



Qikiqtani Truth Commission

Thematic Reports and special studies

1950-1975

Aaniajurliriniq: Health Care in Qikiqtaaluk



Qikiqtani Inuit Association

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Errata

Despite best efforts on the part of the author, mistakes happen.

The following corrections should be noted when using this report:

Administration in Qikiqtaaluk was the responsibility of one or more federal departments prior to 1967 when the Government of the Northwest Territories was became responsible for the provision of almost all direct services. The term “the government” should replace all references to NANR, AANDC, GNWT, DIAND.

Dedication

This project is dedicated to the Inuit of the Qikiqtani region.
May our history never be forgotten and our voices be
forever strong.

Foreword

As President of the Qikiqtani Inuit Association, I am pleased to present the long awaited set of reports of the Qikiqtani Truth Commission.

The *Qikiqtani Truth Commission: Community Histories 1950–1975* and *Qikiqtani Truth Commission: Thematic Reports and Special Studies* represent the Inuit experience during this colonial period, as told by Inuit. These reports offer a deeper understanding of the motivations driving government decisions and the effects of those decisions on the lives of Inuit, effects which are still felt today.

This period of recent history is very much alive to Qikiqtaalungmiut, and through testifying at the Commission, Inuit spoke of our experience of that time. These reports and supporting documents are for us. This work builds upon the oral history and foundation Inuit come from as told by Inuit, for Inuit, to Inuit.

On a personal level this is for the grandmother I never knew, because she died in a sanatorium in Hamilton; this is for my grandchildren, so that



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they can understand what our family has experienced; and it is also for the young people of Canada, so that they will also understand our story.

As it is in my family, so it is with many others in our region.

The Qikiqtani Truth Commission is a legacy project for the people of our region and QIA is proud to have been the steward of this work.

Aingai,

E7-1865

J. Okalik Eegeesiak

President

Qikiqtani Inuit Association

Iqaluit, Nunavut

2013

Aaniajurliriniq

Health Care in Qikiqtaaluk

Inuit health knowledge is holistic in its approach and upholds that all aspects of a person's needs, including the psychological, physical, and social, are connected. For Inuit, healing injuries and sickness goes hand in hand with developing a strong mind and resilient body; for this reason, health is closely tied to personal identity. Adults are expected to act independently with the interests of themselves and their families in mind. Sick people are treated with love and care, and satisfying the patient's needs and desires is considered paramount for recovery. Inuit health knowledge also refers to more than general healing techniques—it concerns knowledge of the body and its social environment.

In almost every sense, Inuit ideas about health are consistent with the widely accepted definition put forth by the World Health Organization (WHO): “Health is a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity.” To date, no comprehensive history of health ideas, needs, and services in present-day Nunavut has been published, although a number of excellent studies of institutions



and medical conditions exist. A full history would require a careful examination of connections between a range of diverse topics, such as cultural practices, language, colonialism, legal history, and medical knowledge. This short history about health care in Qikiqtaaluk is focused on medical practices and policies as delivered by government agencies. It is hoped that others will continue an examination of broader issues in Inuit health history.

One of the few histories to look at broad issues related to the history of Aboriginal health in the twentieth century is *Colonizing Bodies: Aboriginal Health and Healing in British Columbia, 1900–1950*. Historian Mary-Ellen Kelm based her work on oral evidence provided to her by First Nations informants, as well as on many archival, published, and oral sources. The study’s analysis and conclusions have parallels in the health history in Qikiqtaaluk, although it places more emphasis on church-run residential schools and less on health evacuations than is relevant to Inuit history. Kelm describes how Euro-Canadian policies and programs introduced poverty and greater susceptibility to disease, while simultaneously displacing Aboriginal knowledge about health with medical treatments that were intended, in large part, to prove the benefits of assimilation. She also shows how improvements to Aboriginal health were recast as being in the “national interest” in the 1940s, especially over fears about epidemics that were perceived to be spreading from, rather than to, Aboriginal populations. Finally she considers how First Nations set out to reclaim control over their bodies by demanding better health services from government, addressing connections between health and social conditions, and by sharing and applying indigenous knowledge in treatments.

This chapter looks at Inuit experiences with medical services established in Qikiqtaaluk by the federal and territorial governments in the 1950 to 1975 period by focusing on issues raised in interviews for the Qikiqtani Inuit Association (QIA) and the Qikiqtani Truth Commission (QTC). It does not address the histories of St. Luke’s hospital in Pangnirtung, the Eastern Arctic Patrols (EAPs) of the 1920s and 1930s, or services provided

in other parts of present-day Nunavut, such as Coral Harbour and Cambridge Bay, in detail.

The history is divided into three periods, beginning with the early twentieth century. During the period of Taissumani Nunamiutautilluta, when the sea and land provided almost everything Inuit needed, Inuit needing advice or treatment for health matters relied almost entirely on their own health knowledge, supplemented by a small Anglican hospital at Pangnirtung, medical teams visiting trading centres annually by ship, and very limited treatments provided by the Royal Canadian Mounted Police (RCMP), missionaries, and Hudson's Bay Company (HBC) traders.

Taissumani Nunamiutautilluta was followed by several years of disruptions caused by the influx of Qallunaat who were tasked with ensuring that Canada's North and its inhabitants would be subject to southern Canadian ideas, laws, and institutions. This period is called Sangussaqtauliqtiluta, when people were more or less forced to change their ways. Improvements in health services in the region, such as the staffing of nursing stations, were both a belated response to long-standing complaints made by missionaries, researchers, bureaucrats, and American military personnel about high mortality rates and chronic conditions, such as respiratory illnesses, and a result of more government involvement in the provision of health services to Canadians. Some actions intended to improve Inuit health added to suffering by patients and their families. This was particularly true with respect to the removal of Inuit for diagnosis and treatment in the south, for tuberculosis and other diseases. People who were infected or sick were removed without notice for indefinite stays in southern hospitals. Inuit who refused screening or were known to be ill were sometimes tracked down at their ilagiit nunagivaktangat by the ship's helicopter. Inuit sent south for treatment often endured weeks on board the ship even before they spent many months or years in treatment, far away from their families. A number of those people were returned to Iqaluit for observation or to attend the rehabilitation centre and never found their way home.

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Inuit patients sent south were sometimes treated with exceptional kindness, but others were left alone without companionship in very unfamiliar and unpleasant conditions for months or years. Miluqtituttuq Akesuk recalled being sent to Toronto for tuberculosis treatment in 1964 when she was ten years old. She told the QTC, “I thought I was lost. I thought I would never come back here to my parents when I first went down. I really thought I was lost.” Children were particularly vulnerable to the loss of cultural knowledge and language and to lasting psychological impacts. Poor record-keeping led to the return of some patients to the wrong communities, and to tragic circumstances in which families waited for their children and parents to return, not knowing that they had died at the hospital.

By the period of Nunalinnguqtitauliqtiluta, the time when we were actively (by outside force) formed into communities, almost the whole population of Qikiqtaaluk lived in centralized settlements where they were provided with low-quality services that were intermittent and limited in scope. Geographer and historian George Wenzel argues that “few, if any, Inuit, presently living in a government village or settlement, would dispute the importance and benefits represented by the availability of Western-type health care,” but they also knew that the quality and availability of care had not been ideal. Inuit access to medical services during this period was not on par with the care available in southern Canada, and Inuit were not involved in important decisions about how health outcomes could be improved.

In all three eras, bureaucrats, health professionals, and Inuit understood that there were important connections between a healthy body and related health factors, such as nutrition, housing, education, and feelings of self-worth. There is little evidence, if any, that Inuit were asked to provide input into options that could have made their lives better while also addressing grim statistics related to infant mortality, cardiovascular disease, and growing incidences of addiction.

Taissumani Nunamiutautilluta

INUIT HEALTH KNOWLEDGE

Knowledge was typically passed down orally by Elders to everyone who needed it—it did not belong to specific individuals. While someone with special healing powers, such as a shaman, could be sought out in times of need, everyone regularly kept medicines and first-aid equipment in their households. Typical materials would include bearded seal oil and blubber to stop infections and allow wounds to heal, and caribou membranes, Arctic fireweed, lichens, willow leaves, and other natural materials for treating other injuries and sicknesses. These medical supplies were often gathered during the summer and stored for future use. Kudjuarjuk describes one particularly important plant in John Bennett and Susan Rowley's *Uqal-urait: An Oral History of Nunavut*:

There are not too many Eskimo medicines but there is one, which is very good: it is called [pujualuk] and is a little plant that grows in damp mossy areas. They are white on top and brown inside [puffballs]. In the summertime, we used to collect all the [pujua-luit] from the moss for the winter and wrap them and store them in a dry area. These [pujua-luit] have a dry powder in them and on the big cuts we would put on [pujua-luit] as medicine and a bandage to stop the bleeding and heal the wound.

Contact with Europeans, especially whalers, in the nineteenth and early twentieth centuries introduced Inuit to many new infectious diseases. Customary approaches did not work against these diseases, resulting in the deaths of many Inuit, possibly hundreds in the 1850s alone.

