involving Inuit knowledge holders from the general community however, in addressing my research purpose I wanted to understand structural policies and the ways in which healthcare provision met or did not meet the needs and expectations of Inuit for culturally safe health care provision. To access additional perspectives, I therefore also interviewed Inuit and Kablunaaq health care professionals. The Inuit Research Advisory Committee welcomed the two perspectives on this subject and gave direction on how best to move forward with the recruitment processes for both groups of community knowledge holders.

4.4. Recruitment Process

The recruitment process involved potential community knowledge holders contacting the local community youth champion who in turn relayed community members' contact information to me. I then called each community member to discuss the research with them and ask for verbal agreement to join the research. After these initial conversations, each community youth champion then coordinated with the potential community knowledge holder to arrange interview times and ensure the appropriate documentation and consents were signed (see Appendix H). Each community youth champion then confirmed the agreed location, date, and time to carry out the telephone interviews. Community youth champions attended all data collection interviews to

ensure community members who participated in the research, referred to as community knowledge holders, had access to a telephone and understood the research questions. Their presence meant that they could ensure that community knowledge holders had access to good telephone connections and could connect them with the designated translator if translation issues arose. As none of the community knowledge holders wanted translation support, translators were not present for the actual interviews. Furthermore, since the community youth champions were not present during the interviews, there were no ethical concerns regarding community youth champions hearing the stories of community knowledge holders. At the end of each interview the community youth champion returned to give the community knowledge holder a gift card as renumeration. Remuneration for participation in the study was a $50.00 gift card for the community grocery store. This form of remuneration was chosen after conversations with the Nunavut Research Institute about ethical requirements, and consultation with the Inuit Research Advisory Committee and the community youth champions. Gift cards were purchased in advance and held by the managers of the grocery stores until the community youth champion was able to collect them and give them to the community members at the conclusion of the interview.

Health care professionals (who were all either policy makers or service providers) were recruited through recruitment posters placed on community boards. I sent personal emails to individuals who I believed might be willing to participate. I sent emails to individuals that worked not only with the Government of Nunavut but to other Inuit agencies across Nunavut. I had intended to place the recruitment posters on the Government of Nunavut work-site website; however, I was advised at the very last minute that, given TB is such a sensitive subject, a

research disclosure agreement would be necessary before I could advertise or interview any Government of Nunavut staff members.

I must highlight that numerous health care professionals/staff members told me personally that they wanted to participate in the research however, they had concerns related to loosing their jobs if they responded negatively to any interview questions. Despite my assurances about data confidentiality, they were not confident to proceed. Another reason health care professionals employed by the Government of Nunavut declined to participate was that they were concerned that under a research disclosure agreement their responses would not be able to be truly confidential, despite knowing that they have the right to speak freely and anonymously both as professionals and as Canadian citizens whose rights to freedom of expression are protected under the Canadian Charter of Rights[20]. In the end, five health care professionals did agree to participate, and they were also each remunerated with a $50.00 gift card to the local grocery store.

In total I was able to recruit 30 community knowledge holders who ranged in age between 18-80 years and were all bi-lingual in Inuktut and English. This cohort included 25 Inuit who are described as community knowledge holders, and five community knowledge holders who are health care professionals (three identified as Inuit). Inuit community research participants were purposely referred to as "Inuit community knowledge holders" to centre Inuit as the experts and holders of the knowledge this research was seeking. Furthermore, referring to participants as "Inuit knowledge holders" presents an overt challenge to colonial constructions of

[20] The Canadian Charter of Rights and Freedoms is a part of Canada's Constitution Act. The charter protects basic rights and freedoms that are essential to preserving Canadians free and democratic country. It includes freedoms of conscience, religion, thought, belief, expression, press, media of communication, peaceful assembly, and association (https://www.cga.ct.gov.).

Inuit as ignorant in the domain of health care and their own health needs; its intent is therefore decolonizing. The Inuit Research Advisory Committee members said that naming Inuit involved in the research as Inuit community knowledge holders was respectful.

By definition all 25 Inuit community knowledge holders were Inuit; of the five health care professionals, three were Inuit. Of those interviewed, 2 of the 30 [6.67%] were Kablunaaq; since twenty-eight out of the 30 respondents were Inuit, [93.33%] the research findings were representative of Inuit voices. I ensured that Kablunaaq responses were identified as such in my analysis and for inclusion as excerpts in this dissertation. All who participated in the research, declared that they wanted to improve TB for Inuit. The interviewees self-identified as being men or women, with 20 women and 5 men among the Inuit community knowledge holders, and 4 women and 1 man in the health care professionals' group.

4.5. Data Collection: Conversational Semi-Structured Interviews

After potential interviewees spoke with the community youth champions, my first call to each interviewee was to explain the research process, purpose, and objectives (see Appendices I and J) and to ask the potential community knowledge holder if they had any questions. At the appropriate time toward the end of each call, I asked for their verbal consent to join the research. The interviews were conducted over the telephone with one exception where I met the interviewee in person. Community knowledge holders were given the option to use web-based technology, or to respond to the interview questions by submitting a diary/journal which they would review with me later, however, all community knowledge holders opted to join a telephone interview. None of the calls or interviews were recorded, and I made handwritten notes which I later transcribed.

Inuit community knowledge holders were offered the opportunity to take their interview telephone calls in a private room in the local hamlet office, or in a place of their own choosing. All community knowledge holders chose to carry out their telephone interviews from their own homes. Each conversational semi-structured interview lasted between 35-60 minutes. Semi-structured interviews provided for a degree of freedom for community knowledge holders to explain their thoughts and this encouraged the sharing of their lived experiences with SDOH such as TB-related stigma, as well allowing "certain responses to be questioned in greater detail" (Horton et al., 2004). By engaging in dialogue within the framework of the interview guides (Appendices K and L), I was able to allow community knowledge holders to express their own thoughts, feelings, observations, beliefs, and experiences, some of which delved into sensitive and personal topics (De Jonckheere & Vaughn, 2019).

I decided to use a conversational method in combination with a semi-structured interview approach for two reasons. The use of a list of questions as prompts, as recommended for a semi-structured interview, ensured that all areas were discussed in each interview, while the conversational method was prioritized as this is in keeping with Inuit Oral Tradition/ linguistic cultural communications and allowed greater flexibility in my own communications (Anderson & Kirkpatrick, 2015). Listening to a shared story supports the building of dialogue between participant and researcher, and encourages collaboration and reflexivity (Iseke, 2013; Kovach, 2010; Wilson, 2001). Utilizing such a conversational method within semi-structured interviews facilitated deeper and richer responses.

The community knowledge holders were very willing to speak with me in English over the telephone. I had worked very hard to establish a trust-based relationship via numerous communications during which I carried out respectful and honest discussions reflecting my

desire to learn about their lives and expressing my interest in hearing their perspectives about TB. I am also aware that having developed wonderful relationships with the community youth champions undoubtedly supported the ease of communication with community knowledge holders. Communications with health care professionals went well with discussions flowing freely; none of the health care professionals required translation support. I also disclose that I had had numerous rapport-building conversations with each health care professional specific to the research before interviewing them as well.

It must be noted that, unlike many English language speakers, Inuit are known for their very direct speech; over many years of working with Inuit in Nunavut, I have learnt that Inuit do not tend to engage in exaggeration or the use of multiple adjectives to give extra description when asked a question. I recognized that I may encounter community knowledge holders who would give very brief responses to interview questions and that it would undermine cultural safety in the interview process if I pressed for elaboration. I had been unclear however as to the origins of this speech pattern and questioned if this was purely cultural, linguistic or a pattern of speech related to historical colonial interactions where Inuit may not have wanted to engage in long conversations with Kablunaaq. I also wanted guidance in choosing how to respond in such a situation. I spoke with a member of the Inuit Research Advisory Committee about this concern and asked if there was a certain way that I should approach community knowledge holders in conversation. The clarification that I received was that “it’s simply how many Inuit speak” and as long as I spoke with respect to each community knowledge holder then “they will respond how they will” (T. Koonoo, private correspondence, Oct., 14, 2022). These conversations with the Inuit advisor allowed me to ensure my practices were culturally safe.

4.6. Ethical and Political Considerations

Inuit view research as a means to develop long-term trust-based relationships (ITK, 2018a; Nickels & Knotch, 2011). Such trust leads to a "better research-community relationship and leads to even better research results" (Nickels & Knotch, 2011, p. 1). It was critical in this research that a pan-Indigenous approach was not assumed and that the ethics of imposing western knowledge interpretations or views of what constitutes Indigenous identity were not placed on Inuit. My Research Advisory Committee and use of ITK and IQ principles were key to ensuring I was utilizing Inuit specific ethical systems. Inuit are distinct, not a category or subset of other Indigenous peoples in Canada. Inuit homelands are circumpolar, a distinctive land-based reality since time immemorial, with little to no common grounds with the lived experiences of southern-based Indigenous peoples before colonization. Inuit are not First Nations, although they are First Peoples (Alexander & McKee, 2021; ITK, 2018a). Thus, it was necessary, in carrying out this research in Nunavut, that Inuit specific ethical approaches as described by ITK and National Inuit Strategy on Research, were understood and acknowledged, respected, and honoured, upheld, and promoted.

Whereas First Nations peoples utilize ownership, control, access, and possession (OCAP) principles to ensure First Nations ownership, control, access, and possession of their own research data, Inuit did not sign onto the OCAP principles when they were established in 1998. Inuit have their own unique ethical research concerns namely community empowerment, language, and Traditional Knowledge in distinctively northern contexts (ITK, 2018a; Nickels & Kotch, 2011; Nipingit, 2010). Established in 2008, Inuit Nipingit is a national Inuit committee on ethics and research that contributed to creation of the second Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans. This Inuit policy was created to ensure that a

generic, pan-Indigenous approach would not be utilized in research involving Inuit (Nipingit, 2010). I used both the Tri-Council Policy and the National Inuit Strategy on Research which outlines the principles that must be followed when engaging in research with Inuit and the specific criterion for researchers set by the Nunavut Research Institute located in Iqaluit, Nunavut (ITK, 2018a; Nipingit, 2010). In keeping with the above ethical conduct requirements for research involving humans, I ensured all ethical protocols and necessary licensing were attained prior to initiating research. A certificate of Approval from the Human Research Ethics Board at the University of Victoria, ethics protocol number 21-0469 was awarded (see Appendix M). As required by the National Inuit Strategy on Research principles, I was issued scientific research license number 0103022N-A to carry out research in Nunavut (see Appendix N).

Another ethical consideration that should be noted was the need to attain a disclosure agreement with the Government of Nunavut. Despite having approvals from the Human Research Ethics Board at the University of Victoria and through the Northern Research Institute in Nunavut, this agreement was still required before interviewing any employees of the Government of Nunavut. Because this agreement can take many months to be approved those requiring it should begin the process immediately upon receiving Nunavut Research Institute approvals to carry out research in Nunavut.

Being aware that lasting relationship building is critical to Inuit research, my existing relationships, established over decades of both professional and personal engagement with Inuit; have positively impacted this research process. Having already established trust for and respect with many Inuit and in abiding by the ethical guidelines set by Nunavut Research Institute and National Inuit Strategy on Research, this research has continued to maintain and foster ongoing relationships between myself and Inuit community members. I recognize that in the context of

colonization Inuit are vulnerable to dominant patterns of research and researchers and thus, it was imperative that my research did no further harm. Past research in Nunavut has seen Inuit participating in research where they were not compensated for their knowledge nor time and in some cases, were the unknowing participants of medical experimentation under the guise of health care. In 2005, the publication of a book Beyond the Hippocratic Oath, by Dr. John Dosseter, who was presented with the Order of Canada for his commitment to health care, spoke to the medical experimentation whereby skin grafts were taken from one Inuk and placed on the body of another Inuk as part of research for the International Biological Program. Dr. Dosseter claims he obtained community consent from Elders in the very remote and traditional community via non-Inuk translation, however, Inuit in coming back from TB sanitoriums thought this was a mandatory treatment for TB follow up (Dosseter, 2005).

To ensure my research method minimised the potential for harm, I adopted critical reflexivity as a process to promote humility, respect, and honesty in all my interactions with Inuit, especially in my verbal communications carried out at a distance and in my written work. My reality is that my engagement with Inuit will continue long after this research process through my personal and professional associations. I will always be self-aware in recognizing that as a Kablunaaq I am a non-Inuk, and hold different worldviews, beliefs, and values. I am greatly influenced by Inuit ways, and am very familiar with Inuit ways of being, however, I am a Kablunaaq.

4.7. Confidentiality

Confidentiality of individual responses was especially vital in this research because it was not possible to prevent the identities of community knowledge holders being known in the small

Inuit communities. People within the community talk, and snowball sampling encouraged those conversations. Thus, it was critical to, as far as possible, eliminate all direct and indirect identifiers in the data. The community youth champion and I were both aware of the identity of the community knowledge holder during the interview – they were not anonymous. Confidentiality therefore had two key components. First was to talk with each of the community youth champions to emphasise that their confidentiality must be complete. Second was to ensure that excerpts in this dissertation could not be traced back to specific individuals. To protect confidentiality, all direct identifiers such as age, name, address or telephone numbers, and indirect identifiers such as community locations and geographic regions were stored separate to interview data. To ensure the sample included a cross section of the wider Inuit community, data on age ranges i.e., 18-25 yrs., 25-55yrs., 55 yrs. plus., and gender information was collected when the Inuit community knowledge holder agreed to provide such information. The community knowledge holders reported identified as being men or women and had ages ranging from 18 to 80 years of age.

To allow me to connect data with the specific individuals in order to attach relevant characteristics (such as youth or Elder) I had to use a confidential system based on letter codes. Inuit community knowledge holders were not assigned specific numbers in the process of identification, because under colonialism Inuit were issued E-tags (standing for Eskimo) rather than being acknowledged by their names. Giving Inuit community members a pseudo name would have continued the offence of "Operation Surname" (discussed in chapter 2.4), in which colonial representatives of the Government of Canada chose what amounted to being pseudo names for Inuit for the convenience of colonial government tracking systems. I did not ask community members if they wanted to use a pseudo name because I knew that would be

offensive to Inuit as assigning numbers or pseudo names to Inuit would not be culturally safe. My decision to avoid acting in a culturally unsafe way by asking individual community knowledge holders, was supported by a member of the Inuit Research Advisory Committee. In addition, while all except one community knowledge holder signed the secondary consent box giving permission for their information to be utilized, none of the community knowledge holders gave permission for their name to be used on any documents including in my research dissertation. I therefore aimed to eliminate, as far as possible, all identifiable characteristics and content from the excerpts in this dissertation so that even individuals with close knowledge of the communities will not be able to guess the identities of individuals or their communities.

4.8. Review of Strategy and Framework Documents

Since the purpose of this research is to understand Inuit perspectives of culturally safe public health TB policy and practice in Nunavut, I reviewed existing policies before carrying out interviews with Inuit community knowledge holders and health care professionals. These policy documents were not coded nor analyzed in the same manner as the interviews since they were reviewed only to give me greater context and understanding, such that I could determine if they potentially aligned or contrasted with the information, perspectives and experiences that were shared during the interviews. The documents were:

1. Public Health Strategy for Nunavut: Building Healthy Communities – which focused on improving the health of Nunavummiut (residents of Nunavut) (Government of Nunavut, 2008).
2. Canada's Arctic and Northern Policy Framework – a road map to improved health for Northern Indigenous Peoples (Government of Canada, 2019a).

3. Nunavut Tuberculosis Elimination Action Plan, 2020-2023 – which was created by NTI and the Government of Nunavut, and is directed at TB elimination praxis (NTI, 2021).
4. Inuit-Specific Tuberculosis Strategy – which is an overarching strategy to address TB needs in Inuit Nunangat in relation to the ITK framework and principles (ITK, 2018b).

Examination of these documents provided contextual understanding specific to Government of Nunavut health systems and TB public health programs in Nunavut. The documents were thorough in their details and projected positive messaging. An awareness of the inequities in the social determinants of Inuit health was touched upon however, only two of the documents spoke specifically to TB and none of the documents highlighted Inuit perspectives of public health TB policy and practice in Nunavut. Inuit perspectives on TB policies and programs that directly affect their TB experiences and ultimately their health outcomes need to be heard directly from Inuit and understood.

4.9. Reflexive Thematic Analysis

Braun and Clarke defined reflexive thematic analysis as “a theoretically flexible method for developing, analyzing, and interpreting patterns across a qualitative data set” (2022, p. 4). The utilization of a reflexive thematic analysis created the opportunity to explore patterns of meaning found in the data which has enabled greater insight into Inuit voiced perspectives on public health TB policy and practice (Braun & Clarke, 2022; Lochmiller, 2021). As a process it draws upon my experiences, my existing knowledge drawn from work, social, and living experiences in Nunavut, and my social positioning as a Kablunaaq. Beyond drawing upon these experiences, it looks to my ability to critically interrogate the findings based on how these very

experiences, knowledges and my social positioning influences and provides insight in this research process (Braun & Clarke, 2022).

The utilization of Braun and Clarke's approach to reflexive thematic data analysis was chosen because it offers considerable theoretical flexibility and can therefore support both the postcolonial approach and orientation towards cultural safety chosen to inform the methodology for this research (2022). Utilizing an orientation of postcolonial theory in relation to the use of reflexive thematic analysis in this research means that I was critically aware of my own positionality and power as I critically explore the intersecting relationships that support ongoing colonialism in public health TB policy and practice in Nunavut. Moreover, this approach allowed me to continually reflect on my position as someone with epistemic privilege to re-tell Inuit perspectives of public health TB policy and practice in Nunavut. In utilizing Braun and Clarke's Reflexive Thematic Analysis, I have had to reflect on who I am as a researcher, asking myself what has, and continues to, inform and shape my positionality in this research process (2022). I have had to consider the multiple intersecting positions that together create my ever-evolving worldview (see chapter 3). It is from a conscious and continuous reflexive positionality that I approach this research.

Analyzing data by utilizing postcolonial theory and a cultural safety orientation, provided me with the opportunity to understand the cultural, political, and social complexities associated with Inuit health and TB policy and practice in Nunavut. Using a reflexive thematic analysis approach, I was able to gain insights about the factors that promote culturally safe TB policy and practices. For example, I have learnt how TB-related stigma shapes Inuit perspectives of public health TB programming and practices, and how Inuit knowledge can be mobilized to inform and influence Government of Nunavut's TB public health policy and practice.

4.10. Conducting Reflexive Thematic Analysis

In carrying out a reflexive thematic analysis I used Braun and Clarke's guidelines and six phases of analysis (2022). Although the phases have distinct processes, my approach was iterative, in that cycling through the phases of analysis and continually reflecting on what I was learning meant that new insights continued to emerge, and I was able to identify more information and greater understanding with each of the six phases of the process. This afforded me the opportunity to deeply reflect on Inuit ways of knowing in relation to the data collected as it emerged and before taking my themes for discussion with the Research Advisory Committee.

4.10.1. Phase 1: Familiarization with my data

I conducted all the interviews and transcribed the data myself after each interview. To familiarize myself with the transcribed data I began reading and rereading the transcripts until I was able to hear the stories and experiences of Inuit community knowledge holders within the data. This was a long and at times emotional process. The data went from simply being words that I had transcribed and became narratives with reflections that I could visualize happening; they became real and took on meaning. This was an incredible experience and one I had not expected. It was only when these narratives revealed themselves to me that I understood the value that it brought to my analysis. I reflected on each of the interviews through my notes, on paper and in NVivo 12, data management program, and through journaling of my reflections. Use of NVivo allowed me to identify, track and analyze the data by coding key words and concepts to visually extract the themes from the patterns contained. Using postcolonial theory, I was struck by Inuit perspectives that spoke to the degree to which colonialism remains ongoing not only in the Government of Nunavut's health care system but also how embedded it is in public health TB policy and practice delivery.

4.10.2. Phase 2: Initial Coding of the data

Once I had read and transcribed the data, I began to highlight key words and ideas related to the text. This meant that I coded words that Inuit community knowledge holders and health care professionals said, but also made thematic notes in the margins to capture potential meanings. Coding was conducted on all interviews using both paper and the NVivo program. As an example, the word stigma was highlighted. I wanted to ensure that I was listening to the transcribed words in the context they had been spoken ensuring that I was capturing the potential meaning behind them. I endeavored to carry out latent coding as opposed to semantic. I wanted to move beyond the surface meanings of the data [semantic] to identify what Braun and Clarke referred to as the latent meanings or underlying assumptions found in the coding (2022). I then typed my paper notes and transcripts into NVivo to help me capture key ideas and insights.

4.10.3. Phase 3: Looking for themes

I used my codes to help me develop insights and identify patterns across the transcripts; this was an iterative process and one in which I had to keep focusing on seeing the patterns that were actually within the Inuit data. I found that I had become attached to some expected themes only to discover that those were not in fact in the data. Even when I initially noticed their absence, my expectation had been so strong that I hesitated to remove them from my list of themes. For example, I held onto the theme of the "land" since I know Inuit have a strong bond with their land. I had expected that surely this theme would present itself across multiple interviews and shed light on the role of the land in public health TB policy and practice. However, I was wrong, and ultimately had to let it go as a potential theme. I discovered after much more reading on reflexive theme analysis that I had been focusing on achieving a “preconceived” result rather than going through the reflexive thematic analysis process itself.

According to Braun and Clarke, it is common at this stage for researchers to recognize the assumptions that had been carried into their analysis, and to need to pause and centre the data (2022). It was humbling but very important to be reminded to keep returning to the data and the perspectives that Inuit had actually trusted me to share. To further assist my understanding of Inuit perspectives and the data, I drew a visual mind-map, a basic thematic concept map, that would allow me to see if there where points of commonality/overlap between both Inuit Community Knowledge Holders and Health Care Professionals. Using Braun and Clarke's reflexive thematic analysis to look beyond the specific words for connections or relationships in data encompassing the wider context, allowed me to begin to identify some potential themes (2022).

4.10.4. Phase 4: Developing and reviewing my themes

I recognized, being a visual thinker, that concept mapping provided for a clearer understanding of the data and the ability to better explore the data looking for patterns and relationships, thus it was significant in helping to guide my analysis (Braun & Clarke, 2022). For example, in the early stages of exploring patterns and relationships I developed an overlapping thematic map that showed where the two groups overlapped and did not overlap. Having this thematic map allowed me to stand back from the themes looking at them from a critical postcolonial theoretical orientation and ask myself where I saw othering occurring? This would be an inductive approach to the findings where I observed the findings and then sought out patterns in the findings to further explain the patterns found. I sought to find where power imbalances were located and asked myself were there any themes pointing towards ongoing exploitation of Inuit? I asked myself if I could see the cultural and political themes that reflected

Inuit powerlessness. This process became another humbling experience as I began to find the answers to questions that I had been asking myself.

