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We must also thank Memorial University of Newfoundland and Dalhousie University who willingly allowed Dr. Debbie Martin and Dr. James Valcour to work on this exciting community-based health research project. This research project has been a great example of how communities and universities can work together.

We would like to acknowledge the foresight of Darlene Wall who identified the need to learn more about the health needs of the Inuit people of southeastern Labrador. Her tenacity, proposal writing skills and leadership were crucial to this project through each phase. Melita Paul was a key contributor in helping the research team connect with community members and develop an understanding of, and appreciation for, the communities along the southeast coast of Labrador.
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The opinions expressed in this publication are those of the authors and do not necessarily reflect the views of the NunatuKavut Community Council Inc., Health Canada’s First Nations and Inuit Health Branch, nor the Government of Newfoundland and Labrador’s Department of Health and Community Services.

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NunatuKavut Community Health Needs Assessment, February 2012

Produced by Dr. Debbie Martin, Dr. James Valcour, Julie Bull, John Graham, Melita Paul and Darlene Wall for the NunatuKavut Community Council Inc., Labrador

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February 2012
Health incorporates the well-being of everyone at physical, mental, spiritual and social levels. Our people have always faced unique challenges in seeking a balance between each of these elements.

The goal of this community health needs assessment is to describe the health of the local people, identify factors that are influencing health, and identify appropriate actions. Our purpose is to begin to understand the complex interplay of factors that are influencing the health of the people of the southeast coast of Labrador, and to identify ways to address gaps in health and health-related services and resources.

I congratulate all those who participated and contributed to making this project a resounding and a lasting success. It went far beyond expectations, and has become a model and benchmark for any group in Canada wishing to undertake a similar project.

This endeavor is also an excellent example of tripartite (three way) cooperation between the Government of Canada, the Government of Newfoundland and Labrador, and NunatuKavut. Both the federal and provincial governments recognized the need to assess health within the Aboriginal population of NunatuKavut, and took the appropriate steps to finance and guide the project. All parties came together with the goal of helping to construct a better Canada. We anticipate that these governments, who helped to bring us this far, will continue this good work in the future. I would also like to acknowledge the cooperation between NunatuKavut, Memorial University of Newfoundland, and Dalhousie University. All of these groups collaborated to shape a very novel and timely research project.

It is our hope that in the not-too-distant future, we will cooperate to implement “a cure” for our health-related challenges along the southeast coast of Labrador. I feel optimistic that many of the recommendations put forward in this report will bring about action through continued collaboration between NunatuKavut and the various agencies that helped bring this project to fruition. The work of our people in this needs assessment, including our partners from outside of the community, and the recognition of both levels of government makes me proud to be a NunatuKavut Canadian.

Sincerely,

Chris Montague
President
Long before Europeans set foot in Labrador, our ancestors lived in this land. Our ancestors called the large island next to this land Callanosiklik or ‘the land being occupied by Europeans’. Temporary visits to our land (Nuna) by whalers and fishermen in their Omiackinuacs, and other travellers, started in the middle centuries of the last millennium. A small number of European men settled amongst us, married our kin and learned our customs and ways. We are also descended from some of them, and they too are ancestors. We sometimes now describe ourselves as Inuit-Metis and are an adapted Inuit population of south-central Labrador. This is our Nuna. All of our ancestors are buried in this Nuna.

Authorities outside of our own people did not establish control over Labrador until the last decades of the 1900s. Our people maintained our traditional ways of life and we knew who our people were. Our way of life sustained us, and our sense of identity made us proud. Our traditions resonate with the ways of our Elders. Our respect for the environment, the sharing of our harvest, our knowledge of traditional medicines, our care for each other, our own traditional customs and laws – these things we inherited from our Aboriginal ancestors.

Our people have relied upon the resources of this land from time immemorial. Fish, sea mammals, birds, caribou, forests, minerals and other natural things form an integral way of life for us. Whether inland, on the coasts, or at sea, our people are in their traditional territory, and the ways of the land are key to our existence. Even with today’s globalization, we prefer to eat the bounties of the land, rather than imported foods with all they bring, and we prefer to teach our children in traditional ways.

As Aboriginal people, we hold the collective good above that of the individual, for only through the collective can future generations share in our bounty. Without the collective, we could not have survived since time immemorial in Labrador’s harsh, yet ever beautiful, climate and environment. It is the collective good which has sustained us through time.

We respect our Elders. They are the ones who have kept our history alive, in their faces and in their stories. It is they who have kept our life ways and our land safe for a new generation. We have always welcomed outsiders to NunatuKavut. However, our sense of identity as Inuit-Metis within the Canadian family cannot lessen our deep longing for the soul of our grandmothers’ songs or the beat of our uncles’ drums.

This report has captured many of our community health needs and we look forward to working across all sectors and levels of government and community to begin to address these needs.

If you have any questions or concerns regarding this report or the NunatuKavut AHTF Project, please contact Darlene at 709-896-0592, Ext. 2238 or by email at dwall@nunatukavut.ca or Melita at 709-949-0292 or mpaul@nunatukavut.ca.

Sincerely,

Darlene Wall
Health & Social Sector Manager

Melita Paul
AHTF Project Co-ordinator
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Background

In 2004 the federal government launched a new five-year initiative called the Aboriginal Health Transition Fund (AHTF). This initiative provided funding (referred to as envelopes) to provincial and territorial governments and to First Nations, Inuit and Métis organizations in three areas:

1. Integration - to support First Nations and Inuit communities to improve the coordination and integration between provincial and territorial health systems and the health systems within First Nations and Inuit communities;

2. Adaptation - to support provincial and territorial governments to adapt their existing health programs to the unique needs of Aboriginal peoples, including those in urban and Métis settlements and communities; and
3. **Pan-Canadian** - to support cross-jurisdictional integration and adaptation initiatives for First Nations, Inuit and Métis communities, and to support capacity funding to national Aboriginal organizations, workshops, evaluation activities, and overall administration of the AHTF.

The Province of Newfoundland and Labrador applied under the Adaptation Envelope and received $992,151. The Province sent out a request for research proposals from community groups and organizations interested in using a portion of this money to undertake a research study relating to the mandate of the Adaptation Envelope. In July of 2008 NunatuKavut submitted a proposal, led by Darlene Wall, to conduct a community health needs assessment. The project was entitled “Labrador Metis Nation: Health Research Project: Determining the Need – Educating the Stakeholder”. In January of 2009 NunatuKavut received notice that their proposal was approved for funding.

NunatuKavut hired a project coordinator (Melita Paul) and in March of 2009 a steering committee was established with representatives from NunatuKavut, Labrador-Grenfell Health, Newfoundland and Labrador Department of Health and Community Services, Labrador Friendship Centre, Southern Labrador Family Centre, Memorial University, and Violence Prevention Labrador. In the summer of 2009, a research team was assembled that included two

Rainbow in Lodge Bay. Courtesy of Leila Coates.
health researchers, one from Dalhousie University (Debbie Martin) and one from Memorial University (James Valcour), a PhD student from the University of New Brunswick (Julie Bull), representatives from NunatuKavut (Darlene Wall and Melita Paul), and the project manager (John Graham). The research team was tasked with the development, implementation, analysis and dissemination of the NunatuKavut Community Health Needs Assessment (CHNA). The research team worked with the steering committee to develop a plan for conducting the CHNA. This project received ethics approval to begin data collection in January 2010; data collection occurred from February to May 2010. A detailed timeline of key milestones for this project is included in Appendix A and more details about the background of the study is detailed in Chapter 4: The Research Journey.