GOVERNMENT AND MISSIONARY MEDICAL SERVICES

St. Luke’s Hospital and the Outpost Nursing Program

The first permanent clinic and hospital to be built in Qikiqtaaluk was St. Luke’s Hospital in Pangnirtung. It was opened in 1931 by the Anglican mission with the encouragement and support of a government doctor, Dr. Leslie Livingstone. Anglican Bishop Archibald Lang Fleming had been arguing for a hospital in Kimmirut, since the settlement was on the regular supply routes and was accessible to the large number of Inuit residing in southern Baffin Island. The Anglican Church eventually conceded to operating a hospital in Pangnirtung in the hope that a second hospital would be built at Kimmirut. The latter was never constructed, and the government chose to build a nursing station there in January 1946.

St. Luke’s was initially funded by the Anglican Church and private benefactors in England and Canada; government funds were limited to shipping supplies and covering the costs of some drugs. Once the hospital was opened, the Canadian government covered the salaries of hospital staff, mainly female nurses. In fact, the hospital relied heavily on nurses rather than doctors, as they were more likely to live and work in the North. Nurses were generally single women of British descent, sent north on one-year contracts. They were also expected to serve as government representatives in their interactions with Inuit. The support staff was generally Inuit. They included, at times, a receptionist, dental therapist, interpreter, and community health representative. While at St. Luke’s, patients were treated for all kinds of medical conditions, with most of the time spent treating influenza, typhoid and “shiptime fever,” or performing surgeries. From the outset, beds were allocated to tuberculosis patients, a need that increased in later years.

During the Second World War, St. Luke's faced financial and staffing challenges. In some years, such as 1944, there were no doctors, only nurses. Nurses were often capable of providing a wide range of medical services, from standard curative measures to preventative care, immunizations, emergency treatments, assisting with childbirth, identifying tuberculosis cases, and treating other infections. When the hospital had no doctor, the female nurses had to defer to the authority of a council composed of male RCMP officers and the HBC manager.

At the same time, the government often advocated a policy of hospitalizing as few Inuit as possible. The nurses, for their part, were often critical of this policy, which seemed more concerned with budgetary concerns than the health of Inuit. One example can be seen in Edith Prudence Hockin's letter to the bishop, dated October 6, 1943, in which she conveys her concerns:

The *Nascopie* arrived on the 4th in the midst of a snowstorm... We were a little disappointed not to get patients this year as we had heard there were several. The people from *Resolution* were left at [Kimmirut] by the McLean and are *still* there. There were also patients at Wolstenholm, [Kimmirut], and Pond. No very good reason seems to be forthcoming for not bringing any. Looks like a straight case of "saving on the Hospital bills" to me. Dr. Collins from the Dept. is on the *Nascopie* and of the *Resolution* people he said it would be a pity to clutter this place up with them, they are all sick.

At this time, the EAP was responsible for transporting patients to and from the hospital as well as providing hospital supplies. As such, hospital staff often had to anticipate what supplies would be required a year at a time. If patients missed the ship, they also had to wait a year for the next one. At these times, the hospital was responsible for accommodating them while they waited. In order to do so, the upper floor of St. Luke's was converted into a residence.

Eastern Arctic Patrol

Through the 1920s, and into the early 1930s, Inuit across the Arctic had been provided with relief from time to time by the Department of the Interior. The EAP was the first unofficially government-directed health care program in the North. Anxiety over sovereignty, fed by the presence of American whalers in Hudson Bay and Denmark's potential claim to Ellesmere Island, resulted in the government adopting an approach of "effective occupation" in the Canadian Arctic in the early twentieth century. The establishment of RCMP posts throughout the Arctic to be serviced by the EAP vessels *Arctic* (1922–25), and *Beothic* (1926–31), was a product of this approach. While the initial aim of the EAP was to provide support to the RCMP, the ship's doctor occasionally provided basic medical care to Inuit encountered along its route. However, it is important to note that much of the medical assistance provided was limited, and the only point where the EAP met a concentrated amount of Inuit was at Pangnirtung.

By 1926, the Canadian government was feeling more secure about its jurisdiction over the North and more inclined to help northern inhabitants. Unfortunately, the onset of the Great Depression resulted in the government having to cut back on services. In order to save on costs, in 1932, the EAP began conducting its patrols via the HBC supply ship, the *Nascopie* (1932–47). At this time, EAP services expanded to include general inspections of Inuit and game, as well as the transportation of missionaries, RCMP officers, medical personnel, and Inuit going to or from Southern hospitals for medical treatment. During the interwar years, concerns of diabetes, cancer, and heart disease were receiving more attention and some doctors began accompanying the patrol in order to conduct research among populations in the North. The addition of Dr. Charles Williams of the University Of Toronto Faculty of Dentistry to the 1939 charter also raised concerns over the oral health of Inuit in light of the new white-flour diet, and soon after a

dentist joined the wartime EAP medical staff. Nevertheless, health care services, including dental care, which was often restricted to extractions that could be done quickly at ship stops, remained minimal and sporadic.

The federal government's decision to develop more medical services in Qikiqtaaluk was not the result of a simple evolution of thinking on the part of bureaucrats. It flowed from the Supreme Court of Canada's ruling in 1939 (in a decision commonly referenced as "Re: Eskimos") that Inuit were to be treated as Indians under the Indian Act. Prior to this decision, the federal government took advantage of the confusion about its responsibilities for Inuit. Since the 1880s, the government had provided services for "destitute" Inuit in parts of the Arctic through mission schools and medical attention. With an obvious need to deal with infectious diseases in the Arctic, especially TB, the government amended the Indian Act in 1924 to give the Department of Indian Affairs responsibility for "Eskimo Affairs." The meaning of the term "Eskimo Affairs" remained undefined, and the government continued to back away from any interpretation that meant that it was responsible for the people themselves. Even after the government transferred responsibility for Inuit affairs to the Northwest Territories Council, the Indian Act made no reference to Inuit.

A dispute between the governments of Canada and Quebec (the only province with an Inuit population) about which body should be responsible for the costs of assisting destitute Inuit finally reached the Supreme Court of Canada, and led to the 1939 "Re: Eskimo" ruling, which determined federal responsibility. The federal government immediately appealed to the Privy Council in London, but the start of the Second World War delayed the case. While the 1939 ruling effectively became law, the federal government carried on delivering a minimal level of services (specifically health, education, and welfare) to Inuit through various agencies, without the benefit of a policy or legislative framework specific to Inuit.

Sangussaqtauliqtilluta

WAR TIME

From 1939 to 1945, the Second World War focused the government’s attention on sovereignty issues, rather than social ones, and the “Re: Eskimo” decision had little effect on the delivery of government services or programs for Inuit. However, concurrent international pressures would increase the demand for improved Canadian health care in the North. During the Second World War and the beginning of the Cold War, the Canadian and American governments worked together on a number of defence projects in the North, resulting in a substantial influx of US military personnel to the Arctic. This had a tremendous effect on the infection rates of communicable diseases, with far more serious implications for the Qikiqtaalungmiut than for Qallunaat. The 1940s saw a high mortality rate among Inuit resulting from epidemics of influenza, pneumonia, meningitis, typhoid fever, scabies, and tuberculosis.

The Canadian government had asked the US military to provide medical services to all staff, including employed Inuit. The situation was confused by the lack of a clear definition of the meaning of the term “employed” and the reality that Inuit men travelled with their families to bases and weather stations looking for work. When someone living temporarily nearby was in need of medical attention, the local military medic would feel obliged to do what was possible, especially in the absence of Canadian civilian health clinics and services.

Not surprisingly, US military personnel, as well as foreign journalists visiting the military bases, began calling attention to the lack of medical services in the region. Their criticism often concerned the lack of treatment for tuberculosis and treatable infections, such as scabies. At one point, the US military flew medicine into Southampton Island after expressing shock at

the lack of response to a meningitis epidemic. In order to avoid international embarrassment, the Canadian government determined they would have to be seen as helping the Inuit. While the Northwest Territories government largely dismissed the international concern regarding the medical services in the North, the federal government did move to investigate. A 1943 federally commissioned report concluded that the general lack of proper medical care for Inuit was attributable to the distance and isolation of the North and problems associated with transportation. Despite recommendations provided in the report, government officials remained in disagreement over what measures should be taken to remedy the situation and to what extent the government was obliged to provide medical services.

AFTER 1945

In 1945, with only two hospitals operating in the geographic area that is present-day Nunavut, there were only forty-eight beds for just a little under four thousand people. In that year, however, the responsibility for the health of First Nations and Inuit was transferred to the Department of National Health and Welfare (DNHW). The transfer of responsibility for medical programs to the DNHW contributed to the development of a clear mandate to tackle tuberculosis in Aboriginal populations, including Inuit. In 1939, the government figures show the tuberculosis death rate for Inuit was three hundred and fourteen out of one hundred thousand, compared with fifty-three out of one hundred thousand for the rest of Canada. Figures had continued to rise, and finally peaked in the early 1940s. In 1946, tuberculosis was the leading cause of mortality and morbidity in the North. Even though tuberculosis had been a national concern since the First World War, nothing had been done to address tuberculosis among Inuit. Strained government funds and the effects of the Depression most certainly played a role as well. In 1945, the government created an Advisory Committee for the Control

and Prevention of Tuberculosis among Indians. Its purpose was to look into existing efforts to identify, treat, and provide after-care to sufferers, and to recommend improved and efficient means of accomplishing these objectives in the fight against the disease. The Committee's origins were rooted in the government's approach to tuberculosis as a problem to be overcome by medical professionals, rather than a broader socio-economic issue.