As I moved forward in the reflexive thematic analysis process and progressed through the remaining phases five and six, I became aware of the richness of the data excerpts and how they answered the research questions I posed (see chapter 1.3). I had initially thought themes were to be summaries or reflections of the problems that exist in TB policy and practice in Nunavut. However, I learnt through further reading, that themes can be their own stand-alone themes and do not necessarily need to fit together to create a larger overarching theme to answer the research purpose and objectives succinctly (Braun & Clarke, 2022). This allowed me to identify which elements from Inuit responses recurred as being related to understandings and experiences of cultural safety and un-safety. For example, when I started to identify the theme of “Shamanism and spirituality” I was surprised, but by applying Braun and Clarke’s reflexive thematic analysis, I came to realize that it was a fundamental element of Inuit IQ principles and a lifeway of key significance to Inuit; as part of Inuit cultural identity it was clear that Shamanism and spirituality would have a role in ways Inuit understand and experience TB public healthcare policies and practices. I therefore included the theme of Shamanism and spirituality as its own unique and equally important theme.

For me, the process of carrying out this reflexive thematic analysis was like watching a play or theatrical production unfold, with the diverse acts slowly coming together to tell the story. The themes that are highlighted in the next chapter are those that best reflect “this” play as it is informed by a postcolonial critique; the lead characters are Inuit, and their perspectives and experiences of TB public health policy and practices provide the narrative action. Such a play amplifies previously silenced Inuit voices and echoes their thoughts and concerns about

culturally safe TB public health policies and practices. Foregrounding Inuit voices presents a challenge to the colonial belief that Inuit were complacent towards their health care. Inuit are not complacent people, rather Inuit are raised to have great self-control over their emotions and not place themselves in situations where they are vulnerable (Briggs, 2000). I am humbled that Inuit who participated in this research found a brave and culturally safe space to share their perspectives, experiences, and voices in discussing all that encompasses TB public health policy and practice in Nunavut – both safety and un-safety. In chapter five, Inuit voices are amplified in a manner that ultimately provides for an understanding of Inuit perspectives on culturally safe public health TB policy and practice and the factors that ultimately determine and promote such culturally safe TB policy and practice in Nunavut.

Chapter Five: Findings
Inuit Perspectives on TB Policy and Practice in Nunavut

5.1. Introduction

The purpose of this research was to understand Inuit perspectives of culturally safe public health TB policy and practice in Nunavut. The key objectives of this study were to identify and understand: 1) the factors communicated by Inuit, that would promote culturally safe TB policy and practice with Inuit communities, 2) ways Inuit understand how TB-related stigma shapes Inuit perspectives of public health TB programs and limits their participation, and 3) how Inuit envision mobilizing Inuit knowledge to inform and democratize Government of Nunavut public health policy and programs. To engage in equitable knowledge production, and to privilege Inuit ways of knowing, I describe the perspectives and experiences shared by 30 interviewed community members (28 Inuit, 2 Kablunaaq) about their experience with government-run TB public health programs in Nunavut. I highlight Inuit individual and collective knowledges, traditions, and insights by illuminating the recurring themes conveyed by community knowledge holders and confirmed with the three-member Research Advisory Committee and the two community youth champions. Collectively, Inuit responses constitute the data that informs the understandings prioritized in objectives one and two of this research. In chapter six I address research objective three by describing how these findings will be shared with and by Inuit to democratize Inuit and government relations, and to inform equity in health care provision and policy creation specific to public health TB programs in Nunavut.

To advance my research objective to understand Inuit perspectives on culturally safe public health TB policy and practice in Nunavut and the ways that Inuit understand the ways

stigma shapes Inuit perspectives on TB programs and policy, my analysis sought to identify themes raised by Inuit community knowledge holders. Following data collection I engaged in reflexive thematic analysis, utilizing the narratives shared by Inuit community knowledge holders to assist me in understanding Inuit perspectives of public health TB policy and practice in Nunavut and how stigma shapes perspectives. The purpose of this research focuses on what constitutes cultural safety, however, in the analysis it was clear that it was important to the interviewed Inuit community knowledge holders to express first what constituted cultural un-safety. Respecting Inuit priorities is consistent with CBPAR as one approach to decolonize both the research process and ongoing systemic processes of oppression. In the data, the factors first identified as generating a sense of cultural un-safety by Inuit community knowledge holders, were used to imagine the converse and develop the themes that contribute to culturally safe TB public health policy and practice. As these themes directly respond to research objective one, they are a key finding of this research.

Based on the seven themes, the recommendations for addressing culturally safe TB policy and programs for Inuit of Nunavut are that: 1) Kablunaaq, non-Inuit, develop trust and respect towards Inuit; 2) Inuit social determinants of health are addressed; 3) TB-related stigma is addressed; 4) Kablunaaq respect the importance of Inuit Shamanism and spirituality; 5) intergenerational trauma informed care is provided; 6) Inuit Qaujimajatuqangit principles are recognised and used to guide health care policy and programs; and 7) Inuktut language can be used in health care. These seven themes all provide information for research objective one, they are interconnected, and together result from the need to address the ongoing colonial and neocolonial relations that perpetuate TB-related stigma and health inequities in Nunavut.

According to Inuit community knowledge holders, and specifically addressing research objective two, are themes three and four. For Inuit community knowledge holders, stigma stems from: the fear of contracting TB; being treated differently with racialized application of infection protocols by health care professionals; being treated poorly and ostracized by fellow community members; and the despondency that arises because the community is still having to deal with TB. These diverse elements of stigma impact Inuit and limit their participation in health programs. At the community level, TB-related stigma is found to lead to unspoken acceptance of the normalized perception that Inuit are dirty or inferior as portrayed in the colonial stereotypes. This further leads to acceptance by Inuit that, for them, TB is simply reality. On a personal level, the findings also show that as the fear and experience of stigma grows it is internalized and individuals not only come to believe their identity matches the negative stereotype, but also feel shame. These diverse and pervasive elements of stigma have led to the creation of a new Inuktut word 'Apmasuviq' that describes stigma. The findings related to research objective two, TB-related stigma, are provided in detail in chapter 5.4.

Together, these seven themes on advancing culturally safe TB programming and policies and the findings regarding TB-related stigma, constitute the information that Inuit shared to advance knowledge and understanding of Inuit perspectives of culturally safe public health TB policy and practice in Nunavut. This is the collected knowledge that Inuit community knowledge holders and the Research Advisory Committee, hope to mobilize to inform and democratize Government of Nunavut public health policy and programs which responds to objective three, and which is discussed in chapter 6. Figure 3 highlights the seven interconnecting themes contributing to culturally safe public health policy and practice as determined by Inuit.

Figure 3: Seven themes contributing to culturally safe public health TB policy and practice as determined by Inuit community knowledge holders

5.2. Trust and Respect: "We need people to be respectful of us"

For TB public health programs to be culturally safe, Inuit need to feel respected. Identifying how Inuit community knowledge holders conceptualized trust and respect in TB public health care policy and practice is a key element of research objective one. For community knowledge holders respect is about both Inuit knowledge and thinking, and Inuit' individual experiences of their own bodies and the right to participate in choices about their own medical care. A young Inuit woman shared that: "We need people to be respectful of us. Respect our knowledge. I know my own body; Nurses make me feel I don't know…because I'm an Inuk… made me feel not listened to." This Inuit woman from the Kivalliq region of Nunavut spoke about staff not trusting her judgement regarding her own health needs. She felt disrespected and demeaned because her Inuit identity and therefore her knowledge was not recognized. She felt dismissed, and since she lived in a remote community in Nunavut, there were no alternative facilities she could access. The comments this Inuit woman recounted provide an example of the ongoing disrespect and othering that Inuit report routinely experiencing. In the absence of options, such behaviour by health care providers means that for some Inuit who have experienced disrespect, the only option is to refuse to access care or participate in TB programs. Experiences communicated by other community knowledge holders also identified that health care professionals showed disrespect by prioritizing western knowledge systems over Inuit knowledge systems, disregarding Inuit knowledge, and assuming Inuit cannot understand western medical information. It is in ways such as this that Kablunaaq health care providers can perpetuate inequitable power relationships and entrench culturally un-safe practices.

Similar feelings were expressed, but made more explicit by another Inuit woman; an older woman residing in the same community and who by virtue of living longer has experienced long standing public health policies and policy changes,[21] she stated:

> [S]taff make me feel like garbage, like I'm not smart. My Inuk ways of doing are not as good as theirs… They need to learn about Inuit before coming here. We are not like those from the south. But they need to learn that we are humans too. We have feelings, we're not just savages. They need to learn about us before they care for us.

The frustration expressed by this community knowledge holder shows the emotional and psychological burden some Inuit carry as a direct result of the current public health policies and practices. This community knowledge holder emphasized that southern trained health care professionals need to learn about the delivery of culturally safe care before coming to Nunavut. Many southern trained health care professionals come from colonially entrenched academic programs. Such programs have maintained and sustained colonial attitudes and actions of white privilege and superiority. While many academic institutions are now attempting to educate their students about Indigeneity, entrenched racism and prejudices run deep. When this community knowledge holder stated, "we're not just savages", I remember thinking how painful it was to hear someone say this about themselves. The emphatic statement had the dual effect of highlighting that some Inuit resist and resent the impacts of Kablunaaq prejudices on their own self-identity, while also pointing to the dehumanizing effects of internalized stigma. This reflects the long period of traumatization and emotional abuse suffered at the hands of those who hold power and control over Inuit, and may also reflect the age and experience of the individual.

[21] As discussed in chapter 4.7 below, Inuit community knowledge holders were not allocated pseudonyms or numerical values in this research as that would be culturally un-safe and would be counter to my respect for Inuit ways of being.

Considering these statements using a postcolonial perspective highlights the need for decolonizing Canada's healthcare system by providing training programs that explain and contextualize the political, social, and well as psychological process that demean and disempower Indigenous people (Wilmot, 2021). When Kablunaaq embody such training, they may be better aware of the need to allow Inuit agency to make choices regarding their own care.

Trust and respect are key parts of cultural safety and are required to develop relationships of care with others. Trust extends itself to reassurance when difficulties arise where trust fosters an opportunity for healing (Cope et al., 2022). The development of trust is not based on an individual's characteristics, but according to Calnan and Rowe, is constructed from shared experiences and a willingness to understand and empathise on a human level (2006). One Inuit health care professional shared that:

> If staff don't understand our history, with all the trauma [we have faced] then how can we trust them. How do we regain trust in them? There is a need to mend broken trust – one step at a time. There's been lots of broken promises to us. Justice was supposed to improve – but not, health was to improve – but not, and our housing was to improve – not! Our reality is so poor that sometimes Inuit no longer care.

This community knowledge holder was from the Inuit community as well as working as a healthcare professional which added complexity to understanding the role of trust in building connection and relationship. Despair and the lack of trust that result from broken promises and witnessing Inuit standards of living decrease to shocking levels, has been traumatic for many Inuit of Nunavut.

A Kablunaaq health care professional separately described why they believed that Inuit do not trust the systems around them:

> Nunavut for many is the 'come, take and judge place'. You know that saying is true! It's so wrong. But it is what people do. I think Inuit thought that when Nunavut territory was established that Kablunaaq would leave the territory and they [Inuit] would get jobs. It was supposed to be about capacity building for Inuit, but Kablunaaq stayed. I think Inuit lost out. I think Inuit lost trust in their own people leading them. Maybe the speed of change that Inuit had forced on them also added to the broken promises and their lack of trust. How can Inuit trust? We've taken their culture, appropriated, and extracted so much but what have we given back? Truly?

Loss of trust, as identified by this community knowledge holder, is one impact of colonization and the subsequent government policies and actions that resulted in promises to Inuit being broken in Canada over the last 50-60 years. With the direct involvement of government in health care, this loss of trust has impacted all levels of relationships associated with health care.

A direct example of the causality of loss of trust goes back to when Nunavut became a territory in 1999. According to one Inuit Research Advisory Committee member, Inuit believed that they would have their own Inuit led programs and Inuit specific care with the creation of the new territory, however their trust was breached as this was not the case. Nunavut's first public health strategy Developing Healthy Communities: A Public Health Strategy for Nunavut 2008-2013, was not written until 2008 (Government of Nunavut, 2008). From 1999 until 2008, Nunavut was without specific public health strategies, policies, or modes of Inuit specific delivery of health care, and instead used the Northwest Territories public health policies. Even in 2008 there were very few Inuit trained public health nurses or medical staff in Nunavut. Most

staff were from the south, as were the consultants who assisted in the creation of the inaugural strategy document. Their southern origins meant that they brought a southern colonial lens to the redesign of public health policy and programs. The degree to which Inuit community members were involved is questionable.

In 2008 TB was not a focus in the Nunavut public health strategy, and even the most generic SDOH were referred to only in the broadest of senses, with no reference to TB-related stigma or cultural safety (Government of Nunavut, 2008). The importance of IQ principles was noted, but this initial public health strategy highlighted how Inuit themselves needed to build personal skills to empower their communities to take the lead on their own health care needs. This approach is indicative of attitudes that postcolonial critics consider puts the colonized into a position of having to correct the problems created by the colonizer (Moreton-Robinson, 2011).

A different Inuit health care professional working in policy development spoke to how trust between Inuit and the various levels of governments could be re-established:

> You want to establish trust with and for Inuit? The Federal Government just needs to build homes here. We all know TB would eventually disappear if Inuit had decent homes…so the white man pulls Inuit off the land, says we must live in those shitholes [matchbox houses] yet they don't equip Inuit with what they need to survive their ways? Inuit did just fine for thousands of years here on this land. … Just fix the problem. Provide housing, provide opportunities for education and jobs. Inuit will take it from there just fine.

This Inuit healthcare professional highlighted how trust can be re-established through addressing the social determinants of Inuit health. Furthermore, this professional was clear that long before colonialism Inuit had personal skills, they had empowered communities, and they took care of

their own health care needs. Acting on these suggestions would demonstrate to Inuit that their voices have been heard and that efforts are being made to establish a trustworthy relationship.

5.3. Social Determinants of Inuit Health: "People just don't get it…"

In 2013, the need to address social determinants of health that impacted Inuit was identified as part of an Inuit-specific TB strategy drafted by ITK, the National Representational Organization Protecting and Advancing the Rights and Interests of Inuit. At the time, it was hoped that the strategy would influence and guide the government of Canada and the government of Nunavut such that cultural safety would be included in future program delivery, and that intersectoral partnerships would be developed to address the SDOH in Nunavut. Ten years' later, the SDOH identified by the participants in this research identified similar patterns and impacts as continuing to drive TB incidence rates in Nunavut. The key social determinants of health identified in this research, as deemed critical by Inuit community knowledge holders and expressed in their words, are: housing, food insecurity, unemployment, poor access to health care with concerns of racism, "tokenism", and "identity favouring." These are shown in Figure 4. Note that "tokenism" and "identity favouring" are terms used by Inuit community knowledge holders and carry their usage meanings not the meanings that might be attributed by western scholars. For Inuit, "tokenism" involves use of Inuit culture and images by others as a form of branding and commercial exploitation. "Identity favouring" was used to describe situations that might have been described as blatant racism, however Inuit culture means not using such confrontational terminology. These are discussed in chapter 5.3.4 and 5.3.5 below. Considering these Inuit perspectives on SDOH directly addresses research objective two by giving insight into Inuit perspectives of public health TB programs and identifies factors that limit their

participation. In figure 4 below, the interconnectivity of critical social determinants of health are visualized.

Figure 4: Interconnection of Critical Social Determinants of Health: As determined by Inuit community knowledge holders

A highly respected Inuit health care professional working with the Government of Nunavut shared with exasperation that:

> "People just don't get it…. we don't live good. We have bad health, we don't have jobs, we want jobs, we can't afford to buy good food, my people go hungry, we don't have access to good health care, you have choices, Inuit don't! And Kablunaaq come and take the jobs that Inuit should have. Inuit lived for thousands of years here and today, we can barely survive.

This respected Inuit health care professional expressed further her frustration at watching Inuit standards of health decline and feeling that Inuit are the forgotten people in Canada. She spoke specifically to the SDOH and how Inuit deserve a standard of health care that is equal with other Canadians.

5.3.1. Housing: "overcrowding complicates everything…"

The dire need for government to support, not only increased housing, but more northern appropriate functional housing, was highlighted by one man, an Inuit Elder who stated that:

> Housing is a huge problem in our community. We are eight people in two rooms in a very small old matchbox house. If one person gets TB/COVID there is no room to isolate them. This house was built 50 years ago. It's been six years since we got the last new house in our community. If we don't get more houses more Inuit will get TB. It [TB epidemic] will just start all over again.

This Inuit Elder is aware of the relationship between poor housing and the reality of contracting TB. He knows that many Inuit continue to live in the single room dwellings, the matchbox housing introduced in the 1950s, at 288 square feet (compared with 600-1000 square feet averages for most Canadians). Knowing these housing realities, Inuit recognise the impossibility

of meeting public health recommendations that individuals exhibiting symptoms of COVID-19 should keep a distance of 6 feet from others, and that Inuit with highly infectious active TB should isolate even from others in their own homes. The reality for many Inuit is that they do not have the privilege to socially distance themselves and maintain 6 feet from a sick person during COVID-19 pandemic or in general.

Beyond the direct impact on an individual's ability to isolate when unwell, Inuit knowledge holders shared the community's concern that the housing crisis leaves many individuals homeless. One community knowledge holder, a young man, stated that, "Shelter (lack of) is really bad here – people have nowhere to go. Too many people don't have housing even in the winter." For some Inuit, this means that even in frigid winter weather they seek shelter in tents or in old sheds that are otherwise utilized as smoking shacks. Deaths from exposure to the elements occur in Nunavut on a yearly basis. Overcrowding in inferior quality homes was highlighted in this excerpt by the same man living in the Qikiqtaaluk region who said that:

> We need housing. This would make us feel better. It [overcrowding] complicates everything: our mental health, increased domestic violence, increased COVID, increased spread of TB, increased colds and even increased hand, foot, and mouth disease.

It is important to note that this knowledge holder mentioned mental health impacts first: Inuit are very cognizant that the cloud of social determinants impacts everybody's resilience and mental health. Inuit hold one of the highest rates of suicide globally. During the period between 2009 and 2013, the suicide rate in southern Canada was 11 people per 100,000 (Affleck et al., 2020). In the same period, the suicide rate among Inuit across Nunangat, ranged between 60-275 per 100,000, with the rate for Inuit men being an average of 40 times that of Canadian men in the

south (Affleck et al., 2020). Based on their research in the region, Affleck et al. notes that Inuit suicide is not motivated by individual problems, but by the desperation of enduring the hopeless and apparently unending inequities faced by Inuit (2020). Referred to as social suffering, this means that high suicide rates occur for social reasons rather than being a result of individual circumstances or personal suffering (Affleck et al., 2020). Suicide can be considered an outcome of the marginalization of Inuit whose social determinants of health such as housing, food, and employment insecurity can foster and worsen social injustices such as intergenerational trauma, TB epidemics and access to health care services.

5.3.2. Food Insecurity and Unemployment: "It's all too much"

Typically resulting from a lack of employment, federal government restrictions on hunting, and excessive costs for basic food items, food insecurity is a major issue raised by all community knowledge holders as the major issue facing Inuit everyday in Nunavut. An Inuit woman living in the Kivalliq region of Nunavut shared that:

> Half of our community is unemployed. Lots of people [are] 'bumming' for food. We need jobs, we need food we can [afford to] buy. If you're hungry you can't think right, you can't make good choices. Only junk food gets discounted here. We need a food bank.

This younger Inuit community knowledge holder pointed to the fact that Inuit are hungry: people begging for food is not a sign of being food secure. While there are additional costs associated with transporting food to remote stores, with only one grocery store in many communities, prices are not constrained by competition and can be set to suit profitability targets (Forester, 2022). This imposition of arbitrary pricing is another form of neocolonial oppression.

There is a prevailing assumption among Kablunaaq that Inuit can simply go out and hunt, sourcing as much food as they want to fill their community freezers anytime that they want. The same Inuit woman went on to say that this is not the case:

> We struggle with food costs. We need country food to support people. But people can't afford hunting equipment. We need to [be allowed] to increase hunting quotas [so, we can kill more animals] to get food for our people. Community freezers are not enough. Its [food] is all too expensive. It's all too much.

According to historical accounts, Inuit in the central region of Nunavut suffered extreme food insecurity, and many endured near starvation in the early 1900s, with the decline of the *tuktu* (caribou) herds (Borish et al., 2021; Tester, 2010). Today Inuit hunting for food is limited under hunting moratoriums on *ugjuk* (seals), *qilalugaq* (beluga whales), *nanuq* (polar bears), and *tuktu* imposed by southern government agencies (Snook et al., 2020). By and large these decisions have been made without respect for Inuit cultural practices. Inuit ecological knowledges specific to land and waterways management continue to be challenged and silenced. In a population that suffers from extreme food insecurity, Inuit well-being is directly affected by ongoing neocolonial policies that control their environment and social ecology (Snook et al., 2020).

5.3.3. Health Care and Racism: "We all know racism towards Inuit goes on here…"

Despite federal government legislation and national bodies having formal statements condemning racism in public health, racism towards Inuit endures. All Inuit community knowledge holders, Inuit health care professionals, and Inuit advisory group members openly shared their experiences of racism when seeking health care. One middle-aged Inuk woman

described how traditional ways of being and knowledge systems are disrespected through the systemic discrimination that is entrenched within the health care system in Nunavut. She was emotional when she shared:

> People [health providers] treat us differently. [They] tend to think Inuit are dumb. Like we don't deserve to be treated. We are quiet people, so we put up with bad treatment. We don't like conflict. When people don't speak English, they get treated more poorly. People [health care professionals] are racist towards us. We have been called 'dogs' but *I will stand by my traditions*, my ways. We know ourselves, we know how to survive, and we are all humans. We have the same blood. We are all the same. People should not put other people down, we are all people, right? We struggle through life. All of us do. [emphasis in original]

This account reinforces Lavallee's assessment that Indigenous peoples face racism and oppression in accessing health care (2022; see also, Loppie et al., 2014). The perceived need to be agreeable and not complain about racist treatment was expressed by the woman above, "We are quiet people, so we put up with bad treatment".

Limited access to health care in Nunavut, defined as an intermediate SDOH, when combined with systemic colonialism (a distal SDOH), results in significant health inequities for Inuit (Kim, 2019). Inuit living outside the capital city of Iqaluit with its regional hospital, must rely on their local health care centre. With no access to an alternative provider, Inuit in remote communities cannot choose to obtain care elsewhere, and as a result have limited options, which potentially puts Inuit in harmful health care provider relationships, concern over this risk may create barriers to health care access.

The impact of the Inuit cultural preference to avoid conflict is compounded in health care environments by the general lack of knowledge about western health care practices among Inuit. An Inuit healthcare provider explained, “Inuit are not educated, so they believe what is being said to them, so they shut down, go quieter and then they don’t participate in programs.” This is not simply reproduction of colonial stereotypes of Inuit as unintelligent, it is instead a result of a lack of educational opportunities. In conversation, this Inuit health care professional had already clarified that by saying “Inuit are not educated” they were indicating a lack of specifically western education relating to matters of healthcare; education that would allow Inuit to make their own decisions about the nature of care and contribute to decisions being made. This non-engagement leads to many Inuit choosing to opt out of health care programs that do not appear to care about them and is further evidence of the negative impact that ongoing racism has on Inuit health, individually and collectively.