Why is this community health needs assessment important?

To date, no systematic data has identified the health-related service needs of NunatuKavut residents on the southeast coast of Labrador. The purpose of this report is to identify health-related service needs, gaps in current health services, and recommendations to improve existing health services in NunatuKavut communities. A second, equally important purpose of this report is to identify other services, such as education, transportation, food delivery, and even policing, that are not health-care services, per se, but nevertheless, influence overall health. Most importantly this CHNA offers information for use by community members, the NunatuKavut Community Council, Labrador-Grenfell Health Authority and the Newfoundland and Labrador Department of Health and Community Services to discuss health priorities and resource allocation. These discussions will need to take place through a bilateral partnership between NunatuKavut and the Labrador–Grenfell Health Authority, and should foster collaborative and mutually respectful approaches to program and service adaptation.

What is included in this report?

The report is organized into twelve chapters. The first four chapters (including this introductory chapter) provide detailed background information necessary to understand the communities included in the study, the reason why
this type of research is important, and all of the
details regarding how we went about conduct-
ing the study. Specifically, Chapter 2 provides a
review of the current research literature pertain-
ing to Aboriginal peoples in Canada, the social
determinants of health and community-based
health research. Chapter 3 provides a history of
Aboriginal peoples along the southeast coast of
Labrador, a demographic profile of each of the
eleven communities included in this study, as
well as a general demographic profile of the par-
ticipants who took part in this needs assessment.
Chapter 4 describes the process and method of
the study.

Chapters 5-10 present the findings from the
needs assessment. As is explained in Chapter
4, the findings are organized according to the
pieces of an Inukshuk. Each piece represents an
aspect of health-care service delivery that is
needed in order to form a more complete un-
derstanding of the health-care service delivery
needs in NunatuKavut.

Chapter 11 brings together all of these find-
ings, and explores how they are important not
only for health and wellbeing, but also for the
socio-economic, political and environmental
wellbeing of NunatuKavut residents. Finally,
Chapter 12 provides a series of recommenda-
tions and actionable items that emerge as a
result of the data presented in Chapters 5-11.
2.1 Introduction

The following literature review has been prepared for NunatuKavut’s Community Health Needs Assessment (CHNA) by Vanessa Perry. Peer-reviewed journal articles as well as grey literature (which refers to unpublished documents and government reports) were sourced based on the parameters set by the CHNA research team. The result is an overview of Aboriginal health in Canada, with a specific focus on the Inuit of south and central Labrador, Aboriginal conceptualizations of health, the social determinants of health as they apply to Aboriginal populations, health research protocols in Aboriginal communities, and an overview of other community-based assessments that have been conducted.

It is important to note here that the phrases ‘Inuit of south and central Labrador’, ‘Inuit of NunatuKavut’ and ‘NunatuKavut peoples’ are used
throughout this report to describe the population in question. However, prior to spring 2010 when a land-claim document was submitted for review to the federal government, the terms ‘Inuit-Metis’ and ‘Metis’ were often used to describe the Inuit-descendents of south and central Labrador. Consequently, much of the literature (prior to 2010) on this population has referred to them using these terms. As such, the literature search conducted for this review included the terms ‘Inuit-Metis’ and ‘Metis’.

2.2 Literature Review Methods

Articles were collected based on existing bibliographies contributed by the author (V. Perry) and a CHNA investigator (D. Martin) as well as select articles contributed by another CHNA team member (J. Graham). Searches were then conducted of PubMed, CINAHL, EMBASE, and GoogleScholar using a variety of key words and combinations of them including:

- Aboriginal
- Health
- Health Status
- Community health
- Needs assessment
- Labrador
- Labrador Metis Nation
- Métis
- Inuit-Metis
- South East coast
- Social determinants of health

Demographic and health data were also sourced from the Government of Newfoundland and Labrador’s Community Accounts website (Government of Newfoundland and Labrador, 2010) as well as Statistics Canada (2006).

2.3 Aboriginal Health in Canada and on the South-East Coast of Labrador

Aboriginal Health in Canada

According to the 2006 Census, 1,172,790 individuals in Canada identified as Aboriginal (First Nations, Inuit, or Métis) (Statistics Canada, 2006). In the Canadian context, the term Aboriginal describes people who are Indigenous to Canada. This is a young, fast-growing, and increasingly urban population (Statistics Canada):

- The Aboriginal population in Canada grew by 45% between 1996 and 2006, six times the rate of the non-Aboriginal population.
- 48% of the population are under the age of 25.
- The Aboriginal population in Canada is becoming increasingly urban.
- While the proportion of the population living in crowded dwellings has declined, the percentage of those living in a home needing major repairs has not changed from 25% in 1996.
- Aboriginal children are more likely than their non-Aboriginal peers to live with a lone parent, a grandparent, or other non-parent relative.

Health outcomes for the Canadian Aboriginal population are generally poorer than those
of the general Canadian population, with higher rates of obesity, heart disease, high blood pressure, injuries, and suicide (Canadian Institute for Health Information [CIHI], 2004). They are also at a disadvantage in terms of most health determinants, in particular socio-economic conditions (Standing Senate Committee on Social Affairs, Science and Technology, [SSCSAST] 2009). However, these outcomes vary within the Aboriginal population depending on a number of factors, including geography and specific Aboriginal identity (i.e., Inuit, Métis, or First Nations).

Although available research and information presents an insightful overview of health within the Canadian Aboriginal population, the unique interests and specific needs of each Aboriginal group require attention (SSCSAST, 2009). In Newfoundland and Labrador 23,450 individuals reported being of Aboriginal identity; of these, 6,470 identified as Métis. This number includes those who identified as ‘Inuit-Métis’. The Métis in Canada comprise approximately 30% of the Canadian Aboriginal Population (CIHI, 2004). The Inuit-Métis are considered distinct from other Métis groups in Canada, as they are of Inuit and European ancestry, rather than First Nations and French as is most common in the rest of Canada (Hanrahan, 2003). As mentioned previously, those who were previously referred to as ‘Inuit-Métis’ have begun to refer to themselves as ‘Inuit of south and central Labrador’. This shift in self-reported identity is intended to more closely reflect their Inuit ancestry. More on this topic can be found in Chapter 3: A Brief History of South-Central Labrador’s Aboriginal People.

William’s Harbour. Courtesy of Billy Larkham.
Aboriginal Health Research in Canada

A great deal of Canadian health research has involved Aboriginal peoples, but a large portion of this research has been focused on First Nations, to the exclusion of both Inuit and Métis populations (Adelson, 2005; Furgal, Garvin & Jardine, 2010; Wilson & Young, 2008; Young, 2003). Consequently, there is a need for accurate and reliable health information in order to address the individual and community-based effects of health disparities and their sources, particularly for Inuit and Métis communities (Adelson, 2005).

Census information from Statistics Canada provides demographic information for the southeast coast of Labrador. However, the small population makes it difficult to extract information from other national surveys such as the Canadian Community Health Survey and the Aboriginal Peoples Survey, also conducted by Statistics Canada (Loppie-Reading & Wien, 2009; Anderson, Smylie, Anderson, Sinclair & Crengle, 2006). Due to a low representation in the survey sample and potential privacy issues, statistically evaluating relationships between health determinants and outcomes for Aboriginal peoples who live in more rural, isolated areas, such as those found in south and central Labrador, is challenging (Bourassa, 2008; Minnore, Kat & Hill, 2009).