In 1946, the DNHW established Indian and Northern Health Services (INHS) and appointed Dr. Percy Moore to the office of Director. This reform happened for a number of reasons, including sovereignty concerns stemming from the heightened US presence in the Arctic, embarrassment resulting from international concerns over the state of Inuit health, and increased pressure from Canadian medical personnel in the Arctic arguing for the centralization of services. While the reorganization alluded to change in overall policy, in reality, the INHS inherited the position of the previous administrators, which was characterized by inaction, indecision, and limited funding.

In its first year, the INHS spent \$28,620 on Inuit health in the Eastern Arctic. With an Inuit population of roughly six thousand, this amounted to \$4.77 per person, a very small amount by any standards during this period. From the outset, the INHS also actively worked to limit the perception among Inuit that they had a right to free and unlimited medical and hospital services and that governmental funds were unlimited. In a letter to the Director of the Northern Administration and Lands Branch, Northern Affairs and National Resources, Dr. Moore wrote, "Medical and hospital care at public expense is not something [Inuit] can demand as a right . . . [O]ur funds are not unlimited and must be distributed to the greatest possible advantage for those genuinely in need." There is no evidence, however, that Inuit had high expectations about the types of medical services that would or could be offered. The rhetoric appears to have been intended to reconfirm that staff would take fiscal limitations seriously.

The government decided against building hospitals in Qikiqtaaluk in favour of outpost nursing stations in Cape Dorset and Kimmirut under the care of the INHS. If staff at the nursing station determined specialized treatment was required, Inuit were flown out to southern hospitals, often to Quebec. Over time, the chain of INHS nursing stations offered more sophisticated care and grew to include stations in Iqaluit (1955), Hall Beach (1957), Cambridge Bay (1958), and Kuujjuarapik (1962). Generally, two or three nurses staffed the stations, though at times a local priest or RCMP officer operated them. In remote areas in particular, nurses performed a variety of care, including some dentistry, mental health care, counselling, pre- and postnatal care, local public health inspections, and laboratory technician work, including X-rays. In more populated communities, nurses would screen patients and perform diagnostic tests, and visiting specialists would consult. For example, the nurses at the public health clinic in Iqaluit often conducted preliminary screenings for eye health concerns on a request basis, and had the authority to order prescription glasses. Health specialists then followed up as needed.

Nurses were also tasked with public health education focused on reducing preventable diseases and encouraging better infant health. A Royal Commission presentation at the WHO on “Disease and Death in Canada’s North” explained:

The first line of defence under these circumstances, particularly for those who live at some distance from sources of professional care, must surely be the arming of all residents with at least some of the knowledge and the means to prevent disease by the preservation of health, and with knowledge of first aid and home nursing.

The language reflected an underlying belief held by most medical workers that Inuit knew little about health and medicine.

Early on, public health education was greatly informed by the perspectives of the churches. The nurses interacted very little with Inuit, and did not attempt to incorporate traditional Inuit practices or knowledge into their work as health care professionals. One Elder described the conceptual and practical distance inherent in the nurse-patient relationship when she recalled, “the nurse told me whenever one of my children was sick, or when I thought a child might get sick, I was to bring it to the nursing station right away. She would take the child and return it to me when it was better.” She added, “I never know what she does.”

By the 1950s, various private agencies and government bodies were involved in providing a range of limited health care initiatives in the Arctic, resulting in a slow pace of improvement to health services in the region. Even in 1952, the only full-time medical officer working in the region, aside from doctors working for the military or private contractors, was the doctor at St. Luke’s in Pangnirtung. Funds were neither “unlimited,” nor adequate for the population and geography. A memo to the Advisory Committee on Northern Development stated in 1954 that “medical and health services in the Yukon and Northwest Territories often fall seriously below the standards generally acceptable in Canada.” In that same year, in an effort to deal with the issues of inefficiency, the Northern Health Services Division was formed within the DNHW to administer all public health functions as established in the Canadian North. At the same time, a Permanent Advisory Committee on Northern Health was established to “serve as a co-ordinating body” between the federal department and the territorial governments. Medical facilities were now paid for in conjunction with the INHS and Territorial Governments, and beginning in the mid-1950s, the Department of Northern Affairs and Natural Resources (NANR) began sending permanent northern service officers, later referred to as area administrators, to assume the welfare functions.

C. D. HOWE

With the transfer of responsibility for Inuit health to the Canadian government in 1945, and in light of the burgeoning tuberculosis epidemic, the EAP and its medical facilities also became crucial to carrying out the government's policy for treating tuberculosis among Inuit populations. Treatment in the South generally involved isolating people in hospitals. In 1925, Quebec and Ontario each had eight sanatoria specifically for the treatment of tuberculosis, in addition to a number of general hospitals set aside for tuberculosis patients. Ultimately, the same treatment policy was adopted for patients in the North, but Inuit were transported thousands of kilometres away from their homes for treatment. Beginning in 1946, X-rays were conducted by the EAP at each stop; anyone diagnosed as being tubercular had to immediately board the ship to be sent south. The ship was crowded with patients, crew, supplies, government employees, and traders. It was almost as much a source of disease as a method of prevention. It was soon realized that a better-equipped ship was required to bring all active tuberculosis cases to southern sanatoria.

Following the sinking of the S.S. *Nascopie* in 1947, the government purchased and outfitted its successor, the Canadian Coast Guard ship *C.D. Howe*, as a medical and supply ship. The new ship could accommodate a crew of fifty-eight, as well as up to thirty Inuit passengers, and came equipped with radar, echo sounding, and a helicopter for personnel transfers. The medical wing had a surgery room, dispensary, X-ray room, dental office, and six patient beds. Its immediate medical goals were to reduce the incidence of tuberculosis, conduct dental and medical surveys, immunize people, evacuate patients south, and return them to their communities from southern sanatoria.

Since the EAP's inception, Inuit had grown accustomed to gathering at Qallunaat enclaves where the ships stopped for trade or temporary

employment. These stopping points were often dictated by the location of HBC or RCMP posts, or other Qallunaat agencies. The insistence on the part of the government to ship people south for treatment centred on the argument that it was the least expensive available measure. However, it was also very likely the least humane, and the protocol used to identify and evacuate infected Inuit often caused widespread confusion and emotional hardship. Where in the past Inuit had gathered in anticipation of shiptime, the new tuberculosis-screening policies began generating great fear among Inuit. People were rightly worried they would be taken away from their families and sent to a foreign location. A situation that repeated itself all too often was for a family to watch one or more members board the *C.D. Howe* for medical tests, and then watch the ship sail away with the family members still on board, without any goodbyes, and without explanation. Elijah Padluq shared his experiences of his mother's evacuation with the QTC:

[You] didn't have any choice but to go on the ship. You had to see the doctor ... [The] patients were not to get off the ship. They stayed on the ship because they had TB ... They would leave in July ... My mother finally came back a year later, in the following spring.

During his testimony to the QTC in 2008, Walter Rudnicki, a retired social worker, explained that this strict policy of removing infected persons went so far as to separate mothers from their children. "The baby was sent to the person [standing closest] to the mother and she was sent off," he explained, "No concern was given to who would take care of the child. I saw this going on." Similarly, dangerous practices were performed upon the return of people to their communities after treatment. According to Rudnicki, "In winter, they were discharged with their summer clothing. It never occurred to the medical personnel that you don't wear summer clothes in the dead of winter in Pang."

Fear of being sent south became widespread because many people often did not return, having died while being treated away from their homes. In 1955, RCMP reported that Inuit in the Kimmirut area were now avoiding the settlement at shiptime because they had no desire of “being evacuated to the Land of No Return.” Pat Grygier, author of *A Long Way Home: The Tuberculosis Epidemic Among the Inuit*, described, “Sometimes a priest would connive at hiding people who were afraid they would be sent south, and sometimes Inuit in outlying camps would flee when they saw the ship coming or when they heard the helicopter.” The helicopter was often used to seek out Inuit who had not gathered at the port and bring them to the ship for examination. RCMP officers were also asked to help medical officers organize the examinations, but many disliked having to persuade Inuit to board the ship. In an attempt to alleviate some of the fear associated with the evacuations, the NANR instituted a public relations campaign that included distributing photographs, motion pictures, and messages of recovering tuberculosis patients to awaiting family members. The success of this campaign in relieving anxiety among Inuit is not documented.