5.3.4. Tokenism: “Inuit are becoming token on our own lands”

One Inuit woman expressed frustration at what community members referred to as tokenism[22]. Among Inuit, tokenism is understood to involve government and commercial appropriation of Inuit symbols as tokens of an imaginary culture that would benefit tourism corporations and visitors. Her words were raw with emotion when she shared that:

> Inuit are becoming token on our own lands. We’re Inuk but somehow, we are only a positive [and desirable] when people want to look at the North for travel tourism. EE?

[22] It is noted that this use of “tokenism” by Inuit is different to that used in academic discourse where tokenism is understood to occur when a powerful or majority social group uses or invites members of a minority group in order to self-identify as beneficent, diverse, and inclusive of minorities; such acts are understood to be “tokenism” as their apparent generosity is in fact exploitative (Akbar, 2020; Gillespie, 2022). The Inuit usage is utilized herein.

> [meaning, "yes?"] People only want to see nice things. No one wants to see [pause] our crowded houses, or how we suffer [with TB]. Why?

This community knowledge holder expressed her anger, and shed tears of frustration, as she shared the reality that Inuit and Inuit culture are objectified; they are reduced to purchasable symbolic forms and stereotypical representations whose sale to tourists generates profits for government and corporations but not for Inuit. Images of Inuit with eerie throat singing playing in the background while a luxury cruise liner moors in an Arctic cove, fail to encourage non-Indigenous peoples to learn about Inuit history and allows them to ignore or remain ignorant of the current realities faced by Inuit. The use of Inuit faces, lands, customs, and dress to attract, in this instance travelers for Arctic cruises, is cultural appropriation which is rooted in colonization and is a form of neocolonial oppression or Orientalism as defined by Said (1978). Such appropriation and commodification serve to reinforce both an "exoticism or romanticism" and the pejorative "native" stereotypes against Inuit at the same time (Theodossopoulos, 2012; Waldron & Newton, 2014; Westburg, 2021). This form of unauthorised exploitation of culture is not welcomed by Inuit who recognize that being used as symbols or "tokens" in a western imaginary is both racist and is yet another example of Inuit being oppressed on their own lands.

5.3.5. Identity Favouring: "Inuit speak but we are ignored"

Despite legislation and protocols denouncing racism, and in addition to the issues of racism identified by Inuit, on many occasions during the interviews, community knowledge holders used the term "identity favouring". For Inuit community knowledge holders, identity favouring is a deeper and more specific form of systemic racism which, instead of judging Inuit for being Inuit, excludes Inuit for their failure to be Kablunaaq. Many Inuit expressed that they are no longer the priority in Nunavut; the region that is not only their traditional lands but is the

territory Inuit fought so hard to create with the hope of gaining control. Instead, according to many community knowledge holders, it is Kablunaaq who today are prioritized over Inuit-on-Inuit homelands. Identity favouring speaks to how racism manifests itself in allowing for and reinforcing social constructions of discrimination and Kablunaaq superiority (Loppie et al., 2014). One young Inuit woman from the Kivalliq region shared, “Inuit speak but we are ignored”.

Many of the Inuit health care professionals who participated in the research spoke of having experienced this form of racism within the health care system in Nunavut. One Inuit healthcare professional noted that:

> We all know racism towards Inuit goes on in headquarters. People forget who they are supposed to work for. Not just who they are making their money off. Kablunaaq treat us as if we are less than them. They don’t really [want to] integrate with us, only some like you! Ha! Kablunaaq rarely speak to us at work unless to give us a task. We are made to feel that our traditions, beliefs, and morals are bad things. The Inuk in you is a bad thing…our voices and ideas are not important to them.

This community knowledge holder spoke to the racism shown towards Inuit and identified that some Kablunaaq staff adopt an extractive mentality of taking from and judging Inuit rather than seeking to work with and learn from Inuit. Another young Inuit woman shared the conflict she faces “There is such segregation among staff now. Inuit don’t get opportunities to increase their knowledge and skills. But we feel we have to stay on the good side of Kablunaaq”. The impact of this divisiveness goes beyond unpleasantness in the workplace, because, as noted by Calnan and Rowe, trust relations “between providers and between providers and managers, may also influence patient – provider relationships and levels of trust” (Calnan & Rowe, 2006, p. 349). In

other words, the absence of trust and collaboration between health care professionals while creating policy and practice, directly limits the potential for those policies and practices to deliver culturally safe health care to community members.

One Inuk woman and Elder, spoke to the situation of identity favouring (racism) in employment outside the context of health care, when she said:

> Favouritism and segregation against Inuit still happen. Inuit rarely get stable jobs and even when you are an 'educated' Inuk you still only get hired into support positions. Inuit get term positions. Kablunaaq get the full-time jobs with housing. There's lots of jobs Inuit could apply for, but housing doesn't come with it for us, only for Kablunaaq. Inuit can't apply and move to a new job [without housing].

This observation, based on the Elder's years living and working in Nunavut, extends, in her experience, across government and private sector employment. The, perhaps unconscious, bias towards Kablunaaq at all levels of employment has the effect of limiting the opportunities not only for Inuit to gain immediate employment and housing, but to develop the skills and experience needed both by the community and for themselves. The favouring therefore becomes self-perpetuating and continually justifiable based on securing needed skills. This issue shines a light on neocolonial systemic actions that devalue Inuit as "lesser" and the "other".

Another Inuk, in this case a health care professional, expressed how favouritism is internalized and impacts Inuit in their social relationships: "Many Inuit try to be like them [Kablunaaq] and they even take on and put on a stigma against our own people to be in Kablunaaq favour." Changing or attempting to change one's social identity speaks to the colonial narrative of assimilation. This is the realization of the goal of colonialism where the colonized assimilate into the dominant culture. Despite Nunavut's population being majority Inuit and the

territory having been constituted for Inuit, unfortunately, to avoid oppression or fear of falling out of favor with Kablunaaq, many Inuit seek to assimilate. This desire to conform results in rejection of Inuit culture, language, and pride of being Inuit and is a form of internalized stigma.

5.4. TB-related stigma: "The word is *Apmasuviq*"

Directly responding to research objective number two, which was to identify and understand ways Inuit understand that TB-related stigma shapes Inuit perspectives of public health TB programs and limits their participation, community knowledge holders identified the impacts of TB-related stigma on individuals and their participation in health programs. According to Inuit community knowledge holders, stigma stems from: being treated differently by health care professionals; being treated poorly by fellow community members; fearing contracting TB; and feeling despondent because the community is endlessly having to deal with TB. Inuit community knowledge holders' perspectives are in keeping with research showing that TB stigma is a complex process involving both inter-and intrapersonal attitudes (Courtright & Turner, 2010). Being afraid of being stigmatized is a reason community knowledge holders identified when explaining why many Inuit do not seek out health care services when they exhibit signs and symptoms of TB. One middle-aged Inuk man shared quite pragmatically that:

> TB stigma is very real in my community. I don't want to get close to people [who might have TB]. I think I might get it. I don't even want people in my own home. If one person gets it, we will all get it. I feel bad [to think this way] but…

While the community knowledge holder wondered aloud if he should feel bad about feeling this way, his fear reflects the relational context of TB and the inequitable SDOH Inuit face; he is reflecting on the impact TB has on his moral and physical wellbeing (proximal SDOH). The impulse to resist people visiting his home goes against Inuit culture. Inuit visit one another often

and this is an example of how colonially acquired TB continues in a postcolonial form affecting Inuit lives and lifestyles. Similarly, a young woman from the Kivalliq region shared that:

> You are made to feel unwelcome from our own community if you have TB. People gossip about you. Maybe they think you are going to give it to them? People don't want others to know they have TB. People look down on them. People are afraid to say that they are unhealthy. People are afraid to go get help.

This response speaks directly to the strength of TB-related stigma and its ability to prevent individuals from seeking TB screening, diagnosis, and care. Stigma towards other community members is so prevalent that rather than risk being ostracized, people delay accessing care.

In addition to TB-related stigma between Inuit, feelings and experiences of internalized stigma were also described by both community knowledge holders and health care professionals. A younger Inuk health care professional shared that:

> I had TB. I wasn't allowed to go out. I felt depressed, I had bad feelings about myself having TB. I kept it quiet, only had to tell my family. We all kept it quiet. I worried about what others would say [about us]. So, I never told people I had it. They would not let you go into their homes. You are made to feel dirty. Staff make you feel dirty. Stigma because of TB keeps people from getting tested.

This Inuit reflection about TB and stigma indicates that as the fear and experience of stigma grow, the feelings are internalized and individuals not only come to believe their identity matches the negative stereotype, but also feel shame. Internalized TB-related stigma as stigma against the self, is a social practice which speaks to ongoing neocolonial control and oppression against Inuit. Internalized stigma is a recognized predictor of negative outcomes such as deteriorating mental health and low self-esteem, increasing health-compromising behaviors, and

general poor health (Corrigan and Rao, 2012). The internalized nature of stigma that Inuit community knowledge holders identified, is in keeping with Corrigan and Rao when they described that internalized stigma, which includes negative stereotypes and behaviours, becomes normalized (2012).

In reflecting on the impacts of TB-related stigma on the community and potential ways to resolve the issues around a perceived, and often real, need for secrecy, an Inuk and woman Elder asked rhetorically:

> Why is TB so confidential… Why is there such stigma? Is it their [Kablunaaq] way of looking at TB that is put onto us? Then we take it into ourselves? TB is not just an Inuk disease you know. I think TB needs to be normalized in a good way as opposed to making it a stigma.

This community knowledge holder is identifying that Kablunaaq assumptions or understandings of TB in Nunavut are often based on misconceptions of a disease they are unfamiliar with or had thought eliminated. This response highlights the priority given to many westerners' beliefs that Inuit are to be blamed for their experience of TB. But TB is not an Inuit disease. For Inuit to be in any way blamed for TB epidemics speaks to ongoing oppression of Inuit. This community knowledge holder hoped that by removing the secrecy associated with TB, TB-related stigma would disappear, and Inuit would be more open to accessing care so their health would be improved. However, her words also convey the acceptance by Inuit that for them, TB is inevitable. This tragically demonstrates that ill-health has been normalized among Inuit and that such normalization is considered acceptable. Such findings of cultural normalization of TB as an acceptable or expected condition for Inuit, are in keeping with Spivak's observation that normalization of a place of inferiority is a result of colonization (1985). If TB is accepted as a

normal part of life by Inuit, then it becomes a part of the status quo around Inuit and resolution of the health crisis is assumed impossible.

The effect of stigma on Inuit is profound. Whether specific to TB or the wider racial stereotyping of Inuit, stigma has become such a negative force that according to one Inuit health care professional, Inuit have had to address the concept of stigma in their language:

> The word is *Apmasuviq*. It is a new word in our language, we have never needed such a word before. It is not so much one word, but a descriptor, a word that speaks to the 'misconception' towards Inuit culture. The stigmas that are placed on us [Inuit]. The thoughts that we are less because we don't know our health like TB. But Inuit do know their health better than colonizers. We have survived thousands of years living here, long before anyone came to tell us how we should live.

The words of this community knowledge holder are profound. The fact that Inuit have had to create a new word in their ancient language in order to discuss modern TB-related stigma is incredibly disheartening and a reflection on the degree to which Inuit continue to suffer from the effects of colonialism. It also reflects the failure of government systems to address Inuit concerns. If TB is a priority in Nunavut's health care, then addressing TB-related stigma in a culturally safe way as determined by Inuit should a priority to understand, address, and eradicate.

5.5. Shamanism: "We don't talk about it. Bad spirits will return"

Important to exploration of research objective two into ways Inuit understand that TB-related stigma shapes Inuit perspectives of public health TB programs and limits their participation, was the finding about the role of Shamanism. While it was unexpected, all community knowledge holders identified that traditional understandings of Shamanism had

influenced and become incorporated within Inuit knowledge about TB. Inuit community knowledge holders reported that taboos around speaking of 'bad things' that disrupt the community and often bring death, have compounded the silencing effects of TB-related stigma. That is, in addition to not wanting to discuss TB to avoid being stigmatized, conversations about TB are suppressed since TB is a powerful force which must be avoided or countered using the protective taboos advocated by Shamanism. Every interviewed community knowledge holder spoke to or used metaphors to indicate a belief in Shamanism without directly identifying or uttering the word "Shamanism" since even the word itself is powerful and therefore taboo (van den Scott, 2017). The following response, given by an Inuk woman and Elder, is an example of the hesitancy evident in other responses from community knowledge holders on this connection:

> We need to be quiet about TB, no one speaks about having TB. I worry something bad will happen [if we talk about it]. So, I ignore it. We don't talk about it, ok? Bad spirits will return. Some people might talk about TB, but when you talk about bad things bad spirits can come and make you sick. We only try to think good things so we will not get sick. Most Inuit will not say anything about it. If you focus on bad things, bad things come to you.

While taboos meant that few community knowledge holders would directly discuss Shamanism or spirituality, the idea was clearly implied in my research interviews as different Inuit community knowledge holders raised the issue in their own ways:

> "I think this way of evil spirits, because I have been told to think this way."
>
> "I don't want to know if someone has TB. Maybe it will come to you if you talk about it. Maybe."
>
> "We don't focus on bad things. Bad things will follow us."

When I asked one middle-aged Inuit from the Kivalliq region, she explained the hesitancy in elaborating on her response:

> Many in my family had TB. But it's behind us. It's not good to speak of the past. It will bring bad spirits back – so we don't talk about TB. My parents would not talk about their experiences of being sent away with TB. Even when lots of people died.

When I specifically asked this informative woman why she thought Elders said not to speak about this topic, explaining my thinking that perhaps Inuit Elders could provide words of wisdom to the next generations and therefore encourage participation in TB screening and treatment, the community knowledge holder abruptly ended our conversation pointedly saying: "You just don't talk about it."

While I had approached this research with the expectation that some Inuit would address TB-related stigma and the significant role it plays in shaping Inuit perspectives of public health TB policy and program participation, I had not expected to uncover the role and degree to which Inuit Shamanism shapes Inuit perspectives of TB today. The topic of Shamanism had not arisen in my literature review or in my time of living and working with Inuit. I had held a general assumption that Inuit knowledge holders spoke openly to their families about the suffering that Inuit had experienced due to TB epidemics. I expected, since Inuit hold to Oral Traditions of communication and therefore share history with next generations, that knowledge of TB would also be shared. I had anticipated that particular Elders may not wish to share specific stories about attending residential halls due to the abuses that so many experienced; however, I had thought TB would be an openly discussed subject. I was wrong.

In wondering why Inuit Elders had not openly discussed TB within their own families, I questioned whether there was an element of post traumatic stress which might contribute to the

Elders' reluctance and even inability to share their experiences. However, as I reflected, I realized I was seeking a Kablunaaq medicalized explanation for what people were saying, rather than hearing Inuit saying that "We do not want to risk discussing this subject." Applying a postcolonial critique of my own actions, I recognized that my thoughts were nothing more than a settler colonial person's need to control or explain Inuit spoken word and knowledge to suit my limited western based knowledge and understandings. Clearly my actions spoke to a form of colonial othering and this insight was most humbling.

To try to understand the weight of the silences I chose to research Inuit Shamanism and immediately found that this is a topic Inuit rarely discuss and especially not with Kablunaaq (Laugrand, & Oosten, 2010). Today little is known by outsiders about Inuit Shamanism (Laugrand, & Oosten, 2010; Sampath. 1988). According to Qitsualik, Shamanism is not a religion, but instead an ability that some people possess; people that possess this ability or power are referred to as Angakkuit/Anatquq (2018; Stone, 2010). Such people have the ability to affect another's will and thus "warp reality to make it reflect the mind of an individual" (Qitsualik, 2018, p. 2). Qitsualik further notes that Inuit are "careful not to speak of Angakkuit practices and thus, of the unseen powers dealt with by Angakkuit, lest idle chatter attract such forces and bring their influence to bear" (2018, p .2). Interestingly, while these researchers found that in more recent times Inuit youth are asking questions and more Elders becoming prepared to discuss Shamanistic traditions before they are forgotten, there is still hesitation to discuss the topic of taboo (van den Scott, 2017).

After gaining this insight I came to appreciate that for Kablunaaq working with Inuit, being aware of Shamanism means being conscious of taboos and the associated resistances to speaking or sharing knowledge. I wondered if the silence surrounding TB because of taboos,

may interact with and compound the silence that results from stigma. However, following Goffman, I note that taboo and stigma are theorized as distinct social forces (1963). Future research should consider if there is a relationship between stigma and the operation of Shamanistic taboos which require Inuit to avoid bad spirits. It is possible that this may hold value when developing public health TB policy specific to TB stigma among Inuit. Certainly, for TB public health polices and practices to be more effective there must be increased awareness of the importance of Shamanism by Kablunaaq. The data in this research speaks to the past continuing to have a strong influence on current experiences, in a process referred to by anthropology scholars as syncretism.

This research and that of van den Scott suggest that Shamanism is being incorporated by Inuit into current experiences of IQ principles in a nuanced way that has responded to the extreme change of colonialism in Nunavut (2017). Strict adherence by Inuit to taboos arising from Shamanistic beliefs may, however unintentionally, be reinforcing stigma and interfering with TB screening participation, TB treatment, and TB education programs. When working with Inuit to develop culturally safe health systems, Kablunaaq must therefore be aware and respectful of the practice of Shamanism.

5.6. Intergenerational Trauma Informed Care: “Inuit are not to blame”

To promote culturally safe TB policies and practices within Inuit communities, as in research objective one, community knowledge holders identified the need for support to address intergenerational trauma. Intergenerational trauma is understood as not being the result of a specific individual or event, but instead incorporates the layering of antecedent events, the community memory of those multiple events, and outcomes of living in a present that is shaped

by those multiple traumatic acts – it is therefore transferred across generations and results in normalized maladaptive coping mechanisms (Salberg, 2015, p. 2). Despite their resilience, Inuit have not survived the colonially imposed challenges of the past 55-60 years without suffering considerable trauma from the injustices inflicted upon them – trauma that is now experienced intergenerationally (Smallwood et al., 2020). For Inuit, such traumatic acts included the removal of Inuit from the land, residential halls, slaughtering of sled dogs, and banning of Shamanism. To foster healing within communities with embedded intergenerational trauma requires culturally safe and appropriate interventions. One Kablunaaq health care professional shared their thoughts on the need for intergenerational trauma care in Nunavut, saying that:

> Intergenerational trauma is not being recognized enough with Inuit and this is big problem in our health care. Yes, Inuit didn't attend the residential halls as long as First Nations did, but it was so recent. So, on top of being forced off the land just 55 years ago, there were residential halls, and the TB sanitoriums. Seriously, how about just plain trauma; residential halls or not, so many things in Nunavut have not been culturally safe for Inuit.

Intergenerational trauma programs with Indigenous peoples are found to be most effective when focused on re-establishing connection to land and culture (Danto et al., 2022). For example, programs are led by Elders and teach culture, traditional knowledge, and language, while also engaging with the risks and suffering experienced as a result of trauma and cultural loss (Danto et al., 2022). Healing intergenerational trauma in Nunavut relies on Inuit having greater access to land-based programs and support than is currently available (Lochead, 2023b). One positive step being taken in this area is the joint contribution agreement, signed by the Government of Nunavut, NTI, Makigiaqta Inuit Training Corporation, and the Government of Canada to build

Aqqusariaq, formerly referred to as the Nunavut Recovery Centre (Lochead, 2023b). Once built, Aqqusariaq will utilize IQ principles, practices, and values to provide culturally safe treatment including giving priority to “on-the-land healing camps” (Lochead, 2023b). This centre will support the Truth and Reconciliation Commission: Calls to Action number 21, which called for Inuit to have available to them the same variety of services that are routinely available to trauma survivors in the south (Truth and Reconciliation Commission of Canada, 2015).

The timeliness (or lateness) of building a centre that is focused on the need to address Inuit intergenerational trauma is emphasised by the same Kablunaaq health care professional, who added:

> [It is not cultural safety] when the health care system reinforces powerlessness to the point that Inuit are feeling ignored and desperate. Inuit are doing all the right things but not getting anywhere. Not getting ahead.

A health system is not delivering cultural safety when people are placed in positions in which they feel powerless and are unable to access the resources to deal with past traumas. Thus, advancing cultural safety can be considered a universal approach to mitigating traumas caused within health care services.

5.7. Following IQ Principles: “We need our spiritual ways more”

Inuit community knowledge holders communicated that culturally safe TB policy and practice within Inuit communities would mean that their traditional ways of being as encapsulated in IQ principles were utilized and centred in public health TB policy and practice. A young Inuk woman in the Kivalliq region shared:

> We could make TB programs culturally safe and eliminate TB if we utilized IQ Principles. They [IQ] need to be known and implemented. This would ensure cultural safety and decrease TB-related stigma. IQ needs to be underlined and stressed in TB policy and practice.

This young Inuk woman also explained that utilizing IQ principles would mean collaboration, respect, and acceptance of Inuit views, so that all interested community members could participate. Another young Inuit woman community knowledge holder from the same community remarked:

> We need TB programs to be set up more traditionally, to follow IQ principles. Teach people to handle things more in an Inuit way. We need our Inuit spiritual ways more. The Government of Nunavut talks about [following] IQ principles, but we don't see them in programs. We need more connections to IQ…We need more culturally focused programs, [on the land].

These two excerpts are indicative of the community knowledge holders' responses; all shared similar desires to see Inuit ways of being give priority in leading TB policy and practice initiatives. The findings suggest that if the Government of Nunavut visibly utilized and actioned IQ principles this may assist in increasing respect and the re-establishment of trust between Inuit and their health care system.

5.8. We Need Our Language: "Saying my name, the right way, is a good place to start"

All Inuit knowledge holders who participated in this research spoke of the need to have their own language spoken in the delivery of their health care. Inuktut is an inclusive word representing all dialects and regional differences used across Nunavut. Inuktut is the language of

Inuit. There are four primary dialects of Inuktut with two main dialects spoken in Nunavut: *Inuktitut* and *Inuinnaqtun*. The community knowledge holders in this research lived in regions that speak Inuktitut.

A young Inuit man from the Kivalliq region spoke with great emotion when describing how cultural safety could be promoted in TB policy and practice:

> Saying my name, the right way [would be a good place to start]. Our languages need to be used. If not our spoken language, then our syllabics, and we need videos [with Inuit in them] so our children can see themselves.

Saying a person's name correctly takes on great significance for Inuit. Given Inuit past experiences with fingerprinting, E-discs, and Operation Surname, taking the time to learn and say a person's name correctly is a visible attempt to step past colonial oppression and act in a genuine postcolonial manner. This "small" action erodes notions of racial and language superiority and would signal an effort to end treatment that embodies the lack of respect with which Inuit have become all too familiar.

Across the three regions of Nunavut there are Inuit who are unilingual Inuktut speakers and who read the syllabic script, those who easily move between Inuktut and English and/or French, and Inuit who only speak and/or read English or French. Unilingual Inuit are primarily Elders, while Inuit who do not speak Inuktut are often youth. This Inuk man emphasised that many Inuit cannot read English and so are excluded when written health materials are not provided in Inuktut. All community knowledge holders identified the need to use Inuktut language in the TB program and pointed out the English literacy problems faced by many Inuit. Such responses subtly spoke to the compounding impacts of proximal SDOH and challenges Inuit face, i.e., low literacy rates ("lots of us can't read", and othering ("say my name the right way"). For many

community knowledge holders, the inability to access health care provided in their own language, presents a significant barrier to their understanding of and their participation in, public health TB programs (Shawstack, 2019).