A lack of adequate health information can result in barriers to accessing health care and an underestimation of the resources needed to offer appropriate services (Adelson, 2005). As a result, local organizations and communities often respond by developing their own health information systems and measurement models (Anderson et al., 2006). While extremely helpful, these projects do not often receive the sustained funding of government data collectors such as Statistics Canada, and therefore often function with the limitations of project-based funding (Anderson et al.). There is a need for both community-based systems for effective planning and surveillance, as well as universal systems for measuring progress towards eliminating existing health disparities (Anderson et al.).

The Inuit of South and Central Labrador

The Inuit of south and central Labrador are found in small communities along the southeast coast and in portions of central Labrador, and are represented by NunatuKavut (formerly the Labrador Metis Nation [LMN]). There are also Inuit living along the north coast of Labrador who are represented by the Nunatsiavut Government. Although there are many connections between these groups of Inuit, their historical trajectories and subsequent contact with non-Aboriginal peoples has been quite different, leading to the creation of these two distinct organizations that represent the Inuit of Labrador – Nunatsiavut in the north and NunatuKavut in the south. The Inuit of south and central Labrador are the descendants of the Inuit who are indigenous to Labrador, and many also have mixed-European heritage due to the arrival of Europeans in the 18th century (Hanrahan, 2008). The Inuit of Labrador have traditionally led a seasonal migratory life mostly based around hunting and fishing. Historically, they lived in family groups of 20 to 30 people that were associated with specific geographic areas, though the family groups were interconnected through marriage, language and culture (Hanrahan, 2003). Before settling into year-round towns in
the 1950s and 60s, family groups typically migrated seasonally between summer fishing stations on the coast and winter camps located in sheltered bays; this seasonal migration is often referred to in the literature as ‘seasonal transhumance’ (Hanrahan, 2003; Whitford, 2003).

Demographic information on this population can be drawn from the Census, as well as the Canadian Community Health Survey (Government of Newfoundland and Labrador, 2010). The Labrador southeast coast region includes Black Tickle/Domino, Cartwright, Charlottetown, Lodge Bay, Mary’s Harbour, Norman Bay, Paradise River, Pinsent’s Arm, Port Hope Simpson, St. Lewis, and William’s Harbour (more information about these communities can be found in Chapter 3 and detailed community profiles about each community can be found in Appendix D). In 2001, 75% of residents in the region identified as being of Inuit ancestry. The latest data is from the 2006 Census, which recorded 2,615 individuals living in the region, with an average age of 36. Sixty-eight percent (68%) of the population was of working age (18-64) and 9% were over the age of 65. Additionally, the region had a negative growth rate from 2001 to 2006 (-3.9%), suggesting an out-migration of people from the area (Government of Newfoundland and Labrador, 2010). However, there was an increase in the number of youth ages 10-14 in the region from 2001 to 2006, in contrast to a decrease in the number of youth from 1996 to 2001 (Government of Newfoundland and Labrador, 2010).

Health information for the region can be sourced from hospital morbidity information from the Newfoundland and Labrador Centre for Health Information’s Clinical Database Management System as well as the Canadian Community Health Survey conducted by Statis-

Table 2.1. Hospital Morbidity for the southeast coast of Labrador, 2003-2005. Note that the diagnoses shown here do not include all disease classifications included in the total hospital morbidity; for this reason figures do not always add to totals.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Number of Stays</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Male</td>
</tr>
<tr>
<td>1. Diseases of the Circulatory System</td>
<td>75</td>
</tr>
<tr>
<td>1a. Heart Disease</td>
<td>45</td>
</tr>
<tr>
<td>2. Injury and Poisoning</td>
<td>65</td>
</tr>
<tr>
<td>2a. Fractures</td>
<td>20</td>
</tr>
<tr>
<td>3. Diseases of the Digestive Tract</td>
<td>40</td>
</tr>
<tr>
<td>4. Diseases of the Respiratory System</td>
<td>40</td>
</tr>
<tr>
<td>4a. Diseases of the Upper Respiratory Tract</td>
<td>15</td>
</tr>
<tr>
<td>4b. Pneumonia</td>
<td>10</td>
</tr>
<tr>
<td>4c. Chronic Obstructions, Pulmonary Diseases, etc (including Asthma)</td>
<td>10</td>
</tr>
<tr>
<td>5. Diseases of the Genitourinary System</td>
<td>25</td>
</tr>
<tr>
<td>6. Neoplasms (Cancer)</td>
<td>20</td>
</tr>
</tbody>
</table>
tistics Canada (Government of Newfoundland and Labrador, 2010). These sources tell us that:

- From 2003-2005 there were 995 hospital stays (46% were men and 54% women) from the region. Note that this does not indicate that 995 individuals stayed in hospital, as an individual with multiple stays for the same condition would have been counted multiple times (see Table 2.1);

- The median age of those entering the hospital for more than day treatment from 2003-2005 was 40 and the average length of stay (excluding those who stayed more than a year) was 6 days;

- In 2007-2008, 80% of participants in the Canadian Community Health Survey living on the East Coast of Labrador reported their health to be very good (as compared to poor, fair, good, or excellent) and the majority of respondents (66%) believed that this was about the same as the previous year;

- Most respondents (65%) described their mental health as very good.

There is very little population health data available for the Inuit of south and central Labrador (Bourassa, 2008; Hanrahan, 2000). Gustafson’s (2006) review of Aboriginal health research and programs in Labrador from 2000 to 2005 found that the vast majority of peer-reviewed research has focused on Innu (First Nation) and northern Inuit (Nunatsiavut) communities, and very little research has been conducted with the south and central Labrador Inuit communities. For example, in a study of pneumonia hospitalizations among the Aboriginal population of Newfoundland and Labrador, Alaghehbandan and colleagues (2007) compared the Innu and Inuit communities of Labrador with non-Aboriginal communities on Newfoundland’s Northern Peninsula, but did not include the Aboriginal population in the south of Labrador.

Some smaller studies have looked at health specifically in this region. Of particular note is the 2003 needs assessment conducted by the Labrador Metis Nation (now NunatuKavut) for its Learning for Life, Preventing Diabetes program (LMN, 2003). One third of the NunatuKavut members aged 18 or older from Norman Bay to L’Anse au Clair were surveyed. Sampling was broken down by age to make sure young adults and elders were adequately represented in the final sample of 307 people (53.1% female, 46.9% male) (LMN). Some of this study’s findings include:

- The majority of participants were classified as having a body mass index (BMI) of over 25, indicating that they were overweight or obese;

- The prevalence of diabetes was 6.6% which was higher than the Canadian average (3.1%), First Nations average (6.4%), Inuit average (1.9%), and Canadian Métis average (5.5%) at the time;

- All diabetes cases were reported by individuals over the age of 35;

- 72.6% of respondents reported having a family member with diabetes; 69.5% of these were a first-degree relative.
2.4 The Social Determinants of Health

Identifiable determinants help us to understand how social conditions affect health, and can contribute to a wider understanding of health outcomes (Marmot, Friel, Bell, Houweling & Taylor, 2008). For example, a recent Canadian study on Aboriginal status, income, and place suggested that determinants are proxies for opportunities, resources and constraints which result in unequal opportunities in life, thus affecting one’s health (Frohlich, Ross & Richmond, 2006). Measuring these determinants can provide the basis for action aimed at improving these social conditions, thereby influencing health outcomes (Kelly, Morgan, Bonnefoy, Butt & Bergman, 2007).