By 1955, almost one thousand Inuit had been evacuated to Southern sanatoria. Treatment generally averaged twenty months. This meant that in 1956, one in seven Inuit were in hospitals in the South. Frank Tester, Paule McNicoll and Peter Irniq, in an analysis of Inuit accounts from these hospitals, tell us that Inuit patients generally suffered from homesickness, cross-cultural misunderstanding, loss of control over their own health, and irreparable damage to their self-esteem. While the effects of this process on individuals and their communities is discussed later in this chapter, the following quote from a patient letter shows the extent to which a person’s individual autonomy was lost, especially in the case of the sanatoria program:

I really do want to go home. I do want to stay outside. I cannot tell you about my health, as I am not able to understand English... I am

obeying the medical staff. I take aspirins ... It is hard to tell ... Also, I cannot cure myself ... I very, very much want to speak English. I am just trying to obey the directions of the medical people. I want to get home too. Sometimes I appear not to be listening ... I want to follow the wishes of the medical people. I, however, do not understand.

The archival record also shows that the government was aware that the policy of evacuation was very upsetting to Inuit and that many people wanted treatment centres to be established in the North. RCMP Inspector H. A. Larsen wrote in 1951 that the impact of this policy on Inuit was “not good,” and that “the period of recovery and convalescence might be much shorter if the Eskimos went under treatment in the environment to which they belong.” Correspondence between Dr. Moore at the INHS and Anglican Bishop Marsh also serves to demonstrate the degree to which the government was informed about the negative effects of this policy on the well-being of the people to whom they were tasked with administering health care. In one exchange, the Bishop exclaimed in a letter to Minister Jean LeSage, “I have come to the conclusion that the Department of Health and Welfare are not concerned with the true meaning of the two words (as far as the Eskimos are concerned) which make up the title of the Department.”

In addition to being torn from their families and homes, once on the ship, Inuit faced further challenges. Despite the presence of qualified staff, there were many complaints of disorganization, dirty and unsanitary conditions, a lack of effort in providing adequate information for Inuit passengers, and no emergency instructions provided in Inuktitut. Other criticisms described “deplorable service given by the health authorities” and heavy drinking among personnel. Rudnicki told the QTC that he was forced to arrest a captain one year because the man was drunk and putting the lives of everyone on the ship in danger.

Even those who remained behind were affected, as rates of communicable disease infection in the *ilagiit nunagivaktangit*, small communities, and enclaves increased as a result of the EAP visits. Cold viruses, influenza, and other respiratory infections were regularly transmitted from crew members to Inuit working as guides or moving cargo. These infections, sometimes referred to as “shiptime fever,” were often passed on to entire communities and could result in secondary complications like TB. In an effort to curb the infection rates, physicians recommended patients and ship crews be vaccinated and that any sick staff be quarantined during calls at port. Unfortunately, the recommendations do not appear to have been implemented. Indeed, evidence suggests that infection rates continued to climb during the annual port calls, especially at places like Pangnirtung.

CENTRALIZATION

Almost all medical services in Qikiqtaaluk in the 1950s were delivered by nurses. There was never more than one resident physician and only an ad hoc approach to improving services where people lived. From a nurse’s perspective, it was not easy to ensure the effective delivery of health care to Inuit living on the land. Personnel and supply shortages, a lack of adequate equipment, and communication issues were only some of the challenges nurses faced. The Northern Health Services Division tackled these issues in part through a policy of centralizing services in selected areas. The massive construction projects and resulting infrastructure developed in association with joint US-Canada military projects, especially the Distant Early Warning (DEW) Line.

The policy of centralizing services, which began in the 1950s and continued through the early 1960s, was in contrast to the Canadian government’s previous policy of keeping Inuit engaged directly in hunting and trapping. The growth of the outpost-nursing program and greater investment

in hospital services over the years were some of the main outcomes of this policy, and continued during the transition to centralization, whereby almost all Inuit lived in government-supported settlement.

Ethnocentric assumptions and colonial and paternalistic governmental attitudes towards health care in the North were captured clearly when the DNHW asked, “How much public money should be spent trying to save the lives of infants born in hovels to parents who choose to live miles from civilization over rough terrain in one of the toughest climates in the world?” Nevertheless, by 1963, plans were underway for an extension of health care provision to additional outposts by way of medical circuits. The plan called for medical personnel to be transported by aircraft to *ilagiit nunagivaktangit* outside the reach of nursing stations. In addition, Inuit health workers were trained as interpreters and assistants. In Cape Dorset, for example, Inuit workers were employed to help ensure that local families were being screened for tuberculosis and taking their medicine.

In the following years, the government developed additional tools in an attempt to overcome challenges presented by distance and terrain. The health station, the lay dispenser, and the “Eskimo medicine chest” were implemented by the early 1960s to supplement care extended by the nursing station program. Health stations were smaller than nursing stations, and were generally used as medical facilities by visiting personnel or as layovers for patients awaiting air transportation to hospitals. Lay dispensers referred patients to an individual—often a missionary, trader, RCMP officer, or teacher—who was given supplies and a radio in order to tend to the health needs of accident victims or common illnesses, and an “Eskimo medicine chest” was a first-aid kit given to Inuit families for their own use.

With Inuit moving to settlements, nursing stations found it easier to diagnose, treat, and follow patients. More airports made it possible to evacuate people south and to return them north. With that said, it is highly feasible that improvements in health services could have been made sooner. When contrasted with the medical services provided to military personnel

in the North, for example, it is obvious that the capacity for improvements existed long before the 1960s and that the delay cannot be solely blamed on distance, transportation, or difficult terrain.

As was normally the case in the history of Qikiqtaaluk, Iqaluit presented a special situation in the region's history. The development of Iqaluit and the establishment of health services there in the form of a hospital and rehabilitation centre brought about a shift in the administrative hub of medical services from St. Luke's in Pangnirtung to Iqaluit.

Requests for a hospital in Iqaluit stretch as far back as the establishment of the INHS in 1946. The primary reason for constructing a hospital at Iqaluit centred on the argument that flying patients to southern hospitals for specialized medical care was harmful to Inuit and their families. In 1951, RCMP Inspector H. A. Larsen suggested that it would be easier for Inuit to be closer to their home environments during treatment. He also argued that it would be less costly for the government, as there was an opportunity to develop pre-existing infrastructure in the settlement using abandoned US Air Force (USAF) buildings. Larson noted that, while functional, the hospital at Pangnirtung was a "disease trap" and "unfit for human habitation." Unfortunately, it would be many more years before such health care facilities were constructed at Iqaluit.

A rehabilitation centre was eventually opened at Apex Hill (in Iqaluit) in 1956, and a hospital opened in 1964. The construction of the two facilities was a response to the rapid development of the region and the rising associated health concerns for Inuit and Qallunaat. The rehabilitation centre accommodated the large number of Inuit returning from southern sanatoria by ship through Iqaluit.

The massive centralization of Inuit at Iqaluit placed strain on the settlement's resources, and by the late 1950s, threatened public health. The threats were largely due to the overcrowding and unsanitary living conditions in the settlement. Despite the fact that the federal Committee on Eskimo Affairs formally acknowledged in 1961 that "the inadequate housing in

which Eskimos were living” was directly tied to high mortality rates and the spread of disease, the government moved relatively slowly to build more houses. Rather, priority was given to the construction of medical facilities, a school, and an apartment building. The lack of response by the government to the housing crisis persisted in tandem with the undisputed recognition of the link between poor housing conditions and very high rates of infant mortality and tuberculosis. It was three years before the government acknowledged the health “disaster” the housing crisis had caused by exacerbating infectious diseases, but even then, new housing arrived slowly.

Eskimo Rehabilitation Centre

As discussed previously, large numbers of Inuit were evacuated each year for treatment in southern hospitals. After treatment, many of these people were sent home with little consideration given for the problems of reintegration into their communities. This created problems for patients when they returned, as many had trouble adapting to the lives they had left behind, often a few years prior to heading south. These problems were well known by the government by the 1950s, and while efforts by government doctors and prominent missionaries to convince the INHS to build sanatorium facilities in the North were not fruitful, the government did try to introduce ways for patients to establish better communication with families while they were being treated. One of these methods was the putting in place of a letter-writing campaign, so that patients could remain in communication with their families.

The problems incurred from the sanatoria program went well beyond an individual’s loss of self-esteem to contribute to the ill health of interpersonal and familial relationships, and those within the broader community. A former young patient wrote while in a sanatoria in the South:

My parents have not written in a long time. They forgot about me. No wonder, they do not love me. They forgot! . . . I am forgotten about by my mother. I am scared now. Whenever I get home, I wonder what my mother and my older sister will be like. They will not love me . . . it is not a wonder I am scared of my fellow Inuit now.

In 1950, an article in *Canada's Health and Welfare* explained that the fear and lack of trust felt upon returning home was mutual, as ex-patients were often looked upon “as foreign, with suspicion.”