Inuit are people of few words. When they speak, they are direct. Rereading the transcripts many times made me conscious of their pauses and silences. I had to stop myself rushing in to fill the spaces and instead to sit, wait, and reflect. That process of giving over interpretation and control to instead sit with the data and wait, helped me to be more aware of the relational nature of Inuit knowledge. Given the experiences of TB public health polices and practices in a community that suffers a recurring cycle of TB epidemics, it was no surprise that the interview data settled into themes that are related to SDOH and inequities resulting from colonialism. There is anger, frustration, and pain communicated in the conversations I had with many community knowledge holders and that is reflected in these included excerpts. Yet despite these frustrations, Inuit communicated their desire for opportunities to make things better.

The generosity of Inuit community knowledge holders and their courage displayed in choosing to be interviewed, gives a profound weight to the data. Inuit embraced my interview questions about how cultural safety might help them and they responded. They trusted me enough that they did not only criticize and describe their un-safety and social determinants of health, but they also risked sharing words and ideas of quiet hope for what a better, more equitable future might look like. Inuit claimed control of the narrative of what their future could be if cultural safety could become the new TB public health policy and practice paradigm.

In the next chapter I discuss the implications of this research that can guide and inform future nursing research and address research objective three by identifying and discussing the ways Inuit envision mobilizing Inuit knowledge to inform and democratize the development of

culturally safe TB public health practice and policy in Nunavut. Inuit Research Advisory Committee members expressed hope that my findings can be part of a movement for transformation and change that brings about self-determination for Inuit of Nunavut and an end to TB epidemics.

Chapter Six: Discussion
Implications and Recommendations for Inuit Culturally Safe Public Health TB Policy and Practice

6.1. Introduction

This research had the overall purpose of understanding Inuit perspectives on culturally safe TB policy and practice, and in this chapter I discuss the implications and recommendations that emerged from the findings. These recommendations offer tangible options and knowledge that can be incorporated into democratic transformation and changes that advance opportunities for Inuit in Nunavut to make choices in health care and bring an end to TB epidemics. To summarize the knowledge shared by Inuit, this chapter first reiterates the findings developed in chapter 5 as responding to research objectives one and two. It is this collected Inuit knowledge that community knowledge holders want used to inform and democratize Government of Nunavut public health TB policy and programs. This use of Inuit knowledge speaks to objective three of this research. In this chapter I discuss ways that Inuit knowledge can be translated into action that will advance their aim. I highlight the Inuit Advisory Research Committee's suggestions with respect to knowledge sharing and return of information to the community. I then discuss the implications for nursing education, highlighting the importance of nurses being knowledgeable about the populations in and for which they provide care, such that care is carried out in a decolonizing manner and that nurses are held to the highest possible standard in the provision of client care. I draw attention to the implications for nursing research and scholarship, and for conducting research with Inuit communities. I identify the limitations on the research before concluding with some final reflections.

6.2. Collected Inuit Knowledge on Cultural Safety and TB-related Stigma

To advance my research objective to understand Inuit perspectives on culturally safe public health TB policy and practice in Nunavut, and as discussed in chapter 5, my analysis identified seven themes. Three Research Advisory Committee Members and two community youth champions added contextual and cultural knowledge to the interpretations and meaning of the data. I engaged in reflexive thematic analysis, informed by postcolonial theoretical awareness and adopting a cultural safety orientation. The seven themes identified from the knowledge shared by Inuit community knowledge holders as contributing to advancing culturally safe TB public health care policy and practice are that: 1) Kablunaaq, non-Inuit, develop trust and respect towards Inuit; 2) Inuit social determinants of health are addressed; 3) TB-related stigma is addressed; 4) Kablunaaq respect the importance of Inuit Shamanism and spirituality; 5) intergenerational trauma informed care is provided; 6) Inuit Qaujimajatuqangit principles are recognised and used to guide health care policy and programs; and 7) Inuktut language can be used in health care. The themes are interconnected, and together result from the need to address the ongoing colonial and neocolonial relations that perpetuate TB-related stigma and health inequities in Nunavut.

According to Inuit community knowledge holders, TB-related stigma has a significant impact on individuals and on communities. At the community level, TB-related stigma is found to lead to unspoken acceptance that TB is to be simultaneously stigmatized and shunned, while also being normalized and accepted. On an individual level, the findings also show that as the fear and experience of stigma grows, it is internalized, and some individuals come to believe that their identity is degraded and consequently feel shame. Together, the seven themes and the findings regarding TB-related stigma, constitute the information that Inuit shared to advance

knowledge and understanding of Inuit perspectives of culturally safe public health TB policy and practice in Nunavut. This is the collected knowledge that Inuit community knowledge holders and the Research Advisory Committee hope to mobilize to inform and democratize Government of Nunavut public health policy and programs, which is discussed below.

6.3. Incorporating Inuit Knowledge into Public Health TB Policy and Practice

The purpose of this research was to first understand Inuit perspectives of culturally safe public health TB policy and practice in Nunavut. The third research objective was to understand ways Inuit envision mobilizing Inuit knowledge to inform and democratize Government of Nunavut public health policy and programs. Despite the laudable aims of previous programs and strategies involving Inuit groups including ITK, NTI, and Pauktuutit, which included utilizing the language of "cultural safety," the literature review (chapter 2) demonstrates the enduring gap between the aim of cultural safety and actual mechanisms used to achieve it. This chapter 6.3 first describes the recommendations from Inuit community knowledge holders for health care practitioners and for future public health TB policy and practice. I then show how these recommendations are linked to postcolonial theory as they seek to address structural inequities and perpetuation of social injustices. I then provide the recommendations of the Research Advisory Committee for sharing the knowledge, including the feedback both to the community in Nunavut and in academic contexts.

6.3.1. Inuit Community Knowledge Holders' Recommendations for Health Care Practitioners

In interviews, Inuit community knowledge holders shared their experiences of multiple ways in which current TB policies and practice are not culturally safe for Inuit; they discussed

the roles of TB-related stigma, racism, discrimination, and othering in health care contexts; and they described how these experiences affect Inuit seeking TB care or participation in TB programs and treatment. And yet despite the apparent hopelessness of endemic TB, Inuit community knowledge holders also described the resilience of all those Inuit who continue to endure and hope for a future without TB. While clearly not representative of *all* Inuit throughout Nunavut, the research interviewed 30 community members (25 Inuit community knowledge holders and 5 health care professionals, 3 of whom were Inuit), who resided in two regions of Nunavut. The research findings therefore provide insight into indicative attitudes and recommendations that can guide future community consultation and be further developed and incorporated into future culturally safe public health TB policy and practice. Beyond providing criticism, Inuit community knowledge holders were more than generous in their provision of honest and sincere suggestions to inform recommendations and ensure that the Government of Nunavut's public health TB policy and practice can be made culturally safe for Inuit. As a result of their insights, the factors that can be added or eliminated to promote cultural safety in TB policy and practice were identified. The recommendations for health care practitioners, are grouped according to the seven themes Inuit community knowledge holders identified as contributing to culturally safe health care, and include:

- Develop trust and respect:
    - Actively listen to Inuit and confirm understandings by phrasing questions in ways that do not place Inuit in positions that potentially create disagreement or conflict.
    - Learn about Inuit history.
    - Reflect on own biases, unconscious racism, and learned stereotypes.

  - Participate in Inuit culture if/when invited.
- Address SDOH in Nunavut:
  - Recognize and understand the impacts of the SDOH that affect Inuit.
- Address TB-related stigma:
  - Be informed about TB-related stigma and its impacts on Inuit individuals and communities.
  - Reflect on health care practices and protocols and look for ways to make them less othering.
  - Consider ways individuals with TB can be brought together and find their own ways to support each other.
- Respect Inuit Shamanism and Spirituality:
  - Be aware of the existence of Shamanism and taboos that may limit some Inuit in speaking about TB and participating in TB screening programs.
- Provide intergenerational trauma informed health care:
  - Be informed about the impacts of intergenerational trauma in health and nursing literature and be aware of its potential ongoing impacts on some Inuit.
  - Support land based intergenerational trauma care programs where invited.
- Use IQ principles in health care:
  - Learn about IQ principles from Inuit Elders and organizations such as ITK.
  - Consider the impacts of IQ principles and Inuit culture on how individual Inuit engage in health care situations.
- Use Inuktut language instead of requiring English in health care contexts:

- Quickly learn basic phrases and pronunciation in the language. Work to develop proficiency and respect of language variations.
- Make the effort to say people's names correctly.

Community knowledge holders in this research indicated that by health professionals acting on the above recommendations, cultural safety in TB health policy and practice for Inuit in Nunavut would be advanced.

6.3.2. Inuit Recommendations for future TB Public Health Policy and Practice

Involving Inuit in sharing and implementing the knowledge generated in this research maintains the rationale behind the research methodology which utilized a participatory and relational approach. Ensuring that Inuit not only receive the knowledge generated, but are involved in its use, is important not only to understanding TB and TB-related stigma, but to extending insight into how Inuit people experience health care and ways their knowledge can be mobilized for change.

Inuit involved in the research envisioned that the knowledge that they shared could be mobilized to inform and democratize Government of Nunavut public health policy and programs. That is, addressing research objective three, the research findings can also be used to create an opportunity to further engage the wider Inuit community in knowledge mobilization as part of the participatory process, democratization of TB public health policy, and generation of calls to action. The objectives of such engagement would be to implement Inuit perspectives of culturally safe public health TB policy and practice, with the aim of addressing the endemic level of TB in Nunavut. For example, utilizing Inuit perspectives gleaned from this research as a benchmark to measure and improve future policy and practice effectiveness, could ultimately

provide a pathway to increased participation in TB programs and treatment by Inuit, and the mitigation of TB-related stigma. Recommendations for policy makers and program developers have been derived from the application of a postcolonial critical theoretical critique (see chapter 6.3.3) and have had input from Inuit community knowledge holders and the Research Advisory Committee. They identify changes that they believe are necessary to achieve culturally safe public health TB policy and practice in Nunavut. The recommendations are:

- That current program performance is audited against the cultural safety criteria this research has identified as priorities for Inuit. Such audits would seek to highlight hidden ongoing systemic violence and ensure policy and practice does not perpetuate TB-related stigma.
- That all Government of Nunavut health care program development is led by Inuit advice, provided by an Inuit Community Advisory council, whose members are paid for their participation. The inclusion of an Inuit advisory council provides greater support of Inuit self-determination and democratization of the structural development of health care provision.
- That all new health care professionals take an Inuktut language program to ensure they can use basic greetings with patients, and to foster verbal respect for Inuit in their own languages.
- That training in cultural safety and awareness of IQ principles is provided for all health care practitioners, and that such training is provided by Inuit who are contracted and paid to create and deliver this training. Listening to and acting on Inuit direction builds relationships that are founded on Inuit knowledge and build trust and respect.

- That the Government of Nunavut increase and ensure funding for intergenerational trauma informed land-based health programs led by Inuit.
- That the Government of Nunavut work with communities to identify and prioritize options to gain meaningful and appropriate Government of Canada support to address Inuit identified social determinants of health.

These recommendations for policy makers and program developers are summarized in Figure 5.

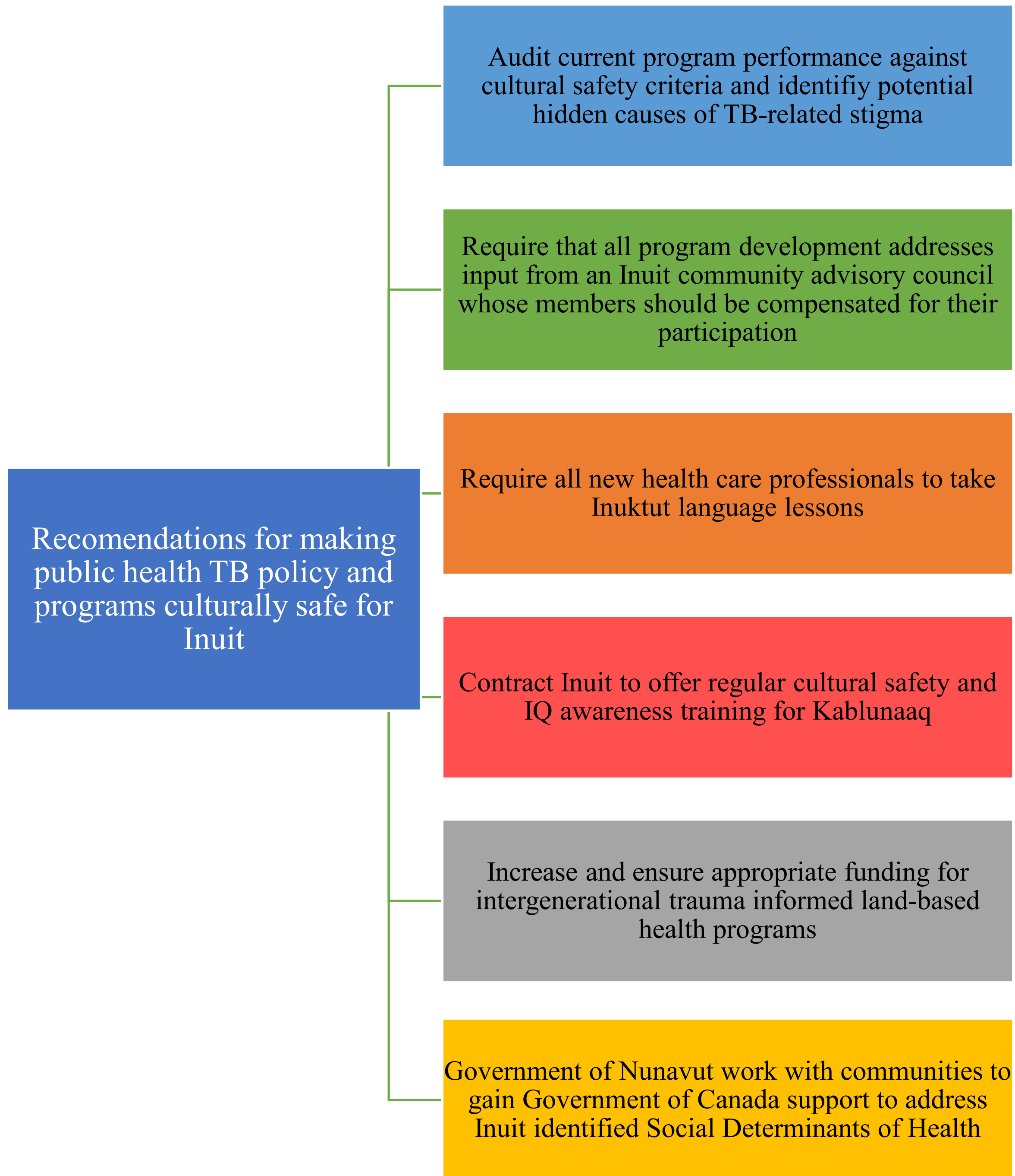

Figure 5: Recommendations for policy makers and program developers to advance culturally safe TB public health care practice as determined by Inuit perspectives

6.3.3. Alignment of Recommendations with Postcolonial Theory

These recommendations link the research and postcolonial theory. Postcolonial theory has been successfully applied in nursing research to redress structural inequities and social injustices such as relationships of dependency but has not been widely applied to public health programming (Browne et al., 2005). Application of this critical theoretical approach in the relational context of TB and its direct correlation to the social determinants of Inuit health, provides a significant opportunity to highlight historical and ongoing processes of colonialism, and to advocate for the need to advance Inuit health in a socially just and equitable manner (Browne et al., 2005; Getty, 2010; Holmes et al., 2008). The further benefits of utilizing a postcolonial theoretical approach are that it focuses in-depth analysis of colonially constructed public health programs in Nunavut and affords researchers the ability to “re-examine, challenge, and resist ideologies and structures of power stemming from western hegemony” (Holmes et al., 2008, p. 42; see also, Bhati, 2022).

Taking up a postcolonial theoretical approach focused on a public health issue such as TB, prioritizes a thorough unpacking of the nuanced and insidious manifestations of colonial domination in all its forms. This means that issues such as racism, discrimination, and stigma were identified and highlighted where they had originated in current public health policies, programs, and practices in Nunavut. Ensuring the identification of such manifestations enables the development of necessary decolonizing structural changes in public health policy and practices, assists in understanding the factors that shape cultural TB stigma, and aids in promoting greater Inuit participation in health programs that will promote Inuit self-determination, honour Inuit knowledges, and provide cultural safety for Inuit. While postcolonial theory explains historical and current practices of domination, cultural safety is an orientation

that helps to uncover, point to, and highlight Inuit perspectives on inequitable power relations that exist because of colonization. It is therefore critical to operationalize cultural safety in TB public health policy and practice for Inuit in Nunavut.

6.3.4. Inuit Research Advisory Committee Suggestions for Knowledge Sharing – Alignment of Recommendations with Participatory Research

To democratize and inform future TB public health policy and practice (research objective 3), I worked with the Inuit Research Advisory Committee to codevelop the next steps for using the findings of this research to promote culturally safe TB policy and programming in Nunavut; this was in keeping with the principles of community-based participatory action research (CBPAR). Seeking direction from and working with Inuit in the determination of knowledge mobilization, ensures that Inuit knowledge is prioritized, appreciated, valued, respected, and continues to be controlled by Inuit. Additionally, for me as the Kablunaaq researcher, this means that I must continue to orient myself towards the values of cultural safety and ensure that I am not the one determining how the Inuit knowledge, that was shared with me, is to be translated and to whom.

The suggestions made by the committee uphold the principles of CBPAR and focus on building upon the current strength in the communities, in the territory and with Inuit Tapiriit Kanatami (ITK). To share the findings and build on the current strengths, it was suggested that a committee member and I co-present the findings to the ITK's health program; the Government of Nunavut; and, to Nunavut Tunngavik Incorporated (NTI) TB program. Emphasizing the CBPAR principle of promoting co-learning and capacity building, and facilitating collaboration and equitable partnerships, means that I was asked to share the findings at the next bi-annual meeting of community health representatives. The infographic flier included in Appendix A will be

provided to the community health representatives in English and Inuktut so that they can share the findings in their communities. Community health representatives work closely with TB education in the communities, and they will be able to share the findings. CBPAR also emphasises integrating research and action, and so it was suggested that a committee member and I co-present the research findings to the Government of Nunavut's public health TB program to share what community recipients of their policies and programs have said. To ensure that I meet the CBPAR recommendation to share the research findings with all Inuit community knowledge holders that participated in the research, I will also share the infographic shown in Appendix A to the communities involved in the research process. Finally, it was suggested by one Inuit Research Advisory Committee member that I should publish the findings in an academic journal so that people (health care providers and researchers) outside Nunavut will "learn about Inuit and our struggles with TB". In the spirit of participatory action research, I plan to invite a committee member to join me in coauthoring that publication.

6.4. Implications for Nursing Education and Scholarship

Within nursing education and scholarship, the journey towards decolonization and recognition of the importance of cultural safety in nursing care has certainly begun with initiatives resulting from the Truth and Reconciliation process such as recognition of the need for awareness of the injustices and inequities resulting from colonization and neocolonialism (Truth and Reconciliation Commission of Canada, 2015). In this research, the Inuit Research Advisory Committee emphasised the need for nurses in Canada to learn about Inuit history and IQ Principles that are distinct from those of First Nations. The need for improved education about cultural safety and not simply cultural awareness is underscored as Inuit of Nunavut reported continuing to feel discrimination and felt unsafe, even when attended by well-intentioned nursing

care providers. I therefore suggest that education should offer opportunities for nursing students to critically explore their own positionality and demonstrate their understanding and willingness to act towards ensuring that their practice comes from a self reflexive, culturally safe orientation that promotes equitable and socially just nursing care to vulnerable populations, including Inuit of Nunavut (Anderson et al., 2003). Reflection on the role of well intentioned but paternalistic and culturally inappropriate nursing care could draw for example on the works of Anderson et al., (2003) and Sweet and Hawkins (2015).

Despite increasing awareness of the impacts of colonization following the Truth and Reconciliation Commission (2015), there is a long journey ahead to ensure that decolonized culturally safe health care is delivered in a practical and equitable manner to all Canadians from coast to coast to coast (Tuck & Young, 2012). In addition to reflection on the self and the discipline, implementation of a postcolonial critique in this research has highlighted the need for Canadian nursing curricula to be expanded to incorporate study of the history of colonization, colonized peoples (Inuit, Métis, and First Nations), Indigenous epistemologies of land, spirit, and interconnection (Karetak et al., 2017), cultural safety (Ramsden, 1992), and postcolonial theorists such as Fanon (1952), Bhabha (1995) and Moreton Robinson (2011). This may add workload to existing curricula and require more funding, however the cost of not implementing Inuit knowledge is a health issue and raises questions of the moral obligation of nursing practice. As discussed above, the data include community members' reports of delaying seeking nursing services, sometimes with tragic outcomes.

In this research, adopting a postcolonial analysis, coupled with my deliberate culturally safe orientation, allowed me to bring together critical understandings of the power structures of the colonial past and perspectives shared by Inuit; this approach has value for future nursing

pedagogy that seeks to implement anti-colonizing or decolonizing research and curricula, as it challenges the inherent presumptions and biases that may exist for culturally diverse cohorts. It is critically important that policies, programs, and the health care professionals delivering this care, are situated in, and taught from a culturally safe orientation that promotes the delivery of diversity, equity, and inclusion, especially given that Inuit do not have the power or opportunity to choose health care alternatives within their remote and isolated communities (Zappas et al., 2021). Training should therefore also foster attitudes and opportunities for nursing as a profession to support Indigenous people, specifically Inuit, in moving towards self-determination in their health care.

As a health care professional with extensive experience in health care delivery with Indigenous Peoples across Canada, I can see the added value to nursing programs, indeed all health-related programs, if such an approach were to be utilized from the first day of the nursing education journey. Incorporating a postcolonial theoretical approach and culturally safe orientation within nursing education from the beginning, when everything is new, normalizes conversations that promote greater understanding of, and commitment to, altering health care inequities facing Indigenous Canadians. New health care professionals and students are often unaware of the extent to which health care systems and health care professionals support, encourage, or blindly maintain the continuation of colonialism against Indigenous Peoples in Canada. People entering health care professions from the wider Canadian society are not always aware of the history of colonialism and may experience "discomfort" when first confronted with the idea that their own country has a morally offensive colonial history (Wilmot, 2021). Such discomfort is understandable not only as histories may implicate their own ancestors or their own privilege, but also because Indigenous Peoples' lived experiences have included being victimized

by their own country's ongoing colonially embedded systems of health care (Wilmot, 2021). Learning that such inequities are not only things of the past, and that nursing praxis can and should fundamentally work against inequity, may produce a generation of nurses who demand social justice for Indigenous Canadians (Blanchet-Garneau et al., 2021). It is important that this learning and reflexive work is done during nursing education and not in the community in the presence of potentially vulnerable Indigenous peoples such as Inuit.