Interest in the social determinants of health has been growing since the mid-twentieth century. A series of government reports have increased awareness and discussion of social approaches to health and the healthcare system. In 1974, the Lalonde Report in Canada raised concerns about the determinants of health beyond the healthcare system itself (Lalonde, 1974). Four years later, the Declaration of Alma-Ata (1978) was made at the International Conference on Primary Health Care declaring the right of health for all. In the 1980s, the Ottawa Charter for Health Promotion (1986) revitalized the public health movement by discussing the broader determinants and calling for international action in promoting health and eliminating inequities. A recent Senate report, A Healthy, Productive Canada: A Determinant of Health Approach, emphasized a social determinants approach that is external to the healthcare system (SSCSAST, 2009). Such an approach involves focusing and taking action on the factors that contribute to health, and their complex interactions (Health Canada, 2010).

Health researchers and government officials have accepted the following determinants as predictors of health (Health Canada, 2010):

- Income and social status
- Social support networks
- Education and literacy
- Employment/working conditions
- Social environments
- Physical environments
- Personal health practices and coping skills
- Healthy child development
- Biology and genetic endowment
- Health services
- Gender

In addition to these determinants, the National Aboriginal Health Organization (NAHO) has identified Aboriginal-specific determinants of health, which include colonization, globalization, migration, cultural continuity, territory, access, poverty, and self-determination (National Aboriginal Health Organization, 2006). These determinants manifest themselves differently depending on their context. The WHO’s Measurement and Evidence Knowledge Network of the Commission on Social Determinants of Health declared that such determinants must be viewed through a lens that considers the local context, meaning and relevance (Kelly et al., 2007). Social determinants impact the health of
Aboriginal groups in Canada differently, due to distinct social, political, and geographical histories of each group. As indicated by NAHO, these distinctions while exacerbated by distinct experiences of colonialism, social exclusion, and racism have similarly impacted the health of Aboriginal groups across Canada. It has been argued that marginalization in education, employment, housing, health care and many other services have created a two-tiered society (SSCSAST, 2009).

An advantage to the social determinants of health approach is that, in keeping with Aboriginal conceptualizations of health, it encompasses not just health care services, but education, housing, management of land and resources, governance, and economic opportunities. This approach suggests that only when all of these services are better integrated will we be able to appropriately address the health of a given population (Adelson, 2005; SSCSAST, 2009).

The next section reviews some of the social determinants of health and how they manifest on the southeast coast of Labrador. Most of the statistics provided are sourced from the Learning for Life, Preventing Diabetes needs assessment conducted with members of NunatuKavut, above the age of 18, living from Norman Bay south to L’Anse-au-Clair (LMN, 2003).

Colonization, Globalization, and Cultural Continuity

The Inuit of south and central Labrador have experienced immense social change over the last century. Of particular importance has been the addition of military bases to Labrador, the introduction of wage labour, mechanization of the fishing industry, and the introduction of
government regulations surrounding resource use, education, policing, and justice (Hanrahan, 2008). Increased government presence in this region in the mid-20th century brought government control over schools and nursing stations, and an increase in commercial establishments and infrastructure (Whitford, 2003). Many government services were welcomed, as they had been absent before. However, the increased government presence also brought a number of restrictions on resource use including limits on hunting, fishing, and acquiring timber (Hanrahan, 2000; Hanrahan, 2008; Martin, 2009). These constraints led to a decreased connection to the land, a sense of less control over nature, and dramatic changes to the diets of the people of the southeast coast (Hanrahan, 2000; Martin, 2009; Martin, 2011; in press).

Efforts to formally recognize the Inuit of south and central Labrador as an Aboriginal group have faced many challenges. When the Terms of Union were set between Newfoundland and Canada in 1949, no mention of Aboriginal people was made. As a result, recognition for Labrador’s Aboriginal groups, including Inuit of south and central Labrador, has arrived slowly and inconsistently (Hanrahan, 2003). NunatuKavut’s most recent efforts to have their Inuit identity formally recognized by the federal government include a land-claim submission to the federal government (which is discussed in more detail in Chapter 3).

Culture and Traditional Foods and Lifestyles

Recent definitions of ‘Indigenous’ have moved emphasis away from temporal definitions (i.e., how long a people have been present in a geographic area), and more toward cultures that place significance on their relationship with the natural world (Cunningham & Stanley, 2003). Among the Inuit of NunatuKavut, as with most Indigenous peoples, health is viewed as a multi-dimensional concept, which includes social, emotional, spiritual, and physical characteristics that recognizes and respects the relationship between the health of the natural world and the health of the people who live in it (Hanrahan, 2000). Central to this concept is the ability to provide the necessities of life for individuals and communities, using the resources available from the natural environment (Hanrahan, 2000; Martin, 2009). Hanrahan (2000) describes NunatuKavut peoples as “active agents of health maintenance and promotion” (p. 233). This means that individuals take responsibility for their own health and well-being, and maintain this through good relationships with the community and environment. Indeed, despite the presence of the International Grenfell Association and its nursing stations and health services in the 1800s, Hanrahan (2000) maintains that Western-style medicine was not prevalent in south-eastern Labrador until relatively recently. Even today, elders in the region still use both Western and traditional medicine (Hanrahan, 2000).

Relationships with the land are a key part of NunatuKavut culture, and therefore traditional diets based on hunting, fishing, and berry picking are integral to the idea of health. Food practices also strengthen community relationships through the sharing of traditional foods. An example of this is the historic tradition of sharing the first salmon of the season among all community members and with members of neighbouring communities (Hanrahan, 2008; Martin, 2009).
Social change and nutrition are highly related, and changes in food practices have had a strong impact on the health status of Nunatu-Kavut peoples in Labrador (Hanrahan, 2008; Martin, in press). Prior to the introduction of store-bought food in the early 20th century, the local natural environment provided all of the nutrients required for a healthy diet (Hanrahan, 2008). Socio-political changes of the 20th century have impacted the Labrador Inuit people’s ability to make traditional food-related choices, individually and collectively (Hanrahan, 2000; Martin, 2009; Martin, 2011; in press). In 1984-85, the Labrador Food Study showed that hunting was still practiced by most families, with “rabbits” (Arctic hare) and “partridge” (willow ptarmigan) being the chief sources of wild meat in southern Labrador, since caribou and porcupine had disappeared from the area (Hanrahan, 2000). At that time, 28.3% of NunatuKavut members reported hunting or cutting wood (Hanrahan, 2000). By 2003, 42.3% of NunatuKavut reported that they did not have adequate access to wild meat, birds, and fish (LMN, 2003). The most common factors preventing access were license restrictions (84.5%), cost of transport (18.6%), and other reasons including scarcity of animals and/or fish, and not having anyone to get these foods for them (34.9%) (LMN, 2003).

**Rurality**

All of the communities along the southeast coast of Labrador can be considered rural or isolated. With a few exceptions, rural areas have been shown to be at a disadvantage in terms of health, with poorer socio-economic conditions, lower levels of education, less healthy behaviours, and higher overall mortality than urban residents (CIHI, 2006; Dixon & Welch, 2000). However, rural areas also often have a stronger sense of community belonging than their urban counterparts, which has been demonstrated to be a protective factor against health-related issues (CIHI, 2006). Almost all respondents (97%) to the 2007/2008 Canadian Community Health Survey from the southeast coast of Labrador reported a very strong or somewhat strong sense of belonging to their community (Government of Newfoundland and Labrador, 2010).

**Education**

In 2002, the southeast coast of Labrador had 10 schools with 61 teachers and an enrolment of 566 students (Whitford, 2003). See also Appendix D for detailed information about the presence or absence of schools in each community. Educational attainment was relatively low, with the majority of surveyed NunatuKavut members over age 18 having less than a high school diploma (52.3%). High school was the highest level of education achieved for 22.4%, and 25% had completed at least some post-secondary education (LMN, 2003).