In recognition of the need to manage the care and repatriation of Inuit returning from southern sanatoria, Rudnicki convinced the government of the need for an “Eskimo Rehabilitation Centre,” which eventually opened in 1956. The centre was run by the NANR, which was in part convinced of its utility due to the knowledge that 25% of patients brought to sanatoria were readmissions. It was believed that this number and associated costs could be lowered with institutionalized rehabilitation. By the time it opened, Apex Hill had already been transformed into a town site around the Centre, which also operated a number of services for nearby inhabitants, such as a coffee shop, bakery, and movie house.

This was different in concept from transit centres, although one building often served both purposes. Transit centres were facilities set up at points between southern hospitals and Inuit communities in the North. It was felt that the development of a transit centre in Iqaluit, and a few other places, would lower an individual's wait time in the hospital, and thus cut down on costs. Government officials felt that this time could be used “constructively” by Inuit while they stayed and slowly adjusted to life in the North again.

In addition to its primary aim of patient rehabilitation, the centre soon became a facility for dealing with what were regarded as behavioural problems stemming from the rapid development of Iqaluit, and the presence of a large Qallunaat population and associated facilities and opportunities for “getting into trouble.” The social problems associated with the opening of

the rehabilitation centre were characterized by the *Edmonton Journal* as “the most expensive experiment in race rehabilitation ever attempted.”

Many Qikiqtaalungmiut remained in Iqaluit due to their stay in the rehabilitation centre. Jonah Kelly from Iqaluit told the QTC that:

[People] who went for medical in Quebec City and Hamilton . . . had to travel back to their communities by plane . . . Before they went home, they were treated at the Rehab centre . . . Abe Ok-pik used to tell me all these things through his travels through the airline and anyone who could travel on the plane was sent to the rehabilitation centre. That is how some stayed in Iqaluit.

Tuberculosis often resulted in permanent health ailments, making it impossible for some people to return to life on the land, or continue with jobs that required physical labour. Many needed continued physical as well as social or financial support, which kept many living in settlements with close access to health care and/or family allowance distribution. Census notes reveal that many of the centre’s patients were youth and children. As a result of their stay in the centre, many have grown up in Iqaluit when they may have otherwise desired to live elsewhere. Sytukie Joamie from Iqaluit talked to the QTC about his mother’s relocation to Apex for admission to the rehabilitation centre there.

Some people do not have resources and they end up living in Iqaluit and Apex because they had no means to return home. It is in the same picture of any relocatee from any other area. They were dumped for medical reasons or so-called health reasons, when in reality, they themselves, younger generations have endured unhealthy lifestyle because of that. Some people’s healthy lifestyle is not the same. There are a lot of people living today, descendants who are stuck where they may not want to live.

Inuit Women and Health

There was some acknowledgement by health care providers stationed in the Arctic of the gendered nature of the changes facing Inuit during this period, specifically those facing women returning from southern hospitals. An article by Irene Baird published in *The Beaver* discusses the shift in lifestyle that occurred when women made the transition to life in the settlements. Baird offered, “Many of us [Qallunaat women], if the roles were reversed, would spend at least part of our time fighting off (or submitting to) a sense of instability and confusion.” Robert Collins agrees that the changes Inuit women faced were likely quite difficult. He laments that the circumstances of the era had Inuit women doubting their worth. “In illness, in education, in the incessant foraging for food, she used to be essential.” Despite the empathetic tone, Baird and Collins reveal the colonial attitudes directed at women and Inuit culture in general. Baird, referring to Inuit customary pre-contact lifestyles, described the “old days” as “evil” and saw the breakdown of Inuit culture as inevitable. Bob Green, a social worker at the Iqaluit rehabilitation centre, remarked, “[T]his assimilation will not be easy. I am absolutely sure there is no painless way for Eskimos to make the transition.” To assist with the “transition” into the role of housewife, in 1959, the rehabilitation centre at Iqaluit began offering classes to women in cooking, clothes making, childcare, and family economics.

Distribution of Services

Literature produced by the DNHW clearly documents that Inuit who needed health care were told to relocate to areas where nursing stations were available. This was often accompanied by promises of housing, family allowance payments, and other services. Many people testified that when

encouraged to move by a Qallunaat agent, they listened. Unfortunately, as with other enticements used by the government, promises related to health care went unfulfilled. Geosah Uniusargaq told the QTC he originally moved to Iqaluit for health reasons, believing the promises that Inuit “would not be deprived of anything,” and that they “would receive cheques every month.” In this case no cheques were received.

The concentration of Inuit in settlements, the establishment of nursing stations in the region, and the building of a hospital at Iqaluit in 1964 lessened the demand for EAP services. Historian C. S. Mackinnon attributes government institutional momentum to the continuation of the EAP and its medical services in the 1960s. Over the years, the number of beds on board was increased from twelve to thirty-six, interpreters and nursing assistants were added to the staff, and racial segregation was ended. With the majority of people living in fixed settlements, and significant developments in air transportation in the Arctic allowing for easier and more efficient access to remote areas, the EAP’s final charter was completed in 1969.

While centralization had obvious benefits for the administration of health care, the increase in concentration of Inuit migrating to sites overwhelmed resources. When DEW Line construction ended, there were about five hundred Inuit living at Iqaluit, half of this number living in homes supplied by the government in Apex and the other half living in a beach community east of the airstrip, for the most part in shack housing built from discarded military waste materials. Concerns began to arise over the conditions of Inuit families living near the bases and the potential impacts on health. Based on his observations and extensive interviews with Inuit, Frank Tester told the QTC that the shack housing being constructed from the waste materials of DEW Line stations and other military activities was “grossly inadequate for both the climate and culture . . . They were a disaster for human health.” The case of Iqaluit, the location of an American air base and hub of related activity, is perhaps the most glaring example of the sort of public health concerns that accompanied the concentration of families

near bases and defence stations. Increased alcohol consumption, conflict between Qallunaat and Inuit, and poor housing and diet are a few of the related consequences, which defined the following decades.

In the end, the government continued to depend on the little service available for providing care to Inuit well into the 1970s, often citing the lack of developed transportation infrastructure and communication capabilities as the reason for the discrepancy in care between northern and southern Canada.

Nunalinnguqtitauliqtiluta

CHANGING NATURE OF RISK FACTORS

Through the dominance of much of the political, social, and economic aspects of Qikiqtaaluk life, all aspects of health and well-being were touched by non-Inuit administration, culture, and expectations. In light of this, a discussion of risk factors is necessarily complex. This era was characterized by shifts in mortality rates as medical epidemics became less common, and by an increase in health problems stemming from colonial policies, socio-economic realities in settlement life, and the effects of modernity. Mental health problems grew both in number and character, and common health issues persisted.

By the 1960s, tuberculosis was no longer a primary cause of death. By the end of the decade, mortality rates were more likely to be due to accident, injury, or violence than disease. This shift speaks in part to the efficacy of the government's overall approach to containing epidemics but also about the impact of decades of policies of assimilation with regards to social organization, culture, and mental health. The socio-economic realities of the time exacerbated health concerns. R. Quinn Duffy, author of *Road to*

Nunavut, refers to a study undertaken in 1958 by the University of Alberta and the DNHW that found “low family income, alcohol, and poor housing, water supply, sewage, nutrition, and education” factored more prominently in infant death rates than circumstances surrounding the provision of medical services. Infants in particular succumbed to disease rapidly, especially in circumstances where parents were also sick and unable to provide the required care.

Accidents, injuries, and violence remained the main cause of death through the 1960s and into the 1970s and included suicide, drowning, crib death, gunshot wounds, asphyxia, motor vehicle accidents, falling through the ice, and homicide. It is estimated that alcohol was associated with 40 to 50% of the incidents. It is worth noting that drugs were not prevalent during this period. In the decades between 1950 and 1970, alcohol consumption had increased among Inuit populations as a result of contact with Qallunaat and colonial policies, giving way to cycles of abuse and self-harm. Alcohol was often mentioned in the QTC and QIA testimonies. Jeetaloo Kakee told the QTC:

After the people got together in Pang, the adults were not looking at the children. The older children were looking for the younger children. They gambled and drank because they got too many people together in one place. The alcohol in 1965 started coming and it didn't come from the Inuit. The Pang social worker planned for alcohol for Christmas, this is when it started pouring in.

Martha Idlout also spoke to the QTC about the impact that alcohol had on her and her family. When asked about her parents' experience with alcohol, Martha responded, “I begged them not to go drinking. Other people were controlling their lives. [My parents] were nice people. They did what other people told them to.” In the community, she recalled, “I guess not too many people had too much food because people were falling into

alcoholism . . . There was a bar here too, military too. The whole time they would get drunk and us children would have to find a place to stay . . . we would be ignored.” Child neglect, sexual abuse, and domestic violence were often directly related to binge and persistent drinking, and to the trauma experienced by the children of drinkers, some of whom became alcoholics themselves. In spite of this, some testimonies reflected a sense of resiliency in the face of this cycle of abuse and dependence. Martha also talked about the changes that she wanted to make for the sake of her grandchildren:

The past has an impact on our lives, some is bad and some is good . . . Everyone was hurting inside, not living as they should. People were growing up with a lot of pain. I don’t want my grandchildren to grow up with that kind of pain and end up like us. We know that we took all the substances, alcohol and drugs because of our pain . . . No one wants to go back to those days, no not at all.