This research has highlighted the need to ensure that new health care professionals planning on working in Nunavut, especially those providing TB care, are presented with the opportunity to learn about Inuit from Inuit. Consistent with addressing this need are the recently announced education modules that will be rolled out to newly hired health care professionals who will be involved in the next series of community wide TB screening clinics. This education will focus specifically on Inuit history with TB and the importance of delivering culturally safe health care to Inuit. The introduction of these modules is a first step in creating awareness through education to assist in the delivery of culturally safe TB care for Inuit. In keeping with this new educational opportunity in Nunavut, knowledge from this research, could also be presented to new health care professionals in Nunavut and nursing students studying courses in Indigenous health.

There are many more ways in which nursing education and scholarship can deliver increased learning opportunities for nursing students about Inuit and inequities they face, including TB and TB-related stigma. Such additional learning opportunities could include:

- Offering the opportunity for nursing students to do clinical placements in Nunavut.
- Ensuring Inuit nurses, community leaders, and researchers are invited to speak and teach in nursing institutions to inform and reform student perceptions about Inuit

(students and faculty alike should learn about Inuit, especially given Inuit inhabit circumpolar regions in five nations).

- Ensuring nursing students are aware of Inuit SDOH and the practicalities of how they intersect with Inuit health outcomes in unique ways.
- Ensuring increased collaborative learning opportunities.

It is worthy of note that the Inuit community knowledge holders and the Research Advisory Committee members did not raise the question of promoting greater participation in nursing education among Inuit. At no point did any of the interviews consider barriers to Inuit entering the nursing profession. It may be that similar factors to those that present as barriers to Inuit accessing TB health care services and practices, also act as barriers to Inuit choosing to enter the nursing profession. This is an area that is worthy of further research and discussion with Inuit community members as new culturally safe TB public health policies and programs are developed.

After the Truth and Reconciliation: Calls to Action (Truth and Reconciliation Commission of Canada, 2015) report, nursing institutions, educators, and researchers should incorporate Indigenous research methodologies in nursing studies. This means that nursing scholarship, not only in the northern regions of Canada, should provide education about Inuit, Inuit knowledge and culture, history of colonization, and particularly IQ principles; Inuit research methodologies from ITK are relevant and need to be respected and incorporated into nursing programs and research studies across the country. Few nursing schools beyond Memorial University, University of Ottawa, and Dalhousie University have formal relationships with Inuit of Nunavut. If adopted, the above recommendations can promote cultural awareness and cultural safety through a systematic approach that will have direct implications for care. Moreover,

upholding respect for Inuit culture and history is paramount in any nursing education that takes the recommendations of the Truth and Reconciliation commission seriously.

6.5. Implications for Future Nursing Research with Inuit

Research is important to the nursing profession as it ensures nursing standards are maintained, encourages continued learning, provides for new methods of knowledge, and improves health care delivery to community members regardless of setting. Nursing's focus on identifying potential problems that interfere with patient care and determining best practices to improve the outcomes of such care, drive us to engage in systematic inquiry that supports nurses in developing new knowledge (Polit & Beck, 2004). This research has shown the importance of expanding nursing knowledge by utilizing Indigenous methodologies relevant to Inuit, such as the Inuit Tapiriit Kanatami (ITK) National Inuit Strategy on Research (ITK, 2018a). Beyond ensuring the research respects Indigenous participants, inclusion of Indigenous methodologies underscores the relevance of the findings and thus increases the likelihood that policies and practices will be more effective in supporting Indigenous health and reconciliation (Foster-Boucher & Thirsk, 2021). Drawing on Indigenous methodologies is indicated as being appropriate in the 5th edition of Singh and Thirsk's Nursing Research in Canada (Foster-Boucher & Thirsk, 2021). The importance of such texts cannot be overstated, however, the literature review identified that the concepts recommended, and those used in this research, are not being widely adopted in methodologies or reflected in research objectives among Inuit. That is, while the literature review revealed that there were vast numbers of nursing research studies carried out with First Nations and Métis peoples, there was limited nursing research into Inuit health. Furthermore, while there were numerous medical articles that consider Inuit and TB (e.g., Alvarez et al., 2020; N'Diaye, 2019), however, very few research studies addressed Inuit

perspectives on TB policy and practice in Nunavut. This gap in considering or understanding Inuit perspectives is especially problematic within the context of the Inuit TB crisis, as research is known to influence current and future nursing best practice (Tingen et al., 2009). The closest identified literature relevant to nursing research was medical anthropology research by Moller, which considered how Inuit in Nunavut experienced TB and its implications for how public health communications should be drafted to address Inuit (2010). More than a decade later, this research goes deeper into Inuit experiences to understand Inuit perspectives of what constitutes culturally safe public health TB policy and practice.

From an epistemological perspective, use of postcolonial theory has great value for nursing research which seeks to disrupt racism, paternalism, and colonialism across research methods with Indigenous peoples including Inuit. Postcolonial theory can be used by researchers to challenge dominant narratives that have silenced voices of those whom western society has deemed to be other. From a nursing perspective the utilization of postcolonial theory disrupts and unsettles the inequalities, inequities, and racialized discourses found within the narratives about Inuit and their health outcomes, asking what it means to know and the relationships therein (Bradshaw et al., 2017). In the context of nursing research, I therefore agree with the perspective that postcolonialism provides an ontological perspective from which to process colonialism. Adopting an ontology that is informed by postcolonial critiques means that I considered “the being or reality of colonialism” rather than the epistemological question of “how one knows colonialism to be” – I recommend this perspective to other future researchers working with Inuit (Bradshaw et al., 2017; see also, Denzin & Lincoln, 2011). This nuance causes nursing scholarship to pose the question of what needs to “be” in order for respectful dialogues to occur

between Indigenous and non-Indigenous peoples, and in this case Inuit and Kablunaaq nurses (McCredden, 2020).

Utilizing a cultural safety orientation in this research highlights for future researchers the importance of attending to power differentials such as those specific to TB health care in Nunavut. Future researchers may find it useful to consider adopting the methodology of using diverse approaches under the umbrella of Braun and Clarke's reflexive thematic analysis and using Ramsden's cultural safety as an epistemological orientation as these were found to be beneficial in framing the research. CBPAR approaches can be utilized as they were here to address these power dynamics by focusing on the research outcomes and how these outcomes could inform and shift current postcolonial TB policy and practice towards ones that would reflect and hold up Inuit knowledge and values in a manner that has been defined as being culturally safe by Inuit. The development of a CBPAR space for interviews fostered trust between the community knowledge holders and me as they expressed and shared their perspectives and knowledge; this may be useful in other contexts. For this research, part of creating this space involved drawing on IQ principles which are known to represent all that Inuit have always known (Karetak et al., 2017; Staley, et al., 2017). Including IQ in the interwoven framework that shaped this research speaks to respecting Inuit ways of doing, thinking, and perceiving. Given that it was Inuit perspectives on TB policy and practice that I sought, it was vital that I gained a greater understanding of the principles that many Inuit live by. IQ, I have learnt, speaks to the cultural context of being Inuit and is grounded in a wholly Inuit worldview (Ferrazzi et al., 2019). Stemming from the same cultural context, ITK’s research and TB strategy was utilized as an approach to the research process to ensure all aspects of my research complemented and moved IQ from knowledge to action to ensure cultural safety in the research

and in the promotion of social justice and equity in health care for Inuit (ITK, 2018a). While the Inuit specific principles and frameworks will not apply directly to researchers outside the Inuit context, the approach may benefit others.

This research has demonstrated for future researchers with Indigenous peoples the importance of bringing together the diverse orientations, lenses, approaches, frameworks, and strategies used in this research. The mix of proven tools as brought together in this research and shown in Figure 2 may be of use to future researchers. The diversity provides a solid contextual and relational foundation from which to better understand Indigenous peoples, in this case, Inuit perspectives of public health TB policy and practice in Nunavut. A further benefit to researchers of using Braun and Clarke's critical reflexive thematic analysis is that the process changes the researcher through the iterations of analysis and critical interrogation of positionality (2022). This continues the important work of decolonizing the nursing profession. For me, Braun and Clarke's critical reflexive thematic analysis allowed me to critically reflect on my own situatedness and positionality within the research and as a policy maker in Nunavut (2022). It allowed me to step back, consider my presumptions, and re-examine perspectives from both Inuit community knowledge holders and the health care professionals. Further, this analytic approach allowed for generation of unexpected insights, such as the prevalence of the importance of shamanism as a theme in the data from community knowledge holders.

This research identified that Shamanism and the associated taboos about discussing topics that are bad or bring death, are limiting discussions and knowledge sharing between Inuit about TB; this silence must be considered if the effectiveness of TB public health policy and programs are to be improved. This was an unexpected finding and points to the need for future research on the role of Shamanism and spirituality in Inuit health. Future researchers may

explore ways that Inuit beliefs and practices relate to spirituality and the spirit world influence everyday day life experiences and create meaning through syncretism. This would be beneficial to determine how Shamanism may be affecting TB program participation and its compounding effects alongside TB-related stigma, on fostering silence, fear, and shame around TB. It is also suggested that such research might consider if there are ways that Shamanism as part of Indigenous ways of knowing, spirituality, and healing, could be mobilized by Inuit to assist in overcoming TB related stigma. It is likely, given the associated taboos, that such research will need to be undertaken by an Inuit researcher who has the contextual background with Inuit relationality.

In a similar way, additional research with Inuit to identify and understand acts of resilience in enduring TB should be undertaken in the future. As described by the Inuit Research Advisory Committee, Inuit are often stoic, are not pretentious, and speak in few words; Inuit do not boast or discuss successes and achievements. Given this innate humility, and since community resilience was not an objective of this research, questions about acts of individual or community resilience were not asked in the interviews and the concept was not raised by Inuit community knowledge holders. Considering Inuit resilience and finding ways to build on those quiet strengths could improve TB public health policy and practice in Inuit. A third future research opportunity would be to evaluate, utilizing a postcolonial approach, current public health TB programs in the light of the findings of this research. Such research could involve thorough reviews of TB care outcomes and interviewing community knowledge holders to determine if they found the programs to be culturally safe, and on what basis.

In summary, the implications of this research for future nursing research among Inuit are all underpinned by the importance of prioritizing the voices and perspectives of Inuit community

knowledge holders. It is only Inuit who can describe their own experiences and determine what constitutes, for them, cultural safety and responds to vital community needs. To expand the knowledge that informs the nursing discipline, it will be important for future researchers to consciously seek to reverse colonial power imbalances and instead prioritize Indigenous knowledge holders, to be critically reflexive and deliberately postcolonial, to critically challenge dominant narratives, and to be alert to topics raised as having direct relevance to Indigenous peoples themselves.

6.6. Recommendations for Methods Appropriate to Nursing Research with Inuit

Findings of this research have implications both for Inuit researchers and for Kablunaaq scholars like me and those who may follow, as it demonstrated the importance of determining how Inuit within the research community prefer to engage in research and in establishing Inuit specific research priorities, before developing the research objectives or questions. It also highlights the vital importance of developing relationships and trust; relationships that will continue after the research is completed and published, such that the findings can be mobilized to achieve change that is meaningful for Inuit. The determination of what protocols for research with Inuit look like and how they can be determined, must be among a researcher's first steps when engaging with Inuit. Fortunately, ITK's National Inuit Strategy on Research is available for guidance (2018a). Questions such as "what is optimal when engaging in community led partnerships with Inuit," must be answered, but can only be answered when the researcher recognizes the importance of relationality to Inuit. For me in this research with Inuit, the initial insights prompted by ITK's documentation raised further questions, such as how could I ensure Inuit were engaged throughout the lifecycle of the research? Knowing not only the answers to these questions, but why as a researcher you should ask such questions of Inuit and yourself as

the nurse researcher, is key to carrying out culturally safe research with Inuit. I wanted to be sure the results were collaborative. As described in the methodology in chapter 3, I worked hard to establish trust with all community knowledge holders; I was constantly aware that Inuit are vulnerable and require respect, and I was emphatic that at no point in my research would Inuit be treated as a simple resource of data to be mined. I recognized that the lifecycle of research began at the outset of forming research questions to conferring over analysis findings, from the sharing of dissertation drafts, and after the successful submission of the dissertation, to community engagement and finally, post doctorate achievement obligations. These relationships will endure for life. My use of CBPAR aided greatly in this recognition and I recommend its use to researchers who follow. At all stages through the research lifecycle I engaged in reflexivity, informed by my Inuit Research Advisory Committee. That reflexivity and engagement will continue for me into my post doctoral obligations both as I maintain relationships with Inuit for the remainder of my life and as we jointly share the work of sharing the findings.

I counsel that doing research in Nunavut requires the investment of a significant amount of time developing multiple relationships with members of the community. The absolute necessity of having an Inuit Research Advisory Committee needs to be emphasized to future researchers embarking on research with Inuit. Without the engagement and support of the Research Advisory Committee members this research would not have been successful. Committee members wanted my research to succeed. I will forever be grateful to them. I cannot stress enough to future researchers the need to have an Inuit Research Advisory Committee, or equivalent, supporting you. Further, the utilization of two community youth champions on the ground, as required by ITK's research strategy and described in the Methodology, was critical to the success of the research (2018a). Given that I could not be present in the territory for data

collection due to COVID-19 territorial wide lockdown, the youth champions were the only reason I was able to successfully complete the interviews for data collection. I am grateful for their energy and enthusiasm, their patience with me, and their desire to have the voices of their community members heard. Thus, I recommend that having youth champions is vital to research success with Inuit. I sincerely appreciate the generosity of the twenty-eight Inuit community knowledge holders who willingly shared their time, knowledge, and stories. Without their sharing and the insights that I had gleaned over many years of working for and with Inuit, I do not believe I would have been able to develop the trusting relationships necessary to carry out this research, nor would I have known enough about IQ to respectfully include this in the framework guiding my research.

6.7. Limitations of the Study

Several limitations presented as challenges in this research. That the research occurred during the occurrence of the global COVID-19 pandemic was a major constraint. The research was also constrained by having limited access to stable internet and technologies in Nunavut, having limited access to spaces for research interviews, being limited to a single data collection method, and being delayed in obtaining a Nunavut Scientific Research License. I will discuss these limitations, explaining how each may have impacted the study, and how I navigated the challenges. It must be pointed out that there was no way that several of the limitations could ever have been imagined or foreseen. Before turning to these specific limitations that may have impacted the data and findings, I note that it is the nature of qualitative research based on interviews, that only a finite number of community knowledge holders can be interviewed, and that only a small number of opinions and perspectives have been captured here. Results identify rich themes that may represent other Inuit perspectives on culturally safe TB policy and practice

but are not meant to be exhaustive of all possible experiences, or representative of perspectives of the population as a whole. In this research I interviewed 30 people. Ages ranged from 18 to 80 years and included men and women who lived in two different communities and two different regions of Nunavut. Views from all individuals were included in the thematic analysis, and the majority are represented in at least one excerpt in this dissertation. Furthermore, it is clearly the nature of cultural safety that the specific findings are limited to the specific Indigenous cultural group - every group is different. The findings should not be directly taken as recommendations for different communities. However, the methodology of working with a cultural Research Advisory Group, youth champions, and prioritizing a cultural safety orientation are transferrable approaches in research with other Indigenous groups.

6.7.1. COVID-19: Determination of data collection method

While the research was in the planning phase, on March 24, 2020, the Government of Nunavut closed entry to the territory to all non-residents other than essential workers, and maintained this position until April 11, 2022 (Dawson, 2020). Even once restrictions were lifted, the Government of Nunavut continued to suggest that all non-Nunavut residents refrain from entering the territory. Not being a Nunavut resident, this meant that I was unable to enter Nunavut to carry out research in person. In addition to the lockdown, strict self-isolation rules were imposed across Nunavut. To stress the degree of isolation that was imposed, Nunavut residents having to leave the territory for essential medical appointments were subjected to strict self-isolation rules prior to returning to Nunavut, which included a two-week mandatory stay in the boarding homes or designated hotels which were referred to as "hubs", and regular COVID-19 testing. These hubs were established in Ottawa, Winnipeg, Edmonton, and Yellowknife, and were staffed with guards to ensure Inuit and Kablunaaq residents of Nunavut upheld isolation

rules. Despite Nunavummiut complaining that these restrictions infringed upon their personal rights, and with the Canadian Civil Liberties Association echoing such sentiments as they claimed the hubs interfered with individual rights and liberties, the territory of Nunavut maintained strict isolation rules (Dawson, 2020; Patar, 2021).

All research that was scheduled to be carried out in Nunavut during the COVID-19 epidemic was placed on hold, and so I immediately began to make the necessary plans to carry out my research at a distance. As a research scientist, the thought of not being able to conduct data collection interviews in person was regrettable as relationality and trust which are important in the development of relationships with communities, are harder to develop when not in person. However, the only available option for carrying out data collection during the COVID-19 lockdown was the utilization of telephone interviews.

Literature speaks to telephone interviews as being the least preferable alternative to in-person interviewing in qualitative research (Novick, 2008). According to Novick in- person interviews have the advantage of contextual, non-verbal data and increased visual cues over telephone interviews (2008). I do not refute the importance of such advantages. I understand that in-person interviews have the potential to create more dynamic rapport opportunities and therefore have opportunities to glean different types of data (Novick, 2008). I also acknowledge that the inability to collect non-verbal data such as facial expressions most certainly puts carrying out telephone interviews at a disadvantage since non-verbal data often gives a greater depth to responses (Novick, 2008). However, I do not feel that I missed out on facial expressions in conducting the interviews. I could "hear" expressions. I qualify this statement by saying that I could hear laughter, I could envision smiles, and I could hear both the frustrations and sadness in Inuit voices. I learnt that I developed a nuanced sense of hearing that allowed me to carry out

wonderful, animated conversations without visually seeing the community knowledge holders. Telephone interviews also afforded community knowledge holders an opportunity to speak their minds with a relative degree of anonymity. Such anonymity may in fact have allowed people to freely disclose information that they may not have done otherwise if they had been in face-to-face interviews (Novick, 2008).

6.7.2. Lack and Unreliability of Digital Connectivity

Even without the COVID-19 lockdown and the need for my research to be conducted remotely, the lack and unreliability of access in Nunavut would have impacted the research. The territory of Nunavut continues to utilize a satellite connectivity system which means that satellite signals are transmitted to multiple networks across Nunavut. The ability for these networks to interconnect is poor (Flynn, 2021). The present low level of telecommunication services in Nunavut reinforces the ongoing “digital gap” that Inuit experience and is another of the ongoing structural deficits experienced by Inuit compared to the rest of Canada (Flynn, 2021). The unreliability, and at times complete lack, of digital connectivity across Nunavut created limitations to this research. When travel to Nunavut became impossible because of the lockdown, I had contemplated using online video calls to conduct my research interviews with community knowledge holders. Despite numerous attempts to initiate tele-communications such as Skype or Teams for the purposes of connecting with community members, youth champions or the Inuit Research Advisory Committee, I finally concluded that being able to have community knowledge holders see me was simply not going to be feasible. Instead, I drew on my years working with Inuit to focus my attention and effort into making the telephone interview process of data collection as vibrant and engaging as possible. As described above, the community knowledge holders stated that they were comfortable speaking in English over the

telephone, and many enjoyed receiving a call to be interviewed during the social isolation of COVID-19 lockdown. What began as a serious limitation ended up offering benefits due to the efforts I had made to build trust, and the flexibility of Inuit community knowledge holders.

6.7.3. Space Restrictions for Research Interviews

In Nunavut it is not only private housing that is at a premium, but also space within health care centers and government offices in general. I had arranged for community knowledge holders to be able to use an office space in the local health centres on selected dates to call in for data collection interviews. However, last minute scheduling of COVID-19 immunization clinics meant that these spaces were no longer available. To ensure community knowledge holders had the option of a private location for the interview calls, I mobilized the youth champions, an Inuit Research Advisory Committee member, and numerous other community resources, all to secure alternate and appropriate spaces. While other spaces were secured, none of the Inuit community knowledge holders chose to use those locations, instead preferring to speak with me from their own residences. Given my knowledge of overcrowding in most Inuit homes I was concerned for the community knowledge holder's ability to speak privately and maintain confidentiality. However, many community knowledge holders revealed that they had told family members they needed the room to themselves as this was a very important call; laughing that this was the only time they had space to themselves. Other community knowledge holders carried out their interviews with numerous voices able to be heard in the background. On several occasions, I smiled as children attempted to interrupt and speak to the Kablunaaq on the telephone. These moments often resulted in great laughter as I respectfully attempted to respond in Inuktitut to the children. Four community knowledge holders expressed that they were enjoying a good cup of tea as they responded to my questions. They further stated that I was the only visitor to come into

their homes in two years and thanked me for 'coming in' even on the telephone. Such comments speak to the isolation that many people experienced due to COVID-19.

6.7.4. Delay in Obtaining Nunavut Scientific Research License

Due to COVID-19 there was a delay in acquiring my Nunavut Scientific Research License (see Appendix N). This impacted the time that I had to carry out my data collection with Inuit communities. Nunavut Research Institute had experienced a deluge of research proposal requests during the period of COVID-19, resulting in significant delays in the processing of such requests (2021). I had applied in March of 2022, anticipating potential summer research if the isolation lockdowns were lifted, but was not granted my scientific research license until the third week of August 2022 with an expiration date of December 31, 2022. The delay, though understandable, meant that my time for carrying out data collection was grossly limited to a much shorter period than anticipated.

6.8. Final Reflections

This qualitative community-based participatory action research sought to understand Inuit perspectives of culturally safe TB public health policy and practice in Nunavut to affect positive changes in TB outcomes for Inuit. Reflecting on the total research process, purpose, and findings, I can see that despite the effects of colonization, neocolonialism, and the devastating impacts of TB, Inuit remain, not only proud but committed to achieving systemic change that means they hold the power of self-determination in health care. The resilience of spirit so often displayed by Inuit and communicated in the generous participation of Inuit community members in this research, is, in my opinion, worthy of greater respect from academia, researchers and Kablunaaq in general. Critical reflection on my positionality throughout the research process has

deepened my awareness of my own, and the nursing profession's, need to be more inclusive of Inuit perspectives on eradicating TB in Nunavut. Despite numerous studies carried out specific to TB and Inuit, few previous studies addressed or included Inuit perspectives of TB, TB-related stigma, and the need for Inuit perspectives on culturally safe public health TB policy and practice. To address this knowledge gap, the objectives of this research were to identify and understand: 1) the factors communicated by Inuit, that would promote culturally safe TB policy and practice with Inuit communities, 2) ways Inuit understand how TB-related stigma shapes Inuit perspectives of public health TB programs and limits their participation, and 3) how Inuit envision mobilizing Inuit knowledge to inform and democratize Government of Nunavut public health policy and programs.