**Income and Employment**

Much of the employment on the southeastern coast is seasonal. In 2003, 44% of LMN members over the age of 18 were seasonal workers, and only 15.3% worked full-time (LMN, 2003). 19.3% of LMN
members had a household income greater than $50,000, 22.6% had a household income between $35,000-$49,999, 25% were between $25,000-$34,999, 21.7% were between $15,000-24,999, and 11.3% had a household income below $15,000 (LMN, 2003).

**Occupational Health**

One particular occupational health issue in Newfoundland and Labrador is the presence of shellfish asthma among workers in shellfish processing facilities. Although shellfish asthma has been researched more extensively with respect to working in crab processing facilities, asthma is also known to occur with exposure to other shellfish, such as shrimp (Lucas et al., 2010). Shellfish processing facilities (crab and shrimp) exist in four communities in southeast Labrador. These include Cartwright, Charlotte-town, Mary’s Harbour and St. Lewis, although the crab processing plant in St. Lewis was shut down in the spring of 2012. Several research projects have been conducted around the experiences of shellfish asthma in four communities in Newfoundland and Labrador; this research showed significant health effects, in particular in positions mainly filled by women (Cartier et al., 2004; Gautrin et al., 2010; Howse et al., 2006).

**Health Behaviours**

In 2003, just over half (54.4%) of Nunatu-Kavut households included at least one smoker (LMN, 2003). 89.3% of individuals reported being physically active at least twice a week, with walking being the most popular form of activity (LMN, 2003).

**Stress and Support**

Approximately 18% of individuals on the southeast coast reported that stress was a concern in their lives (LMN, 2003). The most common approach to dealing with stress was walking and other sports (52.1%), followed by talking to family and friends (39.4%), and other techniques including getting away from the situation, thinking about something else, working, or relaxing (34.5%) (LMN, 2003). People also reported high levels of social support from friends and family. In 2001-2002, 95.8% of residents in southeastern Labrador and the northern peninsula of Newfoundland reported that they had high social support (Whitford, 2003).

**Water and sewage infrastructure**

In 2003, all towns except for unincorporated communities had piped water supply systems (Whitford, 2003). All towns had piped sewer systems serving a portion of the community, and in all cases raw sewage is discharged directly into the sea. Lack of funding and bedrock conditions are key factors limiting the expansion of sewer systems within the region (Whitford). Currently, some communities have significant challenges in accessing potable water, including Black Tickle and Norman Bay (Hanrahan, 2003).

**Health Services**

Health services on the southeast coast are provided by the Labrador-Grenfell Health Authority. As of 2003 these services included community clinics staffed by two nurses, a nurse’s aide and a maintenance person; these are equipped with holding beds and basic trauma and resuscitation equipment (see Appendix D for communities on the southeast coast that have these facilities). Physicians make community visits every six to eight weeks and are always available to regional nurses by telephone. Regional nurses at these stations dispense medication, collect and prepare routine laboratory
specimens, and provide primary health care, (Whitford, 2003). Residents receive travel vouchers with their referrals. Transportation services are provided to coastal residents who need to travel for secondary medical reasons and emergencies (Whitford, 2003).

A 2002 review of the Province’s health services revealed that key challenges include the health status of the population, changes in population size and structure, quality and accessibility of health services (especially long-term care and mental health services), and the sustainability of health services (Ministry of Health & Community Services, 2002). Some of the key goals for the Department of Health and Community Services at that time were to improve the capacity of communities to support health and well-being through the development and improvement of community partnerships, and to improve the quality, accessibility and sustainability of health and community services.

Specialized health provider training programs have been developed in order to better meet local needs (Gustafson, 2006), however, not all of these programs have been available to people on the southeastern coast of Labrador. For example one innovative program is the Integrated Nursing Access Program that prepares nurses specifically for the physical, social, and cultural environments they will encounter working on the Labrador coast, in addition to preparing them for their general course requirements. Currently this program is only open to members of Nunatsiavut. The Northern Family Medicine Education (NorFam) provides in-community training for medical residents, to encourage them to consider working in rural and northern Canada (Gustafson, 2006).
2.5 Community-Based Aboriginal Health Research

Historically, Aboriginal communities and community members have been excluded from the research process, and have therefore enjoyed minimal benefits from the results of research that has studied their communities because research has often not included their perspectives and experiences. Additionally, there are a number of concerns over who owns the data produced in such studies, and what its future uses might be. These concerns have prompted a recent movement toward increased community involvement in research. This Community Health Needs Assessment is a research project that has been both initiated and led by the people of NunatuKavut. Chapter 4 explains in detail the community-based research methods applied to this needs assessment. To add context, this section outlines some other examples of community-based research projects, in particular those taking place in other Aboriginal communities in Canada and around the world. Needs assessments in particular can benefit from a community-based approach, as they can inform action and advocacy for change based on the needs identified by the community itself.

Several barriers have led to the reticence with which many Aboriginal communities approach research. These barriers include the lack of culturally appropriate tools, the need for community-initiated processes, a lack of accountability to the communities themselves, and tension between mainstream and indigenous processes (Anderson et al., 2006). As a result, there have been recent movements towards community-driven and community-owned research. Approaching population health at a community level produces information in a way that is flexible enough to improve health and well-being while respecting social, cultural and local ideas (SSCSAST, 2009). As well, communities have important strengths, capacities, and assets that can be used to enhance their physical and mental health and well-being (Israel, Schulz, Parker & Becker, 1998; SSCSAST).

While much of the movement towards community-led research occurs in an Aboriginal context, these challenges are not unique to Indigenous groups. A series of community panels in the United States spoke of a need to “Change the Frame” of research (in any community) by expanding types of research methods, approaching community engagement as an art and science, moving from an ‘us’ to a ‘we’ orientation, and placing the community first (Clinical and Translational Science Award [CTSA] Consortium; 2008). Key recommendations from these panels included:

- Be aware of the community’s perception
- Ask the community what it wants
- Help to provide expansion and closer coordination of services (as many researchers work in tandem with programs and services)
- Host community events
- Identify long-term community leaders
- Creatively use media
- Identify and address barriers
- Acknowledge historical mistakes
- Raise the prestige of participating in research
Find ways to reward community engagement

The level of involvement in research by communities and their relationships with external researchers lie on a continuum. At one end of the continuum is the typical pattern of scientific research, where external researchers conduct a study “on” or “about” the community. At the other end of the continuum, many believe that the community members should conduct the research themselves. For example, the community panels in the United States believed that researchers should be ‘working themselves out of a job’. Community engagement, in this view, is really about empowering a community to take leadership of its own health (CTSA Consortium; 2008). Another perspective, in the middle of the continuum, is that communities and researchers each have skills that they can contribute to a research project. In this approach, the emphasis is not on being community or researcher-driven, but rather finding a full collaboration between the two in planning and executing the study (Anderson & Spence, 2008). For example, the Bridges and Foundations project, an Aboriginal housing organization in Saskatchewan, found that when the local community participates fully in deciding the survey questions, different sorts of issues are discovered and explored. These benefits are further enhanced when the community also participates in ongoing analysis with external researchers (Anderson & Spence).