Other people told the QTC that alcohol had not been a significant concern in their communities. Levi Evic told the QTC about life in Pangnirtung in the 1960s. He recalled, “We would occasionally see drunk people but not very many . . . They were not in high number but we used to see drunk people on the street passed out, on the ground.”

At the same time, an increase in sexually transmitted infections during this period was viewed by the government as being a social problem associated with “the excessive use of alcohol” and degradation of “morals.” Medical practitioners, on the other hand, were of the opinion that STIs existed primarily among youth, and despite the government’s claim that infection was linked to alcohol consumption, rates in the North were not exceeding the rates reported in the South. Despite the conflicting views, in 1965, the rate of contracted gonorrhoea was legitimately quite high, reporting as just over two thousand five hundred per one hundred thousand people in the Northwest Territories alone in 1965. This was in comparison

to approximately one hundred per one hundred thousand in Canada. By 1971, in Qikiqtaaluk, the rate rose to over five thousand per one hundred thousand. The figure for the rest of Canada increased only to two hundred per one hundred thousand. While syphilis was also present, there are no indications of serious outbreaks during the 1960–1970 period.

While major epidemics diminished, incidences of cold and flu persisted through this period. Eye diseases were also quite common, as were skin diseases and conditions such as eczema, boils, impetigo, lice, and scabies. In the book *Saqiyuk*, Apphia Agalakti Awa recalled traditional treatments for skin infections:

At that time people used to get big boils inside their skin. You would put a lemming skin on top to get the boil out. If there was tobacco around, we would use the tobacco pouch . . . the boils wouldn't always burst by themselves. They would have to be cut to get the pus out . . . that was our way of doing medicine.

Government policies that on the surface had little to do with health at times also affected the care and well-being of Inuit. Many families were told that their children had to attend school, and in many cases, this meant that they had to leave their homes. For some families, this meant that children were no longer able to help care for ailing family members or help out around the home. Leah Otak spoke about being forced to attend school. “We left our mother despite her condition—she was disabled—even though we would have helped her in her many tasks, but we were forced to attend school.”

NUTRITION, FOOD SECURITY, AND DIET

Due to a number of factors, Inuit relationship to food was in great transition throughout the period of 1945–75. As a result of sustained Qallunaat

contact, access to food changed, hunting patterns were affected, and transformations in diet and the nutritional content had major effects on the health and well-being of individuals. Rhoda Kokiapik, who was born near Igloodik in 1931, explains the sort of customary roles that food played in Inuit society:

My ancestors hunted with their own tools, made of stone and animal bone. Pots, oil lamps, and needles were also made of animal bones and stone. For weeks Inuit hunted in hopes of finding game. Sometimes they would come home with no luck. Some days my ancestors drank only melted snow to stave off their hunger. But, if they were in luck, they ate what they caught and shared the meat with other people in their group. Back then Inuit wore clothing made from caribou skin, fox fur, and seal skin. If an animal was killed, nothing was wasted. Inuit ate the meat, made clothing from the skin, and tools from the bone.

When most Inuit lived in ilagiit nunagivaktangit and hunted regularly, their diet “ranged from game to marine mammals . . . supplemented by a variety of land and sea vegetables, such as berries, willow buds, herbs, and some roots.” It centred on the ingestion of meat and fat, consumed raw, frozen, or aged, and understood to be nutritionally complete. It had been long known, and evidenced in 1944 by a nutrition services report, that Inuit who lived long distances from trading posts were healthier than those living in settlements, due to their sustenance on a country food diet. Throughout the 1940s, the link between poor nutrition and morbidity grew clearer. By 1948, as more Inuit were beginning to live in settlements where they purchased Qallunaat food, some nurses expressed concern about nutrition.

The transition from a diet consisting mainly of country food to that of imported southern food was helped along by rather naive presumptions about health and diet within the visiting medical community. Literature

produced during this period often said that meat-rich diets lead to vitamin deficiencies, which would, in turn, lead to a “weakness to germs.” Inuit were compelled to accept heavily processed and sugary Qallunaat foods, such as white flour, tea, sugar, and biscuits through relief programs. Family allowance payments were traded at HBC stores for certain foods, and trapping income was used to purchase food at the stores. Inuit were also unable to hunt country food regularly, and were thus drawn in by the convenient availability of store-purchased food. These means by which Inuit became accustomed to Qallunaat food left many communities vulnerable to fluctuations in availability and costs of food at HBC stores, and the prices of furs, which greatly declined following the Second World War. Living in settlements, as well as steady employment and regular school hours, reduced the time available for hunting.

Inuit were discouraged from customary practices related to food, diet, and food security. Dr. G. E. Gaulton, working in Pangnirtung, displayed an all-too-common assumption that Inuit needed to be coached to eat properly, in spite of centuries of living successfully by hunting: “[T]he fact that most of the deaths occur at the poor camps show that nutrition plays a very important part . . . Camp sanitation is very bad. This, of course, is a matter of education, as is also the proper feeding of children.” Inuit women were dissuaded from breastfeeding, for instance, and encouraged to use baby formula. The payment of family allowances often came in the form of items deemed by the Government to nutritionally benefit the children. The authorized list included canned milk, Pablum, cereals, egg powder, flour, and sugar. As R. Quinn Duffy explained, medical research has uncovered that through the late 1940s and the early 1950s, death of children due to infectious diseases, such as tuberculosis, actually increased. A reduction in the proportion of mothers breastfeeding (as in the rest of Canada), due to access to promoted store-bought items, resulted in markedly higher infant mortality. Although it has decreased substantially since the 1950s, the rate remains about five times higher than the Canadian average.

The issue of food poisoning is another example of government interference in nutrition. This had always been a concern for Inuit. David Kalluk from Arctic Bay told the QTC, “A lot of people got sick after eating contaminated walrus, people were dying from food poisoning. If the seal was not healthy, if you eat a sick animal, that is what apparently happened.” In disregard for customary practices regarding Inuit handling of this issue, nurses created public health campaigns that dictated how they should handle related problems. Nurses tackled botulism in part through the distribution of a letter, drafted in 1971, cautioning Cape Dorset residents against leaving dead seals on the beach.

Access to animals from communities was always an issue. The killing of qimmiit had an impact as well. Shorty Shoo told the QTC, “When there were no more dogs and there was no snowmobiles introduced yet, we would get hungry. I wasn’t the only one, but as a family we would crave to eat.” Solomonie Qiyutaq in Pangnirtung talked to the QTC about her experience with changes in food security.

Dogs were an important source for providing food...we would use the dogs to travel long distances to hunt caribou or seals inland or on sea ice... It seemed as though I became disabled with no transportation available for subsistence hunting. After my dogs got killed, we stopped hunting altogether and stopped consuming seal meat and only ate store-bought foods that was provided, especially during the winter months... We struggled to survive and seal meat was not part of our diets after the dogs were gone, we only survived on luncheon meat that was provided for us.

The transitions to Qallunaat food also had serious implications for dental health. Dr. Curson, a dentist who pioneered a topical fluoride program in 1950, was astonished at the amount of tooth decay among young children, noting, “Today I see children of four who need every tooth in their head

extracted.” He attributes this to a practice whereby mothers add sweetener to milk bottles for their children to suck from for eight or nine hours a day, a practice he also saw in Britain. Prior to the introduction of a Qallunaat diet, however, his study of one hundred and sixty Inuit skulls at a British museum uncovered only seven cavities, and no missing teeth.

Arguments about the superiority of imported foods over Inuit diets disappeared rather quickly. In 1941, a medical officer at Pangnirtung, Dr. J.A. Bildfell, wrote that “native foods alone” protected Inuit “from any dangers of starvation.” He described the quality of imported foods as “very unsatisfactory,” adding that these foods did harm when they were not supplemented by country food. During the 1970s, increased co-operation between intergovernmental bodies and other stakeholders led to a coherent and widely distributed set of infant nutrition guidelines, put in use by those responsible for the delivery of community health programs. Along with better living conditions and improved medical services, a renewed emphasis on the importance of breastfeeding was considered to be an important factor in the reduction of the infant mortality rate, which still remained very high.

The motivation to assimilate Inuit populations informed and coloured many of the policies surrounding nutrition, as did matters of administrative convenience. According to Duffy, the administration was long aware of the negative effects that imported foods were having on Inuit health, although little attention was paid to determining which foods were causing the problem. As well, the prospect of receiving imported foods when the EAP docked each year drew Inuit into the settlements to work on the supply ship, and according to RCMP officer Major McKeand, if imported foods were no longer distributed, at this point “some substitute or other form of entertainment would have to be provided otherwise the independence of the natives would assert itself and many would refuse to come to the settlement. In this event discharge of the ship would be seriously hampered.” The government did nothing substantial by way of policy changes and by 1971,

90% of Inuit were living in communities where the source of food was the local supermarket.