Through the utilization of a postcolonial theoretical approach, and a cultural safety orientation, I was able to critique the ongoing impacts of colonization on Inuit. I found that resulting power inequities and structural racism continue to impact the health of Inuit in Nunavut today. Use of postcolonial analysis allowed me to identify within the data the key social determinants of health, deemed critical by Inuit community knowledge holders. Expressed in their words SDOH are housing, food insecurity, unemployment, poor access to health care with concerns of racism, tokenism, and identity favouring. Application of Braun and Clarke's critical reflexive thematic analysis then allowed me to see the themes related to the rich perspectives on culturally safe TB public health policy and practice that Inuit had shared. The seven themes identified by Inuit community knowledge holders as advancing culturally safe TB public health care policy and practice in Nunavut are that: 1) Kablunaaq develop trust and respect towards Inuit; 2) Inuit social determinants of health are addressed; 3) TB-related stigma is addressed; 4) Kablunaaq respect the importance of Inuit Shamanism and spirituality; 5) intergenerational

trauma informed care is provided; 6) Inuit Qaujimajatuqangit principles are recognised and used to guide health care policy and programs; and 7) Inuktut language can be used in health care. I found that TB-related stigma is pervasive among Inuit and has devastating effects on Inuit health – shaping all perspectives of public health TB programs and limiting participation. TB has been so normalized within Inuit communities that individuals expressed that contracting the disease was inevitable. Such inevitability was reported as routinely manifesting as anxiety, depression, and internalized stigma among community members. The Inuit Research Advisory Committee, as respected community members, confirmed that the findings were consistent with community perspectives. Inuit community knowledge holders and the Research Advisory Committee said that they hope to mobilize the knowledge shared and collected in this research to inform and democratize Government of Nunavut public health policy and programs.

To respect that desire to mobilize the knowledge and affect change in TB public health policy and practice, this research also identified ways Inuit envision the collected knowledge being utilized. The knowledge gifted by Inuit in contributing to this research can be mobilized to inform and influence Government of Nunavut TB policy and practice in a manner that highlights the need for immediate action on Inuit SDOH and promotes the creation of culturally safe public health TB policy and programs as defined by Inuit. Key recommendations for change were identified and connected to the relevant theme. Inuit generously offered recommendations both for health care professionals' practices, and for policy and program development. While the recommendations offer tangible and specific actions, they can be summarized in concept as stating that TB public health policy and practice needs to be driven by empowered Inuit – this is consistent with Ramsden's creation of the concept of cultural safety for Indigenous peoples (1992).

In the pages of this dissertation Kablunaaq can read what Inuit have spoken – it is now possible to begin to understand Inuit perspectives and understandings of the public health TB policy, practice and programs that impact their lives. The complexity of the challenge of eliminating TB and TB-related stigma is great. However, with the knowledge offered by Inuit in this research, the task has begun to jointly take this knowledge and advance culturally safe actions towards the elimination of TB and TB-related stigma in Nunavut. It is now the responsibility of Kablunaaq health care professionals and government to pause and reflect on the biases and tensions they may bring to conversations, so that more Inuit voices are heard as self-determination becomes a hallmark of future public health TB policy, practice and programs in Nunavut.

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Appendix A

Infographic Summary of Research Findings to Return Knowledge to Inuit

Cultural Safety

is listening to Inuit and changing TB public health policy and practice to put an end to

TB-related stigma

English-only health care

ignoring IQ principles

food insecurity

racism and identity favouring

overcrowded housing and homelessness

tokenism

Led by Inuit, it is time to jointly take culturally safe actions towards the elimination of TB and TB-related stigma in Nunavut.

Show Respect Earn Trust

Cultural Safety

is listening and acting when Inuit say they need

Halu

Qanuipit

health care conversations in Inuktuk

help to end TB-related stigma

intergenerational trauma land-based-programs

Kablunaaq to learn about Inuit ways and IQ principles

Kablunaaq to check their individual biases and racism

enough government funding to solve the housing crisis and address Inuit social determinants of health

Led by Inuit, it is time to jointly take culturally safe actions towards the elimination of TB and TB-related stigma in Nunavut

Show Respect Earn Trust

Appendix B
Maps of Nunavut

Figure B1: Nunavut's location in Canada (Rea, 2023)

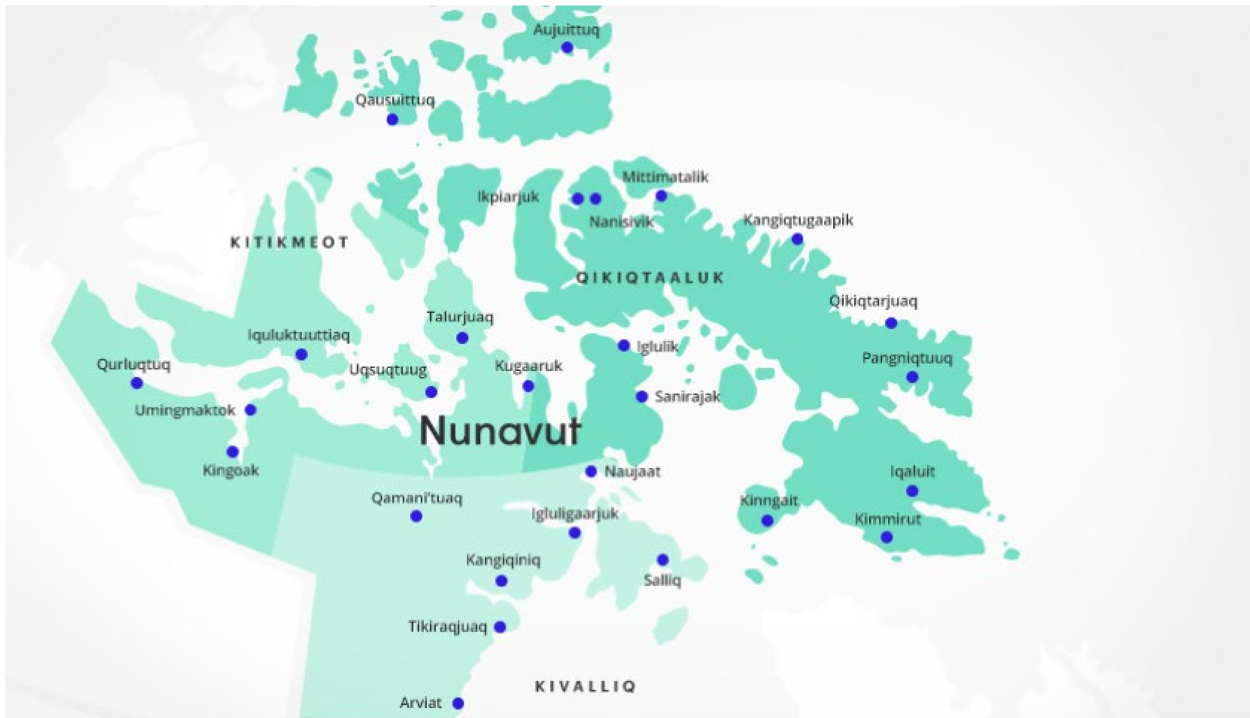


Figure B2: Nunavut Communities (Carrefour Nunavut, n.d.)

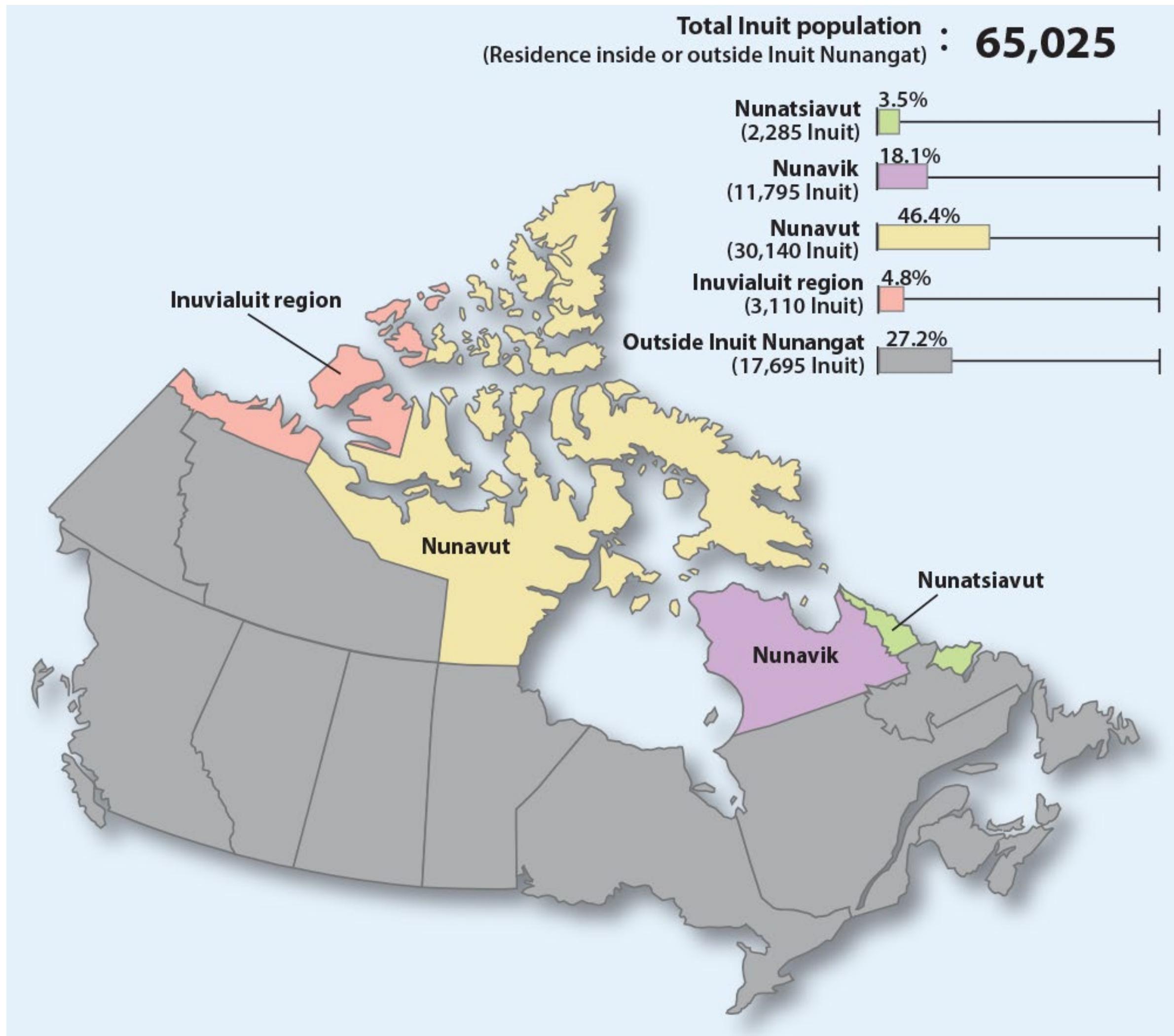
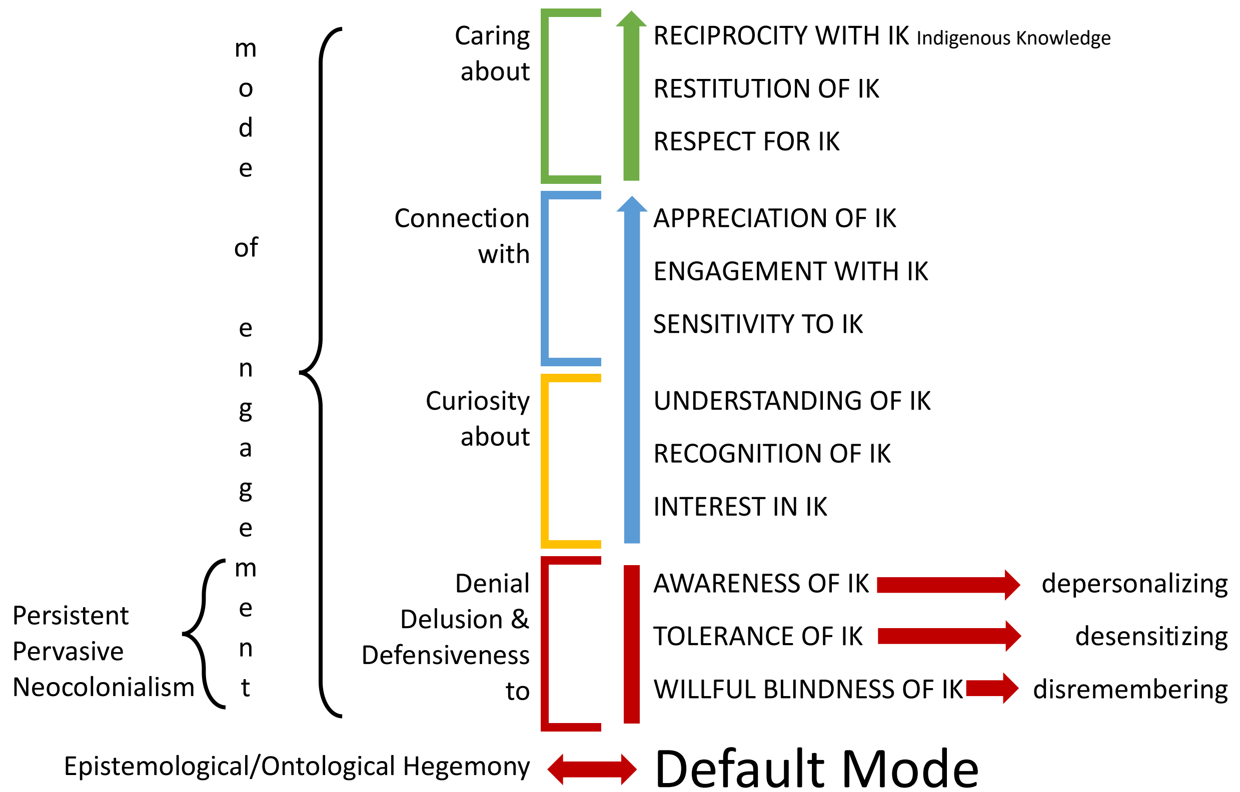


Figure B3: Regions in Inuit Nunangat

Appendix C

D2 Framework: From Default to Deliberation



D2 Framework (Alexander & McKee, 2021).

Appendix D
Self Reflexive Journal – Sample Extracts

August 31, 2022
I spoke with someone that I consider to be a very strong person today. Their passion for their way of life, family and community were deeply felt. I hadn't realized their mother had been sent away for TB and had lived away in one of the sanitoriums for many years. I wonder how she is now, all these years later and I wonder how that separation affected her especially in how she raised her own family. I think to the losses she must have experienced. I think to my own family that were lost to TB in the sanitoriums and know how that affected my own family a generation later. It makes sense to me now, thinking of how this person woman, their siblings and children are especially strong advocates for all things Inuit. How they push for their cultural and language rights, and advocate for Inuit ways of life on almost a daily basis. It must be exhausting to constantly have to fight for the most basic of rights on your own homelands. Its not as though Inuit moved away and then came back trying to re-establish themselves here in Nunavut, as they have never left. This is their lands. I think of all the times I was out on the tundra in the company of Inuit. It was almost as though they and the lands were one. Actually, it didn't seem like it, it was that they were one and the same.

September 6, 2022
I listened to raw expressions of emotion today. I had not expected this person to be so open with their feelings. I felt very honoured that this person would be so direct in their sharing and was pleased that they felt safe in doing so with me. Their frustrations in dealing with the health system in the community was almost tangible. There was an awareness that they were being treated the way they were because they were Inuit, that if this person was Kablunaaq, they would not have been spoken to the same way and that their health concerns would not have been dismissed. This happens all the time to Inuit they said. You would get better care, but we don't. They said I wish we had nurses that acted like they wanted to be here, that wanted to learn about us, were interesting people you know, they said (with a laugh) and that wanted to learn even a few of our words, like you they said. Then chuckled again. We spoke of the frustrations of getting to be seen and not feeling welcomed when they did get into the clinic to be seen. They

spoke to how hard it was to learn about diseases in English and not in your own language. I think how difficult this would be, how as a mother I would have to place such trust in others, and yet, here I'm being told that they are feeling unwelcomed by this very staff. How vulnerable would that leave me feeling? And the fear for your child in not understanding what is being said. They apologized to me for such emotions, and I found myself saying that I felt respected because they had spoken their truth. I am wondering why some nursing staff forget where they are, they are guests amongst Inuit, and what is going on that community members feel disrespected. Is it their schooling background? Is it how they view difference? Is it simply racism? I don't know, but all I do know is that this person should not have to feel this way anywhere, but especially not at home.

Appendix E

Community Youth Champion Confidentiality Form

ᐊᖏᕈᑎ ᖃᓐᖑᓇᕐᓂᒃᑯᑦ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᖑᔪᖅ

ᑐᑭᓯᒪᑎᑦᑎᒃ ᑲᓐᓂᕋᓯᖕᓂᕐᒧᑦ ᑕᒧᕈᒃ ᑯᔾ ᔨᓂᐅᔪᓂᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖕᖏᓂᑦ ᐳᕝᓚᒧᖕᓂᐅᑉ ᒥᒃ ᓵᓄᑦ ᐃᓄᐃᑦ ᑕᐅᑐᒃ ᑕᖕᙯᑦ: ᐃᓄᐃᑦ ᐱᖅᑯᓯᖕᖏᓂ ᐅᒧᓇᐊᓇᖕᖏᑦ ᑐᒦᓪᓗᓂ ᐳᕝᓚᒧᖕᓂᕐᒧᑦ ᕿᓐᖑᔫᖅᑕᐅᓂᐅᕝᒃ ᑐᓂᑦ ᐱᓕᕆᐊᖑᔪᓂᑦ' ᖃᐅᔨᓴᕐᓂᐅᔪᖅ ᓇᓗᓇᐃᕐ ᐳᑦ ᑕᒪᒃ ᑯᓂᖓᐃᓚᐃᓐ ᓇᖏᓂ ᑲᓐᓄᐃᓐᖅᑐᓂᑦ ᓴᖅᑭᑦ ᑎᓂᐊᕐ ᓂᖏᓂ 'ᓄᓇᓕᖕᓂᑦ ᐃᓅᓯᑦ ᑐᖏᓄᑦ' ᐊᒻᒪᓗ 'ᑎᑎᕋᖅᐸᓪ ᓕᐊᓂᐊᑐᒍ ᑐᓵᔨᒧᑦ'.

ᓯᕗᓪᓕᖅ/ ᑲᓐᖑᓇᖅᑐᑦ ᓄᐊᑕᐅᕙᓪᓕᐊᓗᑎᑦ, ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᕐᑯᑎᑦ, ᐊᒻᒪᓗ ᐊᓯᖏᑦ ᑐᓴᐅᒪᔾᔪᑎᑦ ᐅᖃᐅᓯᐅᔪᑦ, ᑎᑎᕋᖅᑕᐅᓯᒪᔪᑦ ᐅᕙᓗᓐᓃᑦ ᑐᓴᐅᑎᓕᕆᓂᒃᑯᑦ ᑕᒪᑐᒪ ᖃᐅᔨᓴᕐᓂᐅᑉ ᐱᔾᔪᑎᒋᔭᖓᑕ Эс-У>Ч

ᑭᐅᓪᓕ/ ᑎᑎᕋᖅᑕᐅᕙᓪᓕᐊᓂᐊᕐᓂᖏᓄᑦ ᐊᑐᓪᓚᕆᐊᖃᕐᓂᖏᓄ/ ᓄᓇᓕᖕᓂᑦ ᐃᓅᓯᒃᑐᑦ

ᐃ. ______________________ ᓇᓗᓇᐃᖅᑐᖅ ᐊᖏᖅᓱᓂᓗ ᑲᓐᖑᓇᖅᓂᖅ ᑐᑭᓯᒪᑎᑦᑎᒃ ᑲᓐᓂᕋᓯᖕᓂᕐᒧᑦ ᑕᒧᕈᒃ ᑯᔾ ᔨᓂᐅᔪᓂᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖕᖏᓂᑦ ᐳᕝᓚᒧᖕᓂᐅᑉ ᒥᒃ ᓵᓄᑦ: ᐃᓄᐃᑦ ᐱᖅᑯᓯᖕᖏᓂ ᐅᒧᓇᐊᓇᖕᖏᑦ ᑐᒦᓪᓗᓂ ᐳᕝᓚᒧᖕᓂᕐᒧᑦ ᕿᓐᖑᔫᖅᑕᐅᓂᐅᕝᒃ ᑐᓂᑦ ᐱᓕᕆᐊᖑᔪᓂᑦ' ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᕐᑯᑎᖏᓂ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᑐᕌᓪᓗᐊᑕᕆᓂᖅᑕᖕᓂ ᐊᒻᒪ ᑲᒪᒃ ᑯᐊ ᑲᓐᖑᓇᖅᑐᑦ ᐊᐱᕐᓯᖅᑕᐅᔪ ᓄᑐᐊ ᐱᖅᑕᐅᔪ ᓄᑦ ᐅᖃᐅᓯ ᐅᓕᒫᓪᓗᑎᑦ.

______________________ ᓇᓗᓇᐃᕐᑐᖅ ᓴᖅᑭᖅᑯᔨᖏᓪᓗᓂ, ᐅᖃᐅᓯᐅᕐᑯᖏᕐᔪᓂᒥ ᐅᕝᕙᓗ ᑭᓇᑐᐃᓐᓇᕐᒧᑦ ᐅᖃᐅᓯᐅᕐᑯᖏᕐᔪᓂᒥᑦ ᑕᒪᑯᓂᖓ ᑲᓐᖑᓇᖅᑐᓕᖕᓂᑦ ᐃᓗᓕᖕᓂᑦ ᐊᐱᕐᓱᖅᑕᐅᖅᑕᐅᑎᓪᓗᓂ ᑕᒪᔾᔨᒧᖓ ᖃᐅᔨᓴᕐᓂᐅᔪᒧᑦ.

ᐱ. ᑲᓐᖑᓇᖅᑐᓕᖕᓂᑦ ᐃᓗᓕᖏᑦ ᑐᖅᑯᑕᐅᓯᒪᑦᑎᐊᕆᐊᖏᑦ ᑭᓇᑐᐃᓐᓇᕐᒧᑦ ᑕᑯᔭᐅᕐᑯᓇᒥᑦ ᖃᐅᔨᓴᖅᑕᐅᓂᕐᒧᑦ ᐊᐱᕐᓱᖅᑕᐅᖅᑕᐅᖏᑦᑐᒧᑦ ᑕᒪᒃᑯᐊᓄᑦ ᖃᐅᔨᓴᖅᑕᐅᓂᕐᒧᑦ ᐱᕐᑰᑦ ᑭᓇᑐᐃᓐᓇᕐᒧᑦ ᐊᑦᑐᖅᑕᐅᔭᕆᐊᖃᙱᑦ.