In the Canadian Aboriginal setting, some changes to research within Aboriginal communities have been driven by a set of principles known as Ownership, Control, Access, and Possession (OCAP) (Assembly of First Nations, 2005; RHS National Team, 2006). These begin to address the historic lack of Western research conducted with and by Aboriginal peoples, and are increasingly being embraced by Aboriginal communities and researchers studying this population (Mill et al., 2008). Some recent and encouraging examples of this move towards community-owned and -driven research include:

- The First Nations Regional Longitudinal Health Survey, conducted on-reserve by the First Nations Information and Governance Committee at the Assembly of First Nations.
- The Canadian Institutes of Health Research (CIHR) Guidelines for Research Involving Aboriginal Peoples, published in 2007 by the Institute for Aboriginal Peoples Health (CIHR, 2007)
- Opportunities in Aboriginal Research, prepared by the Social Sciences and Humanities Research Council (McNaughton & Rock, 2003)
- The Kahnawake Schools Diabetes Prevention Project (KSDPP) and their Code of Research Ethics (KSDPP, 2007)
- A proposed First Nations Health Reporting Framework developed by the Assembly of First Nations (2005)
- CIHR’s nine Network Environments for Aboriginal Health Research (NEAHR) Centres, one of which is the Atlantic Aboriginal Health Research Program, which supports students and research related to Aboriginal health in the Atlantic region, including Labrador. A key emphasis of this research initiative is on projects
conducted in collaboration with or by communities themselves.

While there are many examples across Canada of Aboriginal/non-Aboriginal partnerships and collaborations in health programming and research (Anderson & Spence, 2008; Barnes, 2000; Benoit, Carroll & Chaudhry, 2003; Bisset et al., 2004; Dickson & Green, 2001; Mignone, 2003; Thompson, Greville & Param, 2008; Wahbe et al., 2007), a review of those published in the peer-reviewed literature reveals that they are often initiated by academics and/or government, rather than by the studied communities. This situation could be due to the selection process of publishing peer-reviewed articles. In reality, there may be many community-driven research projects across the country whose documentation is less accessible.

The calls for meaningful dialogue between researchers and communities and for “authentic research relationships” are growing rapidly (Bull, 2009; Wilson & Young, 2008; Young, 2003). There is a clear movement in this direction from both communities and researchers, who are becoming increasingly aware that for collaborative health projects to be successful with Indigenous partners, Indigenous knowledge must be valued and utilized (Wahbe et al., 2007).

Community-Based Needs Assessments

Needs assessments became popular in the 1980s when they gave prominence to regional and local-level health planning in lieu of institutional planning (Hawe, 1996). Often these projects combine a variety of data sources (such as demographic, health, and socio-economic information) with some form of community opinion in order to identify potential interventions and programs (Hawe). These assessments often benefit communities as they create information specific to the location. However, caution has
been exercised around how useful assessments can be if they are not accompanied by change or action (Hawe). The lack of action is often due to the “selective hearing” displayed by health service organizations about what the community identifies as needs, resulting in a disconnect between the priorities of communities and institutions (Hawe).

Appendix E outlines a number of community assessments selected because of their high level of community participation. These assessments were conducted for a variety of reasons, from a better understanding of a community’s general needs to an evaluation a specific project or program. Some challenges in these projects include issues over ownership, overcoming negative perceptions of research, integrating Western and traditional methods of inquiry, and a lack of research capacity within the community. Despite these challenges, all of these projects appear to have been quite successful, with both the researchers and community feeling that important knowledge was gained. In addition, these projects increase capacity within the community for conducting research, empower local organizations to undertake such projects, and begin to shift community perceptions with respect to research projects.

2.6 Conclusions

This chapter presents some of the literature describing the health of Aboriginal peoples, paying particular attention to the research that has been completed along the southeast coast of Labrador. This review also focuses on the social determinants of health, a key means of conceptualizing the health of Indigenous populations. This conceptualization of health is important, as it helps to understand and interpret the results of this community health needs assessment. A general overview of community-based research is also provided. The following chapter (Chapter 3) provides more information about the communities included in the study.

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3.1 A Brief History of South-Central Labrador’s Aboriginal People

By Greg Mitchell

The ancestors of today’s residents of Nunatu-Kavut are descendants of the earlier peoples of the Punuk and Birnik cultures of North Alaska and the Bering Sea Region, also known as Thule Eskimos (Rankin, 2009). These people migrated from Northern Alaska across the Canadian Arctic some time after 1000AD. In the thirteenth century, they began to migrate fairly rapidly into the Canadian archipelago (Friesen and Arnold, 2008), inhabiting Labrador by the late fifteenth century (Rankin, 2009). There is very little evidence that the Thule culture existed in Labrador prior to some type of contact with Europeans (late 15th to early 16th century); indicated by the presence of iron or other European attributes in Inuit artifacts. The archaeological record from recent studies shows that artifacts from
sites in southern Labrador were very similar to comparable sites in Northern Labrador (Rankin, 2009).

Today’s Inuit are descendents of the whale-hunting Thule Eskimos, who appear to have arrived in Labrador around 1500AD. From the available historical information, it appears that the arrival of Europeans in the Straits of Belle Isle occurred around or just after the movement of Inuit to the area. Evidence from the Red Bay site in southern Labrador shows Thule occupation at a Basque whaling site in the late sixteenth century (Rankin, 2009). Further ethno-historical and archival evidence supports the presence of Inuit in the latter sixteenth century in the Straits area and along the Côte du Nord (Quebec lower north shore) (Martijn, 1980a). Also, recent interpretive linguistics work indicates that the Inuit had knowledge of the island of Newfoundland before the arrival of Europeans (Pigott, 2010). During the sixteenth, seventeenth and eighteenth centuries it was well documented that Inuit frequented the Island of Newfoundland for resource procurement and trade (Martijn, 2009).

The Atlantic coast of south and central Labrador was inhabited and used on a year-round basis by historic Inuit from the mid-1500s until the mid-1700s, based on available archival information and recent archaeological work (Stopp, 2002). Evidence also suggests year-
round occupation and land use into the Quebec lower north shore area by historic Inuit at various periods in the past 400 years (Fitzhugh, 2009). Historic cartographic and toponymic evidence from a number of sources also supports the land use and occupancy of south-central Labrador by today’s Inuit descendants (Rankin et al., 2008; Rollmann et al., 2007).

The Inuit occupation of south-central Labrador can be divided into three periods: the Basque period (1535 – 1630), the French colonization period (1630 – 1763) and the English period (1763 – present). The Basque period was characterized by some hostility between Inuit and the Europeans, but much evidence seems to point to a certain degree of co-operation and mutual benefit. The French period was described by Charles Martijn (1980b) as a period of guerrilla warfare between Inuit and Europeans. In the early years of this era, French vessels operating in northern Newfoundland and southern Labrador, primarily from St. Malo, were constantly harassed by Inuit to the point where French fishermen were taxed to compensate for their protection by ships of war (Martijn, 1980b).

Before the English period began (1763), the general culture of the people of south-central Labrador had changed very little from the ways of their Thule ancestors, other than the acquisition of wooden boats and some trade goods, including iron for harpoon and arrow heads. With the onset of English claims to Labrador following the Treaty of Paris, the Inuit experienced drastic changes to their way of living and culture. These changes are still in motion today.

Near the beginning of this period (1765) the English entered into a treaty with the south-central Labrador Inuit in an effort to establish trading, fishing and sealing posts along the Atlantic Labrador coast (Lysaght, 1970). This treaty was facilitated by Governor Palliser and Moravian missionaries, who were familiar with the Inuktitut language and were anxious to establish a mission amongst the Inuit (Hiller, 2009). A mission was established at Nain in northern Labrador in 1771, and the Moravians made efforts to contain the Inuit in the more northerly regions to avoid interference with the British fisheries in southern Labrador. Their efforts were not very successful. The Inuit continued to roam freely up and down the coast (Rollmann, 2010; Kennedy, 2009) maintaining a subsistence lifestyle based on seasonal migration. They continued trading in the south much like Inuit families in the north.