An important relationship exists between epidemics, social issues, and food security. Government correspondence reveals that it recognized that epidemics left Inuit vulnerable to “mental and physical depression.” The toll that high death rates took went further than individual physical suffering, to a wider impact on the families and communities, which had intergenerational consequences. Relocation of family members often occurred as a result of a death in the family, and many were unprepared for trapping season, or were not caching food in the fall. Relief offered by the government was then often a means of feeding the family.

The concentration of Inuit into settlements and the increased capacity for surveillance made it easier for government and independent Qallunaat researchers to undertake their work on and among Inuit populations. The 1960s and early 1970s were in fact marked by what Helle Moller referred to as “extensive” biomedical examinations.

Rhoda Katsak recalls Qallunaat researchers visiting Pond Inlet in 1972 to transplant skin grafts from children’s arms to those of their siblings:

In Igloolik there was lots of research going on about the “Eskimo.” There was study after study about us . . . It was like they couldn’t get enough! Sometimes I wonder why people agreed all the time when they didn’t want to. I guess what it comes down to is that Qallunaat have always been the people with authority . . . the grafts didn’t heal into my skin. Jake’s and Oopah’s skin fell off, and the holes healed over . . . I have had the scars ever since.

Research for the QTC did not reveal more context about the reasons why specific experiments were done or the number of people affected.

MENTAL HEALTH

The period covered in this report saw widespread transformation in mental health. It is theorized that this was due to the various impacts from socio-economic changes brought about by policies of assimilation, sustained contact with non-Inuit, and treatment practices of shipping patients to southern hospitals. A form of mental illness referred to as “pibloktoq” is said to have already been prevalent in many parts of the Arctic. This condition involved convulsive behaviour, such as seizures, and was occasionally followed by amnesia or in rare cases symptoms of conversion, a disorder where psychological stress is expressed physically. According to Frank Vallee, author of a study on Inuit theories of mental health, conditions of mental illness other than “pibloktoq,” including manic depression or self-directed aggression, were rare or non-existent among Inuit prior to sustained Qallunaat contact.

For historian and social worker Frank Tester, the rise of social problems in the 1970s was linked to a rise in mental illness. He explained to the QTC that, from his experience as a social worker in the Arctic, “mental health is cultural health,” and that when “people were in charge of their own lives . . . people were much better off.” Several people testified to the QTC about the existence of mental illness among their family members. Often it was attributed to the inability to take charge of their own lives, poor nutrition, the lack of ability to participate in important cultural practices like hunting, and feelings of worthlessness, often resulting from assimilationist policies and the consequences of government decision-making.

Many of the above triggers were often caused by the loss of one’s qimmiit. Beginning in the 1950s, and continuing through the 1960s and in some cases into the 1970s, many Qikiqtaalungmiut reported their qimmiit being shot by RCMP and other Qallunaat agents. These shootings were often associated, in part, with the Ordinance Respecting Dogs, which required qimmiit be tied up at all times within settlements. Qimmiit had long held an

important role in Inuit culture and day-to-day life. Their destruction often left Inuit to have feelings of terrible loss and helplessness as they were, for a time, a person's only means of transportation. Many Qikiqtaalungmiut spoke at length with the QTC and QIA about how the loss of qimmiit impacted their lives. Laimiki Innuaq explained how he felt after his qimmiit were killed: "I am never satisfied with things. I started noticing, 'Why do I look for things all the time?' I realized that it was from losing my dogs. It impacted me psychologically to such a degree that I became psychologically disturbed."

Many people also spoke about the pain of watching a family member suffer after their qimmiit were killed. Alicee Joamie remembered:

We could hear the moaning and growling of the dogs . . . I was trying to soothe my husband. I wondered, "How am I going to help my husband?" He was quiet for such a long time. He held the whip in his hand for the longest time. He was gripping the whip so much that his knuckles turned white . . . My in-law had to take care of my kids because my husband was moving around. I was trying to soothe him. I didn't know how to care for him or how to make him feel better. He almost uttered things to me but he shut his mouth before he said anything . . . My son cried for the longest time because his father was the most important person to him.

Memories such as this were so traumatic for Alicee, as for many Inuit, that she noted, "It was only when I started going to healing groups that I started to get these memories back."

For many people, schooling also played an important role in poor mental health. The removal of children from their families and homes had a tremendously negative impact on both the individuals who attended schools and their families. Thomas Kublu described the impact on his siblings of receiving a Qallunaat education as "poison." He explained:

My younger brother Paul Quuliit attended the residential school in Chesterfield Inlet from 1955 for three years until 1958. He forgot the family values, Inuit culture, and family ties and responsibilities in the family system. He was a stranger by then. He was detached and had no sense of family or Inuit values . . . He no longer had a clear identity or a sense of belonging. Being caught up in the two cultures, neither of which he was comfortable in or could call his own, he became an alcoholic. He died of a massive heart attack in September 1987 . . . The three younger ones went through the educational system and the colonizers' attempts to kill the Inuk in them and make them like the Qallunaat was too difficult for them emotionally, mentally and spiritually. Physical illnesses in the end killed them when they too should have enjoyed living longer, like me. I would be alive with them today had they not been forced into the school system . . . I regret that my younger siblings died so early in life; the educational system killed them.

In addition to the effects of loss of language and identification with Inuit culture and values, the trauma of having been a victim of physical and sexual abuse at the schools also had implications for health, self-esteem, and well-being well into adulthood. Many Qikiqtaalungmiut told the QTC about the abuse they experienced while attending school and the effects it had and still has on them. Annie Shappa explained how the abuse children suffered often affected their intimate relationships. She shared the following:

I can say for a fact that when we were young teenagers and we moved to Arctic Bay, those students were sexually and physically abused. It became a fact of life. It was part of that system in the community . . . Those of us who had husbands, those who were abused at residential schools, were not the only ones affected because of our experience. It seems as though they forgot about us

and disregarded us. Those of us who experienced that abuse . . . I don't know if it was because of us that it happened.

Certain health care policies contributed to the increased incidence of mental illness. As mentioned earlier in this report, the large numbers of Inuit who were sent south to be treated for tuberculosis in sanatoria often suffered in ways unrelated to tuberculosis. Culture shock and homesickness left individuals feeling isolated and confused about identity, and communication between family members was often strained or non-existent. Mental health was affected in the sanatoria, and the strain on individuals when reintroduced to their home communities also affected their well-being.

Inuit suicide is closely linked with the problems discussed in this section. When considered in light of corresponding trends and within historical context, like mental health overall, Inuit suicide throughout this period has its roots in colonialism and the effects of aggressive assimilationist and paternalistic policies. Tester and McNicoll demonstrate this by pointing out the marked decline in suicide rates during the period covering the move to settlements, where there was initial and sudden access to medical care and comforts such as electricity, water, and housing. A survey of seventy-nine Inuit conducted by John J. and Irma Honigmann in Iqaluit in 1963 revealed that “with few exceptions, informants who answered said they were content.”

Over time, however, the initial sense of opportunity and community associated with settlement life dampened with the children leaving to go to school, the slaughter of qimmiit, the gradual loss of relative autonomy, and the constant surveillance of settlement life. Honigmann and Honigmann put it:

True, parents, camp leaders with authority, and strong shamans exerted some power, but there was nothing like the subordination of nine hundred people to the laws of Canada and the Northwest

Territories and to the power exerted by administrators, doctors, school principals, police, and traders. The Eskimos today must perform to meet relatively “foreign” standards. They must satisfy people whose values often diverge radically from their own. An Eskimo’s happiness depends on such performance. He may hunt game birds only in season, must send his children to school, must go to the hospital if he is tubercular, must control himself from drunkenness, dare not trespass on forbidden property, must report for work on time, may use his car only with due propriety, etc.

In the 1970s, suicide rates in the Eastern Arctic greatly surpassed those of the national average. Tester and McNicoll also believe that the manner in which historical experiences of shame, abuse, and anger as a result of colonial practices and policies have been communicated through generations of Inuit have led to internalization of emotions, fostering the potential for self-harm.

IQALUIT

The doors of the new hospital at Iqaluit, with the current institutional name of Qikiqtani Hospital, opened in November 1964. It had twenty adult beds, eight children’s beds, an operating suite, a maternity and nursing station, an outpatient department, an X-ray unit, a dispensary, a dental suite, and a public health lecture and demonstration area. It was staffed by a small number of doctors, nurses, visiting specialists, and a few rotating residents from the Montréal General Hospital and the Montréal Children’s Hospital. McGill University allowed medical staff to undertake research in Iqaluit on general health issues and on topics more specific to Inuit, such as respiratory diseases. One chronic disease resulting from repeated exposure to cold air became commonly known as “Eskimo lung.”