ᐱᖓᓱᖓ/ ᖃᐅᔨᓴᖅᓂᖅ ᐱᔭᕇᕐᑐᓂ

ᑖᓐᓇ ᖃᐅᔨᓴᕐᓂᐅᔪᖅ ᐱᔭᕇᕐᑐᓂ ____________ ᐅᑎᖅᑎᑦᑎᓂᐊᖅᑐᖅ ᖃᐅᔨᓴᕐᓂᐅᔫᑉ
ᑕᒪᑐᖓ ᖃᐅᔨᓴᕐᓂᖅᐅᔪᒧᑦ ᑐᕋᖓᔪᓂᑦ.
ᖃᐅᔨᓴᕐᓂᒧᑦ ᑭᖑᕙᕆᖓᔪᑦ ᑖᓇ ᐸᕐᓕ ᒪᒌᒧᑦ, ᐋᓂᐊᕿᑎᓪᓚᖑᒧᑦ ᐅᑎᖅᑎᑕᐅᓂᐊᖅᑐᑦ, ᑎᖅᑲᑎᒍᑦ ᐊᐅᓪᓚᖅᑎᑦᑕᕆᐊᓕᒃᑯᑦ ᖃᖓᑦᑕᐅᑎᖓ ᐊᑭᓕᑲᐅᑎᒋᓯᒪᔪᒃᑯᑦ, ᐱᔪᑎᒋᓪᓗᒍ ᑖᒃᑯᐊ ᑎᑎᕋᖅᐸᓪᓕᐊᔪᖅ ᐅᕝᕙᓗ ᓄᓇᓕᖕᓂᑦ ᐃᓅᓯᒃᑐᖅ ᐊᐱᕐᓱᖅᑕᐅᖅᑕᐅᔪᑐᐊᑦ ᑕᒪᒃᑯᓂᖓ ᓇᓕᖅᑲᖅᑖᕈᓇᖅᑯᓗᒥᑦ.

Appendix F

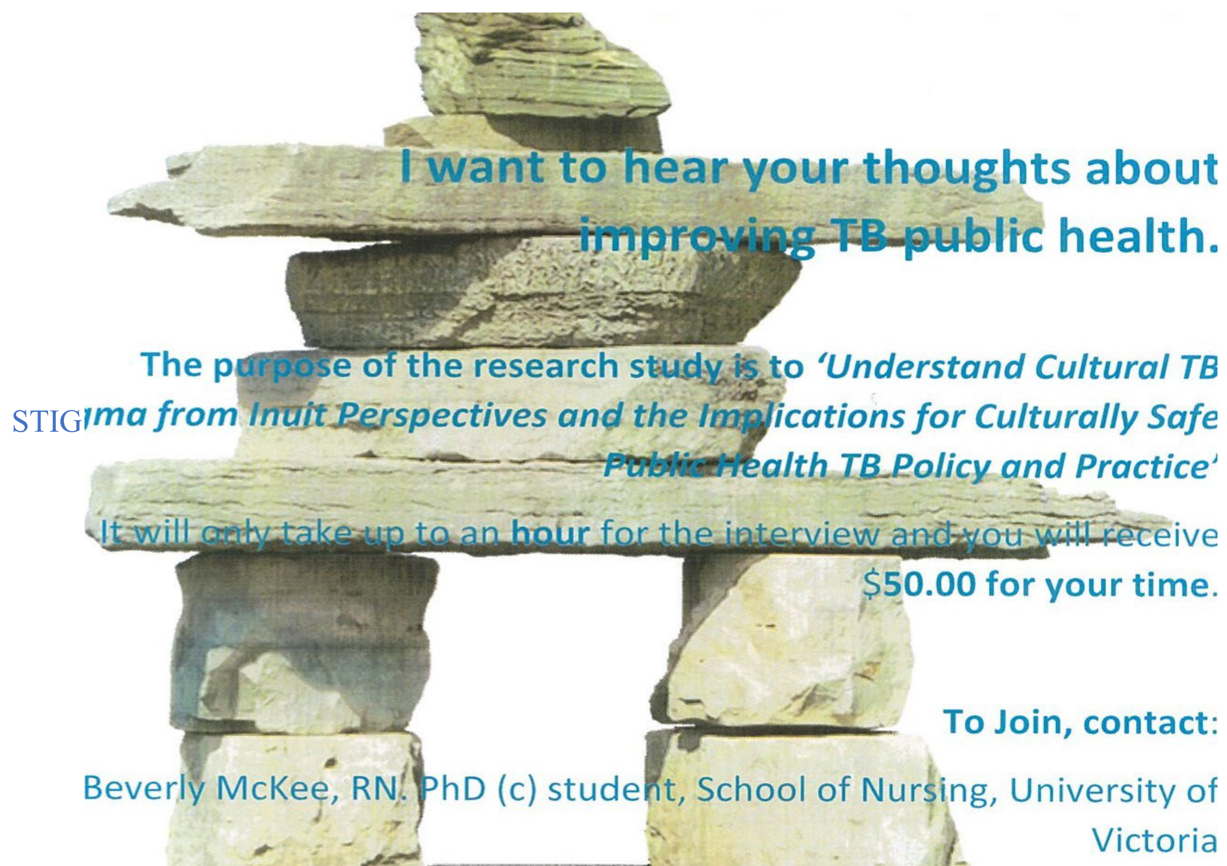
Recruitment Poster: Inuit Community Knowledge Holders (Inuktitut)

Appendix G

Recruitment Poster: Inuit Community Knowledge Holders (English)

Are you an Inuk over the age of 18 years and

live in XXXX, XXXX, or XXXX?



Appendix H

All Participants Consent Form

University of Victoria

Participant Consent Form

Understanding Cultural Stigma of Tuberculosis from Inuit Perspectives: Implications for Culturally Safe Public Health TB Policy and Practice

You are invited to participate in a study entitled 'Understanding Cultural Stigma of Tuberculosis from Inuit Perspectives: Implications for Culturally Safe Public Health TB Policy and Practice. This research is being conducted by Dr. Nancy Clark and D. Beverly McKee PhD Candidate.

Dr. Nancy Clark is a faculty member and D. Beverly McKee is a graduate student in the department of nursing at the University of Victoria. You may contact them at: Dr. Nancy Clark XXXX and/or XXXX) and D. Beverly McKee (XXXX and/or XXXX) if you have further questions.

As a graduate student, I am required to conduct research as part of the requirements for a degree in Nursing. It is being conducted under the supervision of Dr. Nancy Clark. You may contact my supervisor at the above contact number.

Purpose and Objectives

The purpose of this research study is to understand what factors shape cultural stigma of TB for Inuit communities, and how can this information be used to promote culturally safe public health TB policy and practice in Nunavut. The key objectives of this study are to understand the factors which shape cultural stigma related to TB from the perspectives of Inuit communities; to understand what constitutes culturally safe policy and practice in relation to Inuit TB programs; and to use Inuit perspectives to influence Government of Nunavut public health policy related to the uptake of TB screening and programming.

Importance of this Research

Research of this type is important because Inuit voices must be heard on how cultural TB stigma plays a role in Inuit health. Understanding this will change public health policy leading to the promotion of improved health equity, health care access, and the provision of culturally safe public health programs, such as TB screening in Nunavut.

Participant Selection

You are being asked to participate in this study because you work as a health care professional, policy maker, and/or as an administrator in public health TB policy, are involved in and/or have an interest in TB programs in Nunavut.

What is involved

If you consent to voluntarily participate in this research, your participation will include signing this consent form, and participating in an approximately 45—60-minute interview with D. Beverly McKee by telephone (a translator will be provided if you wish to speak in Inuktitut). Questions will be focused on your experience with TB policy and practice, and your perspective on cultural safety and cultural TB stigma in Nunavut.

Written notes will be taken by Beverly to collect the knowledge you choose to share.

Inconvenience

Participation in this study may cause some inconvenience to you, including carrying out the interview during work hours, and taking an hour of your time.

Risks

There are some potential risks to you by participating in this research and they include potential emotional and/or psychological feelings related to the topic of tuberculosis. A mini pre- and post-debrief session will occur with the interview, and a list of telephone numbers to mental health support services and/or a contact person to speak to will be provided to each participant.

Benefits

The potential benefits of your participation in this research include the ability to:

1/ To be able to anonymously express your opinions and give input regarding public health TB policy and practice 2/ Be a part of creating public health policy and practice that meets the needs of Inuit TB health, as determined by Inuit,

Compensation

To compensate you for any inconvenience related to your participation, you will be given a 50.00 gift card to the Northern store.

Voluntary Participation

Your participation in this research must be completely voluntary. If you do decide to participate, you may withdraw at any time without any consequences or any explanation. If you do withdraw from the study your data will be used only if you give us permission to use it. Also, if you do withdraw from the study at any point, you will still receive compensation for your time.

Anonymity

In terms of protecting your anonymity all knowledge shared will be coded so that your name nor community location remains unknown to all but the research investigators.

Confidentiality

Your confidentiality and the confidentiality of the data will be protected by the investigators. Confidentiality will be prioritized in this study. All data will be stored in a password protected computer, stored in a locked cabinet in a locked room, and will be kept safely stored for the mandatory time required and then appropriately destroyed. Only the investigators will have access to this data.

Dissemination of Results

It is anticipated that the results of this study will be shared with others in the following ways: formal gathering of government and community representatives, potential arts-based methods including storyboards, videos, pod casts, and informal community gatherings. Further, the results will be presented at scholarly meetings and will be published in a dissertation and published journal.

Contacts:
At any time, if you wish to discuss this research study you may speak to D. Beverly McKee at (XXXX) or Dr. Nancy Clark at (XXXX).

In addition, you may verify the ethical approval of this study, or raise any concerns you might have, by contacting the Human Research Ethics Office at the University of Victoria (XXXX or XXXX).

Your signature below indicates that you understand the above conditions of participation in this study, that you have had the opportunity to have your questions answered by the researchers, and that you consent to participate in this research project.

______________________	______________________	____________
Name of Participant	Signature	Date

If I withdraw from this study, I authorize that any collected data I have shared can be used in this research study —————————— (please initial)

A copy of this consent will be left with you, and a copy will be taken by the researcher.

Appendix I

Research Study Information Sheet (Inuktitut)

<u>ᑐᓴᐅᒪᔾᔪᑎᒃᑲᓐᓂ ᖃᐅᔨᓴᕐᓂᐅᔫᑉ ᒥᒃᓵᓄᑦ</u>

“ᑐᑭᓯᐅᒪᑎᕐᑎᒃᑲᓐᓂᕋᓯᖕᓂᕐᒧᑦ ᑕᓗᕈᒃᑯᔾᔨᓂᐅᔪᓂᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖏᓐᓂᑦ ᐳᕙᓪᓗᖕᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐃᓄᐃᑦ ᑕᐅᑐᒃᑕᖕᒐᑦ: ᖃᓄᖅ ᐳᕙᓪᓗᖕᓂᕐᒧᑦ ᕿᙵᒎᓵᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᖑᔪᓄᑦ ᐊᑐᐃᓯᒪᓂᕆᔭᖓ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖓᓂᑦ ᓴᐳᔾᔨᓂᕐᒥᑦ”

ᑐᙵᓴᐃᓂᖅ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᖑᔪᒥᑦ ᐊᐱᕐᓱᖅᑕᐅᓂᕐᒧᑦ:

ᑐᙵᓱᒃᑎᑦᑎᕗᒍᑦ ᐊᐱᕐᓱᖅᑕᐅᔪᒪᔪᓂᑦ ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᑕᒪᒃᑯᓂᖓ ᑐᑭᓱᒃᑲᓐᓂᕈᑎᐅᕙᔭᖅᑐᓂᑦ ᑕᓗᕈᒃᑯᔾᔨᓂᐅᔪᓂᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖏᓐᓂ ᐳᕙᓪᓗᖕᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐊᒻᒪᓗ ᖃᓄᖅ ᐃᓄᒋᐊᒃᑐᓄᑦ ᐋᓐᓂᐊᕐᑲᕐᓇᖏᑦᑐᓕᕆᔾᔭᒃᑯᑦ ᐳᕙᓪᓗᖕᓂᕐᒧᑦ ᕿᙵᒎᓵᕐᓂᕐᒧᑦ ᐱᓕᕆᐊᖑᔪᓂᑦ. ᑎᑭᕋᕐᔪᐊᕐᓂᐅᑕᐅᓂᕐᓄᑦ, ᑯᙵᕐᓂᐅᑕᐅᓂᕐᓄᑦ ᐊᒻᒪᓗ ᕿᑭᖅᑕᕐᔪᐊᕐᓂᐅᑕᐅᓂᕐᓄᑦ 18-ᒧ ᐅᖕᒐᑖᓄᑦ ᐅᑭᐅᕐᑲᕐᓂᕐᓄᑦ ᐊᑲᐅᓛᖑᓇᓯᒋᒐᑦᑎᒍᑦ ᐊᐱᕐᓱᖅᑕᐅᕙᕐᑲᕐᑯᓪᓗᑎᑦ. ᑖᓐᓇ ᑐᓴᐅᒪᔾᔪᑎᒃᑲᓐᓂ ᓇᒧᓇᐃᕐᓯᒪᑦᑎᐊᖅᑐ ᑭᓯᓂᑦ ᐃᓗᓕᕐᑲᕐᓂᐊᕐᓂᖏᓐᓂᑦ ᐊᒻᒪᓗ ᖃᓄᖅ ᐊᐱᕐᓱᖅᑕᐅᓂᕋᔭᐃᑦ ᐋᑐᑎᕐᑲᕐᓂᐊᕐᓂᖓᓂ. ᑖᓐᓇ ᑐᑭᓯᐊᕈᑎᒃᑖᓐᓂ ᐅᖃᓖᒪᓪᓗᐅᖅᑎᓪᓗᒍ ᐊᐱᖅᑯᑎᒃᓴᖃᑐᐊᕈᕕᑦ ᐊᐱᕆᓪᓚᔾᔪᖏᑦᑐᑎᑦ. ᑖᓐᓇᓗ ᐊᖏᕈᑎ ᐊᑎᓕᐅᕐᑯᓂᐊᕆᓪᓗᑎᒍ ᐊᐱᕐᓱᖅᑕᐅᓂᕐᒧᑦ ᐱᕐᑲᐅᔾᔭᕐᓇᕐᓂᕐᓄᑦ.

ᐃᓚᐅᓂᕆᔭᐃᑦ ᐊᑭᓕᕐᓱᖅᑕᐅᖏᕐᔪᑎ/ᐱᔪᓐᓇᐅᑏᑦ ᐃᓚᐅᓂᕐᓄᑦ:

ᐊᐱᕐᓱᖅᑕᐅᓂᕆᔭᐃᑦ ᐃᓱᒪᕐᓱᕐᓗᑎᑦ ᐊᐱᕐᓱᖅᑕᐅᔪᒪᒐᕕᑦ. ᐊᐱᕐᓱᖅᑕᐅᖏᓐᓇᕈᒪᒍᕕᑦ, ᖃᖓᑐᐃᓐᓇ ᐊᐱᕐᓱᖅᑕᐅᔪᓐᓃᕈᓐᓇᖅᑐᑎᑦ ᐱᔾᔪᑎᒋᔭᑎᑦ ᐊᐱᕐᓱᖅᑕᐅᔪᒪᔪᓐᓃᕈᑎᒋᔭᐃᑦ ᐅᖃᐅᓯᕆᐊᖃᕋᔭᖏᑦᑎᐊᖅᑐᑦ ᐊᒻᒪᓗ ᐊᐱᓇᔭᐅᔾᔭᖏᕐᔪᑎᑦ ᖃᓄᐃᒪ ᐊᐱᕐᓱᖅᑕᐅᔪᒪᔪᓐᓃᕐᓂᕐᓄᑦ. ᑕᒪᒃᑯᐊᓗ ᐅᖃᐅᓯᕆᓇᕋᑖᖅᑕᑎᑦ ᐃᓚᓕᐅᑎᕐᑯᒍᕕᒋ ᑭᓯᐊᓂ ᐃᓚᓕᐅᔾᔭᐅᓂᐊᖅᑐᑦ ᓄᐊᑕᐅᕙᓪᓕᐊᔪᓄᑦ.

ᖃᐅᔨᓴᕐᓂᒃᑯᑦ ᐱᔾᔪᑎ

ᖃᐅᔨᓴᕐᓂᕐᒧᑦ ᐱᔾᔪᑎᖃᓗᐊᙱᐊᖅᑐᖅ ᑐᑭᓱᒃᑲᓐᓂᕋᓱᒃᑯᓂ ᓄᓇᓕᖕᓂᑦ ᑕᒪᒃᑯᐊ ᐱᔾᔪᑎᓪᓚᕆᐅᔪᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖓᓂ ᑕᓗᕈᒃᑯᔾᔨᓂᐅᖃᑦᑕᖅᑐᓂᑦ ᐳᕙᓪᓗᖕᓂᐅᑉ ᒥᒃᓵᓄᑦ, ᖃᓄᖅ ᓴᖅᑭᑎᑦᑎᒃᑲᓂᕈᓐᓇᕐᓂᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖓᓂ ᐅᑐᓇᐊᓇᖏᑦᑐᒦᑎᑦᑎᓂᕐᒧᑦ ᐱᕚᓪᓕᕈᑎᐅᒃᑲᓐᓂᕈᓐᓇᖅᑐᓂᑦ ᐃᓕᖅᑯᓯᓇᔭᐅᔪᑦ ᐳᕙᓪᓗᖕᓂᒧᑦ ᐱᓕᕆᐊᖑᔪᑦ ᐊᑐᐊᒐᕋᓃᓇᔭᐅᔪᓪᓗ ᓄᓇᕗᒻᒥᑦ. ᐱᔾᔪᑎᐅᑐᐊᙱᐊᓇᓪᓗᓂ ᑐᑭᓱᒃᑲᓐᓂᕈᒪᓪᓗᑎ ᖃᓄᐃᓪᓚ ᑕᓐᓇ ᑕᓗᕈᒃᑯᑎᐅᑲᑦᑕᕐᒪᖔᑦ ᐃᓄᐃᑦ ᓄᓇᖏᓐᓂᑦ ᐳᕙᓪᓗᖅ; ᑐᑭᓱᒃᑲᓐᓂᕋᓯᕐᓱᓂᖅᑐ ᖃᓄᖅ ᑕᒪᒃᑯᐊ ᐊᑐᐊᒐᓕᐊᕆᓯᒪᔪᑦ ᐱᓕᕆᐊᖑᓯᒪᔪᓂᖅᑐ ᐳᕙᓪᓗᖕᓂᒧᑦ ᑐᕌᖓᔪᓂᑦ; ᐊᒻᒪᓗ ᓄᓇᕗᑦ ᒐᕙᒪᒃᑯᖏᓐᓂ ᐋᓐᓂᐊᖃᕐᑕᐃᓕᒪᔪᓕᕆᔾᔪᖏᓐᓂ ᐃᓄᒋᐊᒃᑐᓄᑦ ᐃᓚᓕᐅᑎᓯᒪᑦᑎᐊᕋᓗᐊᕐᒪᖔᑕ ᐃᓄᐃᑦ ᑕᐅᑐᒃᑕᖓᖓᓂᑦ ᕿᙵᒎᓵᖅᓯᓂᕐᒥᑦ ᐱᓕᕆᐊᖑᔪᑦ ᐳᕙᓪᓗᖕᓇᖅᑐᓕᕆᔾᔪᖓᓂᑦ.

ᓂᕆᐅᒋᒐᔭᖅᑐᖅ ᑭᓯᓂ ᐃᓗᓕᖅᑲᖅ?

ᐃᑲᕐᕋᓪᓗᐊᒥᑦ ᐊᐱᕐᓱᖅᑕᐅᒐᔭᖅᑐᖅ ᐊᐱᕐᓱᖅᑕᐅᔪᖅ, ᐊᒻᒪᓗ ᑖᓇ ᐸᐳᓕ ᒪᑮ, ᐋᓐᓂᐊᓯᐅᑎ, ᖃᐅᔨᓴᖅᑎᓪᓗᐊᑕᐅᓪᓗᓂ, ᐊᐱᕐᓱᖅᑎᓪᓗᓂ ᐅᖄᓚᐅᑎᒃᑯᑦ. ᖃᐅᑕᒫᖅᓯᐅᑎᑦᑎᒍᑦ ᑎᑎᕋᖅᐸᓪᓕᐊᔪᒪᓐᓂᕈᕕᒋᑦ ᐳᕙᓪᓗᓇᐅᑉ ᒥᒃᓵᓄᑦ, ᑎᑎᕋᕝᕕᒃᓴᒥᑦ ᑐᓂᔭᐅᒐᔭᖅᑐᑎᑦ, ᑭᖑᓂᐊᒍᑦ

ᐅᖃᓚᐅᑎᒃᑯᑦ ᐊᐱᕐᓱᖅᑕᐅᓕᕋᔭᖅᓗᑎᑦ ᐊᖏᖃᑎᖐᓐᓂᖃᓚᐅᖅᑎᓪᓗᓯ ᖃᖓᒃᑯᑦ ᐊᐱᕐᓱᖅᑕᐅᔪᓐᓇᕐᒪᖓᖅᐱᑦ.

ᐃᑲᔪᕈᑎᐅᓂᐊᖅᑐᑦ

ᑕᒪᒃᑯᐊ ᑲᖐᒋᔭᐅᔪᑦ ᐃᑲᔫᑎᕖᓪᓕᕈᑎᐅᓂᐊᕋᓱᒋᔭᕗᑦ ᐅᑯᐊ:

ᓱᕗᓪᓕᖅ/ ᓱᕗᓂᑦᑎᓐᓂ ᓄᓇᓕᖕᓂᑦ ᐋᓐᓂᐊᕕᖕᓂᑦ ᐱᕖᓪᓕᕈᑎᒃᓴᐅᔪᓐᓇᖅᑐᓂᑦ ᐅᖃᐅᓯᖃᕈᓐᓇᕐᓂᐊᕋᕕᑦ

ᑭᖑᓕᖓ/ ᑕᒪᒃᑯᓄᖓ ᐳᕙᓪᓗᕐᓂᕐᒧᑦ ᐸᖅᑭᔭᐅᖃᑦᑕᖅᓯᒪᔪᓂᑦ ᑕᕝᕙᒃᑯᕕᓂᐅᖃᑦᑕᖅᑐ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖏᓐᓂ ᖃᐅᔨᓯᒪᔭᑎᑦ ᐅᖃᐅᓯᕆᔪᓐᓇᕐᓂᐊᕋᕕᑦ ᑭᓇᐅᓐᓂᑦ ᓇᓗᔭᐅᑲᔭᖅᓗᓂ

ᐱᖓᔪᖓ/ ᐱᕕᖃᕈᓐᓇᕐᑯᓐᓂᑦ ᑕᒪᒃᑯᓇᖓ ᑕᕝᕙᒃᑯᕕᓂᐅᖃᖅᑕᖅᑐᓂᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖏᓐᓂ ᐃᓱᒪᒋᓯᒪᔭᑎᑦ ᐅᖃᐅᓯᕆᔪᓐᓇᕋᔭᕋᕕᖓᑦ

ᑎᓴᒪᖓᑦ/ ᐱᕕᖃᕈᓐᓇᕐᑯᓐᓂᑦ ᐅᖃᐅᓯᕆᔭᒪᔭᑎᑦ ᐊᐅᓚᓕᕐᕿᑦᑕᖅᑕᖓ ᖓᒪᒃᑯᑦ ᐳᕙᓪᓗᖕᓂᐅᑉ ᒥᒃᓵᓄᑦ ᐱᓕᕆᐊᖑᔪᓂᑦ ᐊᑐᐊᒐᓕᐊᕆᔭᐅᓯᒪᔪᓂᑦ, ᐃᓅᓕᖅᓯᖅᑕᐅᓂᐅᕙᒃᑐᑦ ᒥᒃᓵᓄᑦ ᐊᒻᒪᓗ ᑕᒪᒃᑯᐊ ᖃᓄᖅ ᑕᕝᕙᒃᑯᕕᓂᐅᕙᒃᑐᑦ ᐃᓄᐃᑦ ᐱᖅᑯᓯᖏᓐᓂ ᐳᕙᓪᓗᖕᓂᐅ ᒥᒃᓵᓄᑦ ᐋᖅᑭᐸᒌᓪᓕᕈᑎᐅᓂᐊᕋᓱᒋᔭᖅᑐᓂᑦ

ᑕᓪᓕᒪᖓ/ ᐱᕕᖃᕐᑯᓐᓂᑦ ᐊᑐᖅᓯᒪᔭᐃᑦ ᐳᕙᓪᓗᖕᓂᒧᑦ ᐊᒻᒪᓗ ᖃᓄᖅ ᑕᒪᓐᓇ ᐊᑦᑐᖅᓯᒪᖕᒪᖔ ᖃᑦᑐᒍᑎᒌᓯᒍᑦ ᓄᓇᒋᒻᒥᐅᑕᐅᓂᑰᓯᓐᓄᑦ.