By the beginning of the nineteenth century the south-central Labrador Inuit experienced new changes. With the influx of European men
in trading posts, sealing posts and fishing fleets, the subsistence economy began to change moving toward singular activities around the posts and a higher reliance on a monetary economy. This led to several changes in lifestyle and culture. First, the Inuit began to increasingly rely on the post/fishing/trading economies (Kennedy, 2009; Kennedy, 1995). Second, European men began to co-habit with or marry Inuit women (Clarke & Mitchell, 2010). These changes were significant in terms of culture. They led to some losses of the Inuktitut language, and a more sedentary lifestyle for the Inuit peoples (Clarke & Mitchell, 2010). The changes also led to stigmatization of Inuit and ‘half breeds’, in some cases leading men to change their Inuk names or adopt English names. In situations where Inuit women married European men, the predominant way of life in the household remained Inuit in terms of many technologies, species hunted and consumed, and eating habits (Boduoin, 2008).

The population of south-central Labrador remained low into the twentieth century and the advent of globalization. During the nineteenth century influx of Newfoundland fishing families to the coastal area, the ‘natives’ were those who remained on the coast in winter and were well known to the summer visitors (Hussey, 1981, p. 111). The absorption of less than fifty European men into the families of southern Inuit people during this time did little to change basic lifestyles and culture. Despite gradual changes, the communities continued to rely largely on hunting and fishing for subsistence, used dogs and kometiks (sleds) for transportation, and maintained traditional Inuit harvesting and household tools which had changed very little in several centuries.
The southern Labrador Inuit have maintained transhumance (seasonal migration) lifestyles from antiquity (Stopp, 2002). Into the twentieth century, harvesting began in the spring when families moved to fishing berth locations on the coast to harvest seals and codfish. In the summer, cod fishing continued simultaneously with the salmon runs and berry picking. Once fall arrived these activities were replaced with bird and seal hunting. Toward the end of fall, families would move to the inner bays to prepare for a winter of trapping, and the caribou hunt (Jackson, 1982). Even today, many people in the area follow the traditions of their ancestors, keeping as many as four different homes to accommodate the various harvests. Thus the traditional transitory lifestyle persists into the twenty-first century among the Aboriginal people, today collectively represented by the NunatuKavut Community Council (Clarke & Mitchell, 2010). The people living in southeast Labrador today are the descendants and representatives of the historic southern Inuit culture in Labrador, which is the southern-most Inuit culture in the world.

3.2 Overview of NunatuKavut Communities

The southeast coast of Labrador is home to 11 NunatuKavut communities. These include: Cartwright, Paradise River, Charlottetown, Pinsent’s Arm, William’s Harbour, Black Tickle/Domino, Norman Bay, Port Hope Simpson, St. Lewis, Mary’s Harbour and Lodge Bay. The settlement of each of these communities occurred over a very lengthy time period – some communities are known to have been inhabited by Inuit as early as the 1500s (St. Lewis and Cartwright), while others were settled by European traders as late as the 1950s (Charlottetown), or did not become permanent settlements by local residents until the 1960s (Norman Bay).

The population of each community ranges from 15 (Paradise River) to 572 (Cartwright). There are five communities (Paradise River, Pinsent’s Arm, William’s Harbour, Norman Bay and Lodge Bay) that have fewer than 100 people. Services in each of these communities are extremely variable, with some communities featuring road access, airstrips, basic municipal services like garbage removal and water, and nursing clinics, while others remain without these services and must travel to other communities to access them.

Each of the communities included in this study is profiled in more detail in Appendix D.

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4.1 Introduction

This chapter offers insight into the community-based processes and methods that were used to create the NunatuKavut Community Health Needs Assessment (CHNA). It focuses on the approach used to design the research study, as a growing body of research – particularly research conducted with Aboriginal communities – points out that any study’s findings are only as strong as the processes used to reach those findings (Kovach, 2010). In other words, the journey is at least as important as the final destination. With this in mind, the research team has placed a great deal of emphasis on creating a research project that strives to enact the principles of community-based, participatory approaches to research.

This chapter is divided into four sections. The first section outlines the background for the study – why the study was needed, how funding was
acquired, and how the research team was assembled. The second section outlines the theoretical or conceptual basis of the study, including principles of community-based participatory research and how this approach was successfully applied in NunatuKavut. The third section describes the ethical considerations and the methods used to carry out the study. The fourth section describes in some detail the demographic profile of those who participated in the survey portion of the research project. This chapter ends with a description of the Inukshuk, an important symbol in Inuit culture, and explains why and how this symbol was used to organize our findings.

4.2 Study Background

The Federal Government announced the Aboriginal Health Transition Fund (AHTF) at the September 2004 Special Meeting of First Ministers & Aboriginal Leaders. It was designed to:

1. improve the integration of federally-funded health services within First Nation and Inuit communities with Provincial/Territorial (P/T) health services;
2. improve access to health services for all Aboriginal peoples;
3. make available health programs and services that are better suited to all Aboriginal peoples; and
4. increase the participation of all Aboriginal peoples in the design, delivery and evaluation of health programs and services.

The AHTF consists of three sections or ‘Envelopes’. They are as follows: Pan-Canadian, Integration, and Adaptation.

The Pan-Canadian Envelope funds cross-jurisdictional initiatives in the adaptation or integration of health systems in three streams: First Nations, Inuit and Métis. Priority areas for funding are determined through discussions with national Aboriginal organizations.

The Integration Envelope provides funding to develop and implement regionally-focused integration plans to improve the integration of federally-funded health systems and P/T health systems in First Nations/Inuit communities.

The Adaptation Envelope provides funds to develop and implement P/T plans to adapt local health services to better meet the needs of all Aboriginal peoples. The NunatuKavut Community Health Needs Assessment was funded through the Adaptation Envelope.

This study was conceptualized by members of NunatuKavut, who submitted a proposal to the Government of Newfoundland and Labrador, for funding through the Aboriginal Health Transition Fund Adaptation Envelope. This study is somewhat unique in that it was conceived through a grassroots initiative. Although both university researchers and community members were involved, this study did not follow the typical pattern where the researchers acquire funds and ask the community for permission and/or input. This research project has been driven by the community. NunatuKavut members identified the need for a community health needs assessment, acquired the funds, and then sought researchers to partner with them. They approached the Co-Principal Investigators, Debbie Martin and James Valcour, to take the lead on carrying out the study. Julie Bull, a PhD student, was hired as a data consultant for the project. A steering committee – comprised of government officials, health-care workers and community members – has informed all aspects of the study design and has encouraged the different partners to work together. NunatuKavut community members were hired and trained to conduct both qualitative and quantitative data collection, with the idea of building capacity for research amongst community members. The project is intended to be ‘reflexive’, meaning that the research participants have had the opportunity to comment on and provide feedback about the study, which has been incorporated into this report.

Chronology of Events
(Note: See timeline, Appendix A)

From 2006 – 2008 Darlene Wall, NunatuKavut’s Health & Social Sector Manager, attended several national meetings at the Congress of Aboriginal Peoples (CAP) regarding this initiative. As an organization, NunatuKavut had never been invited to apply for funding before, but in January 2008 a consultant from the Province of Newfoundland and Labrador met with Darlene and NunatuKavut’s President, Chris Montague, regarding this funding. They were advised that there would be a Request for Proposals (RFP) issued soon, and that NunatuKavut would be invited to also sit on a provincial committee to oversee this funding.