INHS director Dr. Moore had been reluctant for years to sign off on the construction of the hospital at Iqaluit for practical and budgetary reasons, but also because he felt staffing the hospital would pose a challenge. In reality, finding doctors to work at the hospital did not prove nearly as difficult. Rather, other staffing issues, such as dissension, resignations, and in-fighting between coworkers caused the most problems. It seems the problems stemmed from poor administration, and, in at least two cases, frustration with the inconsistent delivery of health care to Inuit in Qikiqtaaluk. Two physicians wrote in their resignation letter:

We were ostensibly hired to provide medical care for the [Baffin] Zone; however, in fact, continuous medical care was provided only to the inhabitants of Frobisher Bay. The remainder of the population would see a doctor only when critically ill or when visiting the *C.D. Howe*. Each year the *C.D. Howe* was staffed by different physicians, and each year it passed by some of the settlements.

Responsibility for delivering medical services in Qikiqtaaluk was beyond the resources of one hospital alone. Even before the EAP was cancelled in 1969, some communities never saw a doctor from one year to the next. Proposals for improvement were regularly sent to Ottawa, but were always rejected. This resulted in constant frustration among medical staff in Iqaluit.

The growing importance of Iqaluit for health services had impacts elsewhere, especially in Pangnirtung. In 1972, the Anglican Church abruptly closed St. Luke's Hospital in Pangnirtung to the surprise of the government. The hospital had largely become a treatment facility for tuberculosis patients, and since incidences of infection had declined, the per-patient costs had increased greatly. In its place, a temporary nursing station was constructed by INHS to service the needs of the seven hundred Inuit in the area who were left without a local medical facility—a permanent station was only planned for 1975.

By the early 1970s, Canada's Eastern Arctic was experiencing a dramatic increase in population. According to medical practitioners working in the area, Inuit had the highest birth rate in the world, three times higher than in southern Canada, in 1971. In the smaller communities, Inuit midwives were still delivering 70% of babies. In response to a questionnaire distributed to Inuit that included questions on the topic of childbirth, an unknown respondent stated with regard to childbirth, "Some Eskimo women come [and] help. Usually women. Maybe wife's mother, husband's mother, and friends." Another respondent points out, "Certain women do better than others. Usually the older ones ... But if it is a difficult birth they ... call a doctor." A third respondent indicates that the "husband tells people of birth of baby ... they tell police of the birth of the baby five days afterwards." In the mid-1970s women were sent to southern hospitals for delivery, sometimes for the last six weeks of their pregnancies. Only later would this role pass to the hospital at Iqaluit.

The RCMP raised concerns over the availability of birth control, and during the NWT Council Debates session in 1970, Dr. Barber presented a motion that was carried concerning family planning in the North. The motion stated that current employment opportunities and resources were incapable of sustaining the population if it continued to grow as it was. Action was required in order to develop appropriate family-planning education and "devices." Dr. Barber continued to press the NWT Commissioner in June 1969 and January 1970 regarding the government's progress on the matter. The Commissioner responded by referring to the existing birth control information available at health centres across the NWT. He simply offered that any new development would be a lot of "hard work," and that the matter is under review.

The history of access to birth control in the North is complicated by the experiences of women who were convinced or forced to undergo sterilization. Roman Catholic priests called attention to the issue, which received national coverage. Father Lechat estimated that 23% of women in Igloolik

had been sterilized; nationally, the Minister of National Health and Welfare said that four hundred and seventy Inuit and Aboriginal women had been sterilized in 1972 alone. Similar procedures also occurred at the hospital at Iqaluit, in addition to male vasectomies. Barry Gunn, a former regional administrator in Iqaluit, claimed women agreed to the sterilization procedures and signed forms to that effect. However, due to language issues, they may not have realized what they were agreeing to. Medical personnel have argued that the policy was not rooted in malice and the women were not forced. Discussions about birth control and the reports of sterilization were revealing about Qallunaat and government attitudes towards the role and future of Inuit. J. R. Lotz, who had worked for the NANR, wrote an article in 1968 about “northern development” that set out in stark terms the way in which racial factors influenced policy. He wrote:

Despite the demand by the government for people to go north and develop the area, the same government manages to give the impression that there are too many Eskimos and Indians. At their Spring 1968 Session, the Council of the Northwest Territories noted high infant mortality in the North, squalid living conditions, reduced health services, and came up with the inevitable statement that birth control services were needed. If Eskimo women keep losing children—a source of wealth and comfort to them—then no amount of propaganda about birth control will convince them of the need to keep the population down. The Northwest Territories showed a curious paradox in 1968—all the official talk was of boom and economic expansion and the need for labour in the North, whereas the Territorial Council endeavoured to keep the native people from reproducing.

The analysis hit many points, including the reality that medicine, just like economics, religion, and art, is a product of culture as well as science.

Conclusion

Canada’s national Inuit organization, Inuit Tapiriit Kanatami (ITK), believes that “health and the environment are interconnected and a holistic approach is essential to Inuit well-being.” The history of health services and experiences in Qikiqtaaluk in the 1950–75 period demonstrates that institutional approaches pursued by government rarely, if ever, considered the value of the “Inuit model,” as described by George Wenzel in 1981, in which illness was always to be connected to social and environmental relationships.

The nurses, doctors, and dentists who delivered medical services on behalf of government focused on treating Inuit bodies alone, albeit with some references to the impact of poor nutrition, housing, and sanitation. Inuit themselves, as well as medical practitioners, sought options that could bridge the gap between the desire to have access to new medical treatments that were only available through professional staff and facilities and their need to sustain cultural values that placed great emphasis on individual choice and on maintaining family relationships. They faced a bureaucracy that could not or would not establish a forum where fulsome discussions about health could take place. One of the first tasks of the new Northern Health Services branch in 1954, for example, was to meet with other bureaucrats to sort out funding responsibilities, not to understand health issues.

Generally, bureaucrats, even more than politicians, evoked images of a remote, isolated, and indomitable Arctic landscape in which language and cultural barriers were too high to allow the delivery of appropriate medical services. They also tended to ignore the impact of poverty on health even though it was often at the root of the problems they were paid to address. In 1951, Inspector Henry Larsen of the RCMP estimated that the value of a month’s family allowance for a child in an Arctic community would only cover two or three days’ worth of food for that child. Bureaucrats often

blamed the HBC for limiting food options in settlements, but offering better food could only make sense if it was affordable.

Over the period of study, medical practitioners in the region increasingly tried to refocus government efforts from the fear of contagion, especially tuberculosis, to even more serious issues. As one example, physician John S. Willis pointed out in 1959 that tuberculosis rates were dropping, but that statistics from 1957 showed that 23% of all Inuit infants died before they reached the age of one year; the figure for the rest of Canada was only 3%. Very few people, including the medical community, were impressed with the results of the health programs in Canada's eastern Arctic. In 1967, a year when Canada was celebrating its achievements, a leading bureaucrat, Gordon Robertson, wrote: "We could take no pride ten years ago at the condition of most of the people of the North, and we can take little now, despite the efforts that have been made."

This dramatic difference in mortality rates has persisted to the present day and was always visible to Inuit when they looked at the Qallunaat in their midst. As a result, health care remains a very serious issue in Qikiqtaaluk. Of particular importance are high suicide and violent death rates, as well as infant mortality rates.

John D. O'Neil, the author of a health study conducted in 1985 in the Keewatin District, almost two decades after most Inuit had moved from the land into settlements, found that Inuit were "ambivalent" about medical institutions and their dependence on nursing stations. They found their encounters to be "stressful and humiliating." Even the nurses and doctors "expressed comparable sentiments." Typically, medical staff were frustrated at being unable to communicate, especially when so many people who went north were "instilled with egalitarian ideals and cross-cultural interests." Patients objectified them as The Nurse or The Doctor and they were very discouraged by the "inertia of the medical system." He concluded that cross-cultural understanding was not enough; decolonization was required

whereby Inuit would have more or complete control over the medical system in their communities.

The complexity of the history of health services in Qikiqtaaluk is clear in the words of Mary Iqaluk, as told to the QTC in Sanikiluaq:

I was moved to Hamilton because I had tuberculosis. It was hard to understand their language at first. We were being assisted very well. I remember one person who was not doing so well. They had to send him back here for a while because he really needed to come back. I had been using headphones just before we ate and the nurse hit me because I had not been prepared just before meal time. I was young and that was a bad experience for me in some areas but I am very grateful that they helped us get better. I remember some of the patients down there with me being sent away. They said they would come back sometime but I don't recall them coming back so those are just some main things that are imprinted in my mind.

Like those of so many people who spoke to the QTC, Mary Iqaluk's words acknowledge that Inuit appreciated that there were people—doctors, nurses, and police—who repaired broken bones, healed damaged lungs, and saved children's lives, even though government institutions and rules could have been more responsive and helpful to Inuit.

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For many years, Inuit Elders in the Qikiqtani (Baffin) region have been haunted by a deep sense of loss as they remember how their lives changed in the decades after 1950.

The thematic reports and special studies in this collection explore themes that emerged during the work of the Qikiqtani Truth Commission. What started as an inquiry into the slaughter of sled dogs quickly grew to include other experiences of profound colonial change.

Commissioned by the Qikiqtani Inuit Association, this book and the companion volume of community histories weave together testimonies and documents collected during the Qikiqtani Truth Commission in the hopes of achieving Saimaqatagiiniq, peace between past opponents.