ᐅᓗᕆᓇᕈᑎᑐᐃᓐᓇᕆᐊᖃᕐᓂᐅᕙᑦ

ᐊᐱᕐᓱᖅᑕᐅᑎᓪᓗᑎ ᐅᓗᕆᐊᓇᕈᑎᑐᐃᓐᓇᕆᐊᖃᕐᓂᐅᕙᑦ ᐅᑯᐊᖑᑐᐃᓐᓇᕆᐊᖅᑐᑦ ᐊᑐᐃᑐᐃᓐᓇᕆᐊᖃᕐᓂᖓᓂᑦ ᐃᑉᐱᓐᓇᐃᓂᑎᑦ, ᐊᒻᒪᓘᓐᓃᑦ ᐃᓱᓪᓖᑦᓚᒍᑎᑐᐃᓐᓇᕆᐊᖃᕐᓂᖓᓂᑦ ᐳᕙᓪᓗᖕᓂᐅᑉ ᒥᒃᓵᓄᑦ. ᐊᐱᖅᓱᖅᑕᐅᓚᐅᖅᑎᓐᓂᕐᓂᑦ ᐊᐱᕐᓱᖅᑕᐅᔭᓖᖅᑎᓪᓗᑎᓪᓗ ᐅᖃᓪᓚᖅᑎᒋᐊᕐᔪᓂᐊᕌᑎᑦ ᐊᒻᒪᓗ ᐅᖄᓚᐅᑎᓂᑦ ᑐᓂᓂᐊᓇᓪᓗᓂᑎ ᐅᖄᓚᕖᒋᐊᖅᑲᖅᑕᕐᓄᑦ ᐅᖃᖅᑎᒃᑲᓂᕐᓇᑲᐅᖅᑯᓯᒍᕕᑦ ᐋᓂᕐᓂᕐᓄᑦ ᐃᓱᓪᓖᑦᓚᖕᓂᕐᓄᓪᓗᐋᓃᑦ ᐃᑲᔪᖅᑕᐅᒃᑲᓂᕐᓱᓪᓗᑎᑦ.

ᐃᑲᔫᓯᐊᖑᕐᔪᖕᓂᖅ

ᓂᐅᕕᕈᓇᐅᑎᒥᑦ $50.00-ᒥᑦ ᓂᐅᕕᕐᕕᖕᒧᑦ ᑐᓂᔭᐅᓂᐊᖅᑐᑎᑦ ᐊᐱᕐᓱᖅᑕᐅᓂᕐᓄᑦ, ᐊᐱᕐᓱᖅᑕᐅᓂᕐᓄᑦ ᓈᒪᓈᕈᑎᖏᓐᓂᕈᓂᓗ ᐊᐱᕐᓱᖅᑕᐅᓂᕐᓄᑦ.

ᑭᓇᐅᓂᑦ/ᑲᙳᓇᕐᓂ

ᑭᓇᐅᓂᓇᔭᐃᑦ ᓇᓗᓇᐃᖅᑕᐅᓯᒪᔾᔮᖏᑦᑐᑦ ᑲᙳᓇᕐᓂ ᒪᓕᒃᓗᑎᒍ ᑭᓱᐊᓂᓕ ᓈᓴᐅᑎᑎᒍᑦ ᓇᓗᓇᐃᕐᓯᒪᓂᐊᖅᑐᒍᑦ ᐊᒻᒪᓗ ᓇᑭᙶᕐᓂᓇᔭᐃᑦ, ᓄᓇᓕᖕᓂᑦ ᓇᓕᐊᖕᓂᙶᖅᓯᒪᔭᐃ ᓇᓗᓇᐃᕐᓯᒪᔾᔮᖏᒻᒥᔭᖅ, ᑭᓇᑐᐃᓐᓇ ᖃᐅᔨᒪᔾᔮᖏᑦᑐᖅ ᖃᐅᔨᓴᖅᑎᑐᐊ ᐊᐱᕐᓱᖅᑐᑐᐊ ᖃᐅᔨᒪᓂᐊᖅᑐᖅ. ᖃᐅᔨᓴᖅᑎᐅᔪᒧᑦ ᓴᐳᑎᓯᒪᔭᐅᓂᐊᖅᑐᖅ ᑲᙳᓇᕐᓂᓇᔭᐃᑦ. ᑕᒪᓇᓗ ᑲᙳᓇᕐᓂᐅᔪᖅ ᓱᕐᕋᑦᓯᐅᑎᔭᐅᓯᒪᓂᐊᕐᔪᓂ ᑕᒪᓯᒥᖓ ᖃᐅᔨᓴᕐᓂᐅᔪᒥᑦ. ᑕᒪᒃᑯᐊᓗ ᓄᐊᑕᐅᕙᑦᑎᐊᔪᑦ ᑐᖅᑯᔭᐅᓯᒪᓂᐊᖅᑐᑦ ᓴᐳᑎᓯᒪᑦᑎᐊᕐᓗᑎᑦᑕ ᖃᓇᓴᐅᔭᑎᒍᑦ ᑖᓇᓗ ᒪᒃᐱᑕᐅᔾᔭᓇᕋᔭᖏᑦᑐᖅ ᑭᓇᑐᐃᓇᕐᒧᑦ, ᐊᒻᒪᓗ ᐃᓚᓗᑭᓯᐅᑉ ᐃᕐᓕᕐᕕᒃᑯᕕᙵᓂᐊᖅᑐᑦ ᑮᓯᒪᓗᔭᖅᑐᖅ ᐃᓚᓗᑭᓯ. ᐊᒻᒪᓗ ᑕᒪᒃᑯᐊ

ᓄᐊᑕᐅᓯᒪᔪᑦ ᓄᐊᑕᐅᑦᑎᐊᓚᐅᖅᑎᓪᓗᒋᑦ ᐃᑭᑕᐅᓘᖅᑐᑦ ᐃᑭᑕᐅᔭᕆᐊᖃᓕᖅᐸᑕ. ᑖᓐᓇ ᖃᐅᔨᓴᖅᑎᑐᐊ ᑕᒪᒃᑯᓂᖓᒐᒐᓚ ᐊᑦᑐᖅᓯᔪᓐᓇᖅᓴᖅᑐᖅ ᑭᓇᑐᐃᓐᓇᕐᓗ ᕿᒥᕐᕈᔪᓐᓇᖅᓴᖏᑦᑐᖅ ᓄᐊᑕᐅᔪᕙᓂᕐᓂᑦ.

ᖃᐅᔨᓴᖅᑕᐅᓂᐅᔪᑦ ᓴᖅᑭᑕᐅᓕᕈᑎ

ᓂᕆᐅᒃᑐᒍᑦ ᖃᐅᔨᓴᖅᑕᐅᓂᐅᔪᑦ ᓄᐊᑕᐅᓯᒪᔪᑦ ᓴᖅᑭᑕᐅᓕᕈᑎ ᐊᐟᐹᕆᖏᑦᑐᕈᓘᔭᕐᓂᑦ ᐊᑐᕈᒪᓪᓗᑕ ᑐᓴᐅᒪᔾᔪᑎᐅᒃᑲᓐᓂᕈᓐᓇᕐᓂᐊᑐᓂᑦ ᓱᕐᓗ ᒐᕙᒪᒃᑯᑎᒍᑦ ᑲᑎᓐᓂᕆᖅᑲᑦᑕᖅᑕᖏᑦ ᒪᓕᒡᓗᒋᑦ ᐊᒻᒪᓗ ᓄᓇᓕᖕᓂᑦ ᑭᒡᒐᖅᑐᐃᐹᖏᑎᒍᑦ, ᑎᑎᕋᐅᔭᕐᓂᒃᑯᑦ ᐱᔪᓐᓇᕐᓂᕆᔭᐅᖃᑦᑕᖅᑐᓂᑦ ᓴᖅᑭᑕᐅᖃᑦᑕᖅᑐᓂᑦ ᓱᕐᓗᓕ ᐅᓂᒃᑳᓯᐅᕐᓂᒃᑯᑦ, ᑕᕐᕆᔭᒐᒃᓴᓕᐊᖑᓯᒪᔪᒃᑯᑦ, ᑐᓴᐅᑎᒃᑯᑦ ᑐᓴᒐᒃᓴᓕᐊᕆᓯᒪᔪᒃᑯᑦ ᓂᐱᓕᐅᖅᓯᒪᕙᕇᖅᑐᓂᑦ, ᐊᒻᒪᓗ ᐸᕐᓇᒃᑕᐅᓯᒪᖏᑦᑐᒃᑯᑦ ᑲᑎᒪᓂᐅᖃᑦᑕᖅᑐᓂᑦ. ᐊᒻᒪᓗᒃᑲᓐᓂ, ᖃᐅᔨᓴᖅᑕᐅᓂᐅᔪᑦ ᓇᓗᓇᐃᑕᐅᖅᓯᒪᔪᑦ ᓴᖅᑮᔭᖅᑎᑕᐅᒐᔭᖅᑐᑎ ᐅᖃᓪᓚᒋᐊᖅᑐᖅᓯᒪᑎᓪᓗᒍ ᐃᓕᓐᓂᐊᖅᓂᕆᔭᖓ ᒪᓕᒃᓗᒍ ᐊᒻᒪᓗ ᐅᖃᓕᒫᓚᓕᐊᕆᔭᐅᖃᑦᑕᖅᑐᓄᑦ ᔫᒃᑖᓄᑦ ᐋᓐᓂᐊᓰᑎᓄᓪᓗ.

ᐅᖅᖃᑎᒋᔪᓐᓇᖅᑕᑎᑦ:

ᖃᖓᑐᐃᓐᓇ, ᐅᖅᖃᑎᖃᕈᒪᓐᓂᕈᕙᑦ ᑕᒪᑐᒪ ᐃᓕᓐᓂᐊᖅᑕᒻᒪ ᒥᒃᓵᓄᑦ ᐅᖅᖃᑎᖃᕐᓇᑦᑎᐊᖅᑐᑎᑦ ᑖᓇ ᐸᑯᓕ ᒪᑮᒧᑦ ᐅᕗᖓ 1-902-680-2027–ᒧᑦ ᐅᕝᕙᓘᓐᓃᑦ ᑎᑎᕋᖅᕕᒋᓗᒍ ᐅᕗᖓ XXXX– ᒧᑦ ᐅᕝᕙᓘᓐᓃᑦ ᓘᒃᑖ ᓈᓐᓯ ᑕᓛᒃ ᐅᕗᖓ 1-250-472-4703-ᒧᑦ ᑎᑎᕋᖅᕕᒋᔪᓐᓇᕆᓪᓗᒍᓗ ᐅᕗᖓ XXXX -ᒧᑦ.

ᖁᔭᓐᓇᒦ ᖃᐅᔨᓴᕐᓂᐅᔫᒃ ᒥᒃᓵᓄᑦ ᐅᖃᓕᒫᓚᐅᑲᒃᑲᕙᑦ.

ᐊᐱᖅᓱᖅᑕᐅᓂᖅᒧᑦ ᐱᖃᑕᐅᔪᒪᓂᐊᖅᓂᖅᓄᑦ ᓂᕆᐅᒃᐳᒍᑦ!!

Appendix J

Research Study Information Sheet (English)

"Understanding Cultural TB Stigma from Inuit Perspectives: Implications for Culturally Safe Public Health TB Screening Programs"

Invitation to participate in a research study:

You are invited to take part in a research study that wants to understand cultural TB stigma from Inuit perspectives and the implications for culturally safe public health TB screening programs. We think that you as an Inuk, over the age of 18 years of age and living in either XXXX, XXXX, or XXXX, communities that hosted the community-wide TB screening clinics, are suitable to participate. This information sheet explains the research study and your role in it. After you have carefully read this information sheet, you can ask any questions you might have. After that we will ask you to sign a consent form to participate in the study if you wish.

Voluntary Participation/ Informants Rights:

Participation in this study is voluntary. Choosing not to participate is okay. If you do choose to participate in the study, you can also withdraw from the research at any time you wish without giving a reason. If you withdraw from the research or withdraw your consent, any data collected from you before the withdrawal can be used as part of the research data if you give consent to that.

Purpose of the Study

The purpose of this study is to determine what factors shape cultural stigma of TB for Inuit community members and how this information can be used to promote culturally safe public health policy in relation to TB programs, such as the TB screening program in Nunavut. The key objectives of this study are: 1/ to understand the factors which shape cultural stigma related to TB from the perspective of Inuit community members, 2/ to understand what constitutes culturally safe policy and practice in relation to Inuit TB community-wide screening, and 3/ to use Inuit perspectives to inform and influence Government of Nunavut public health policy related to uptake of TB screening and programming.

What will the participation involve?

Participation will involve up to one hour/ 60 minutes of your time in answering questions asked by D. Beverly McKee, RN. PhD (C) primary researcher, during a telephone interview. If you would like to write down your thoughts about TB in a journal first, a journal will be supplied, and then a telephone interview will be held at a mutually agreed upon time up to four weeks later.

Benefits of taking part in the research study.

The potential benefits of your participation in this research include the ability to:

1/ have an active role in one's own personal and community's health care future
2/ to be able to anonymously express your opinions and given input regarding cultural stigma you have faced in receiving TB care
3/ to be able to anonymously express your opinions and give input regarding cultural stigma you have faced in receiving TB care
4/be able to anonymously express your opinions and give input regarding Government of Nunavut TB policies, prevention, and treatment programs 3/ to be able to anonymously express your opinions and give input regarding cultural stigma you have
faced in receiving TB care
4/be able to anonymously express your opinions and give input regarding Government of Nunavut TB policies, prevention, and treatment programs and how they address and/or do not address cultural TB stigma
5/ share your own lived experience with TB and how TB has impacted your and/your family member lives as Inuit in Nunavut.

Possible Risks involved:

There are some potential risks to you by participating in this research and they include potential emotional/and or psychological feelings related to the topic of tuberculosis. A mini pre-and post-debrief session will occur with the interview, and a list of telephone numbers to mental health support services and/or a contact person to speak with will be provided to each participant.

Compensation

As a way to compensate you for any inconvenience related to your participation, you will be given a 50.00 gift card.

Anonymity/ Confidentiality

Your anonymity is maintained via coding all knowledge that you share with us. Your name nor location, unless you wish to self-identify, will remain unknown to all but the research investigators. Your confidentiality and the confidentiality of the data collected will be protected. All data will be stored in a password protected computer, stored in a locked cabinet in a locked room, and will be kept safely stored for the mandatory time required and then appropriately destroyed. Only the research investigators will have access to this data.

Dissemination of Findings

It is anticipated that the results of this study will be shared with others in the following ways: formal gathering of government and community representatives, potential arts-based methods including story boards, videos, pod casts, and informal community gatherings. Further the results will be presented at scholarly meetings and will be published in a dissertation and published journal.

Further information on the study

At any time if you wish to discuss this research study you may speak to D. Beverly McKee at (XXXX) or Dr. Nancy Clark PhD., (XXXX)

Thank you for taking the time to read about the research study.

We hope you will want to participate!

Appendix K

Interview Guide for Community Knowledge Holder Participants

1/ Greetings. How are you today? Thank you for participating in this research study.

2/ How long have you lived in this community?

3/ What would you like to tell me about your community and your life here?

4/ How has TB affected your community in the past and in the present?

5/ What has been your own experience with TB? (Self, family, or community).

6/ What do you think would make and/or have made this experience with TB better for you and/or your family or community?

7/ Do you go to the health care center? What has been your experience in attending the health care center?

8/ What makes you feel safe and comfortable when there?

9/ Or what makes you feel unsafe and uncomfortable when there?

10/ What do you think could make public health services more culturally safe for you as an Inuk and for your community?

11/ Do you think the TB health program is culturally safe from an Inuit perspective?

12/ What do you think needs to be done to make TB care in your community more culturally safe?

Appendix L

Interview Guide for Health Care Professional Participants

This guide was used for both Inuit and Kablunaaq participants.

1/ Tell me how long you have worked here? What brought you to your position?

2/ Could you explain exactly what you do in your position?

3/ What's your experience and understanding of Tuberculosis (T B)? Where you familiar with TB prior to your current position?

4/ What is your experience with TB policy and practice?

5/ If you see clients, what type of clients would you normally see? Do you work with clients that have TB?

6/ What do you consider cultural safety to be? What do you think Inuit may consider cultural safety to be related to TB?

7/ Do you think the TB program and its policies have attempted to and/or succeeded in making the TB program culturally safe for Inuit?

8/ What factors do you think might make present TB care in Nunavut culturally unsafe for Inuit?

9/ From your perspective can you provide specific examples of how the TB program provides culturally safe TB care for Inuit?

10/ Do you think more can be done to promote cultural safety with respect to TB in Nunavut? And if so, what?

11/ What do you think cultural stigma is?

12/ How do you see this manifested in tuberculosis in Nunavut?

13/ What do you think can be done to address TB cultural stigma in Nunavut?

14/ Is there anything else that you would like to share specific to TB in Nunavut?

Thank you, Matna, Nakurmiik

Appendix M

Certificate of Approval, Office of Research, University of Victoria

University of Victoria 250-1700 STN I
Office of Research Services I Human Research Ethics Board
472-4545 Williams | Building F 250-721-8960 Rm B202 | uvic.ca/research PO Box
ethics@uvic.ca CSC Victoria BC V8W 2Y2 Canada

Certificate of Approval

PRINCIPAL INVESTIGATOR:Nancy Clark (Supervisor) PRINCIPAL APPLICANT: D. Beverly McKee PhD student CIVIC DEPARTMENT: Nursing NURS	ETHICS PROTOCOL NUMBER Expedited review - delegated	21-0469
		1 1-Mar-2022
	ORIGINAL APPROVAL DATE:	1 1-Mar-2022
	APPROVED ON: APPROVAL EXPIRY DATE:	10-Mar-2023

PROJECT TITLE: Understanding Cultural TB Stigma from Inuit perspectives: Implications for culturally safe public health TB policy and practice

RESEARCH TEAM MEMBERS:
Catherine Worthington - committee member, University of Victoria
Marjorie MacDonald - committee member, University of Victoria

DECLARED PROJECT FUNDING: None

DOCUMENTS INCLUDED IN THIS APPROVAL:
tcps2_core_certificate.pdf - 21-Nov-2021
TB Manager letter of support.docx - 01-Dec-2021
Mental Health Support Numbers document version 1 .docx - 14-Dec-2021 letter of support from XXXX Mayor.pdf - 22-Dec-2021
community recruitment poster version 1 .docx - 30-Dec-2021
Recruitment poster for health care professionals version 1 .docx - 30-Dec-2021
Confidentiality Agreement for Community Youth Champions, Transcriptionist version I .docx - 30-Dec-2021
Interview Guide Questions for Group A.docx - 30-Dec-2021
Interview Guide for Group B version 1 .docx - 30-Dec-2021 MOPH letter of support.pdf - 13-Jan-2022
graphic_for_pubIic_heaIth_measures_ian_25_nunavut_excluding_igIooIik.jpg - 20-Feb-2022 order_re_social_distancing_and_gatherings_21 -_212124.pdf - 20-Feb-2022
Co-created research training for Community Youth Champions.docx- 22-Feb-2022
Participant Consent Form Group A Version 2.doc - 22-Feb-2022
Participant Consent Form Group B Version 2.doc - 22-Feb-2022
COVID-19 guidelines for CYC version 1 .docx - 28-Feb-2022
Letter of Support for Beverly McKee January 2022.docx - 28-Feb-2022

Appendix N

Nunavut Research Institute Scientific License

Nunavut Research Institute / ᓄᓇᕗᒻᒥ ᖃᐅᔨᓴᕐᑐᓕᕆᔨᒃᑯᑦ
Box 1720, Iqaluit, NU X0A 0H0 phone:(867) 979-7279 fax: (867) 979-7109 e-mail: mosha.cote@arcticcollege.ca

SCIENTIFIC RESEARCH LICENSE

LICENSE NUMBER 01 030 22N-A

ISSUED TO: Donna Beverly McKee
Faculty of Nursing
University of Victoria

TEAM MEMBERS: N.Clark,C.Worthington,M.MacDonald

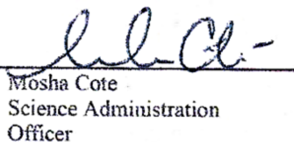
TITLE: Understanding Cultural TB Stigma from Inuit Perspectives:Implications for Culturally Safe Public Health TB Policy and Practice

OBJECTIVES OF RESEARCH:
Inuit in Canada have an average rate of active TB that is 300 times greater (170.1 cases per 100,000) than all other Canadian-born Canadians (Patterson et al., 2018; Stats Can 2018). Non-Indigenous Canadian-born Canadians have an incidence rate of active TB that is 0.5 per 100,000 (Kilabuk et al., 2018) and in comparison, active TB rates among First Nations peoples on reservations is 40 times higher than non-Indigenous Canadians born in Canada (Stats Can 2018). The prevalence of TB is related to a history of colonialism and current health care inequities. The Government of Nunavut in response to such alarming incidence rates initiated community-wide TB screening clinics in three remote communities with the intention of carrying out clinics across Nunavut. However, post evaluation of the first of the three community-wide TB screening clinics identified community responses of exclusion and alienation, loss of control over own TB health treatments, and feelings of community disruptions. These findings suggest that Inuit may be experiencing further marginalization as a result of cultural TB associated with a lack of Inuit inclusion in public health policy development and programming. Gaining an in-depth understanding of Inuit perspectives related to what promotes cultural safety in public health TB policies and programs is needed to mitigate historical health inequities of Inuit in Canada.

TERMS & CONDITIONS:

DATA COLLECTION IN NU:
DATES: May 30,2022 to December 31,2022
LOCATION

Scientific Research License 01 030 22N-A expires on December 31,2022
Issued at Iqaluit, NU on August 18,2022



Mosha Cote
Science Administration
Officer