In April 2008 Chris and Darlene attended a meeting with stakeholders from across the province in St. John’s. There was a lot of discussion ensued around what projects would actually be funded through the AHTF.

In May 2008 a letter of interest was submitted to the province for funds to conduct a
community health needs assessment on the southeast coast of Labrador. In June of 2008 the letter was approved and NunatuKavut was asked to submit a proposal. A proposal was submitted to AHTF in July 2008. In October 2008 NunatuKavut were advised that it had a good chance of being funded, and was asked to modify our budget. In early November 2008 we were notified that our project proposal had been approved and that the contribution agreement would follow over the coming weeks.

Melita Paul, an employee of NunatuKavut, began preliminary work on the project. Melita and Darlene discussed potential advisory committee members and invited stakeholders to the first meeting, which took place in May 2009.

With the research team in place, the following study objectives were identified building upon those submitted in the original proposal:

**Study objectives**

1. To determine the health status of the southeast Labrador Inuit population, through quantitative and qualitative research methods:
   a. research existing methodologies and assessment tools
   b. consult with steering committee on possible approaches
   c. select appropriate assessment tool and finalize method
   d. collect and analyze data
   e. share results with participants, organization and regional health authorities (RHAs)

2. To deliver a “southeast Labrador Inuit Health Status Report Card”:
   a. review data and analysis with Labrador Grenfell Health Authority (LGH)
b. prepare report identifying gaps and strengths in existing programs

c. identify areas for potential adaptation based on Needs Assessment.

d. meet with RHAs to discuss correlations between identified needs and existing programs and services

e. report on meetings to participating communities and the Province

f. design an education package based on Needs Assessment

3. To exchange information and foster collaborative relationships and mutually respectful approaches to program and service adaptation:

a. meet with LGH to outline the project’s goals and objectives.

b. review Needs Assessment methodologies used by LGH and consider the adaptability to the Aboriginal population

c. share selected methodologies with LGH

d. discuss gaps and strengths in programs and services for Aboriginal peoples

e. identify potential adaptation areas for future consideration

f. share the results of the Needs Assessments with LGH

4.3 Theoretical Background

A movement originating within Aboriginal communities is changing how research is understood and conducted in those communities (Kaufert et al, 2004). A key characteristic of this shift is that communities, rather than researchers, set the research agenda. In fact, some argue that the most desirable position is for an external research team to be approached by the community (Lightfoot et al. 2008), which is exactly what happened in the case of the NunatuKavut Community Health Needs Assessment. The following section presents a detailed look at the community-driven approach that guided the Community Health Needs Assessment.

As we began working on this project, we discussed the constant balance that must exist between communities and researchers. Our team included three brand-new academic researchers. The NunatuKavut research team also included community-based workers. Our process involved continuously discussing and negotiating our roles and responsibilities so that both parties could contribute to the project in ways that were meaningful and beneficial to all.

As the conversation about the research project evolved over time, and as our relationships with one another grew stronger, we came to realize that the process is as important as the outcome. For us, this meant that the research project unfolded through clear and frequent communication (in person wherever possible, but also via teleconferences, email and Skype). We learned that there is no ‘one-size-fits-all’ approach for conducting a community health needs assessment, particularly in a remote area. Geography, isolation, and the commitment level of the research team and community members all vary from one project to the next and must determine the course of action. Although the specific details of how a project unfolds should be unique for each project, we feel that we have learned some valuable lessons about how to conduct research that is both meaningful and useful. We hope that by documenting this process, we will
encourage other researchers and communities to undertake research that follows some of the same principles that we have used and have found to be successful.

“Establishing and negotiating partnerships with researchers will foster the development of ownership, while experience in research builds capacity and contributes to access and control” (Bull, 2008, pg. 89)

Community-based participatory research

Community-based research methods have been gaining momentum in various contexts, especially in research involving Aboriginal peoples. In fact, current national guidelines for the ethical conduct of research involving Aboriginal peoples indicate that a participatory method should be used where possible (CIHR, 2007).

We used Israel, Schulz, Parker, and Becker’s (2001) definition of community-based participatory research: it can be seen as a collaborative process that involves all parties equitably, while recognizing the strengths that each brings. It begins with a research topic that has relevance to the community (in this case, the need for baseline community health data, identified by NunatuKavut) with the aim of bringing about social change to improve health (i.e., adapting existing Labrador-Grenfell Health and other services to better suit the needs of people living in NunatuKavut communities). Community-based research assumes that all involved people have their own knowledge to contribute to the research, which brings a level of meaning and accuracy that could not exist with only one perspective (i.e., only community or only academic). This is clearly evident in the NunatuKavut Community Health Needs Assessment, as the community itself recognized the need for such research, and looked for academic researchers to collaborate on all stages of the project. In this process, we have assumed that the community expertise and academic expertise complement each other, and that we need both in order to gather meaningful information on the health and health services of NunatuKavut communities.

Figure 4.1 illustrates the holistic nature of CBPR methods and is a visual representation of the major principles and processes we used in the Community Health Needs Assessment.

The strengths of CBPR methods include collaboration, mutual respect, shared ownership, and reciprocal capacity build-
ing (Flicker & Savan, 2006). A common pitfall of using a CBPR approach is that many elements of CBPR (e.g., engaging communities prior to ethics review, collaborative research design, and joint ownership of data and publication rights) challenge conventional “scientific” practices and methodologies. Each member of the research team has applied his or her own expertise to produce useful, complementary, empirical data to answer the questions generated by the community. We have asked questions and shared our process throughout the study, to ensure the community is part of the research and that their ongoing needs are being met. NunatuKavut approached two professors and one doctoral student, two of whom have been trained specifically in Aboriginal Health Research and who are members of NunatuKavut (Bull and Martin). The third researcher (Valcour) brings epidemiological knowledge to fully understand the quantitative aspects of the project. The academic researchers understand the complexities of working with Aboriginal communities and are committed to ensuring that the research is designed, conducted, and disseminated in a way that is respectful to the communities of NunatuKavut.

**Building sustainable partnerships**

This needs assessment will provide data and information for NunatuKavut and Labrador-Grenfell Health to continue their collaborative relationship to improve the health of the Inuit of south and central Labrador. Furthermore, this project will create a framework through which other changes and initiatives can be developed.

Monitoring and evaluation will be ongoing through a bilateral partnership with the LGH.

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**Cape Charles. Courtesy of Leila Coates**

Academic partnerships have also been established that can foster future research relationships and research projects within NunatuKavut (see Chapter 12 for recommendations on future research directions).

**4.4 Research Ethics & Methods**

Ethics approval for this study was granted by Dalhousie University’s Research Ethics Board (REB), the Human Research Ethics Authority (HREA), Labrador-Grenfell Health, and the
NunatuKavut Community Council.

**Informed consent process**

In research involving Aboriginal peoples, the consent process is twofold. Firstly, collective consent needs to be obtained from relevant community leaders. For this study, the process of acquiring collective consent from the community was somewhat streamlined because the partnership was initiated by NunatuKavut. The leadership (President and Council) of NunatuKavut worked together to access the funds for this project, and then collaborated with the researchers to design the methods to be used. By virtue of engaging researchers in the process the leadership’s collective consent was built into the process from the beginning. This is not to say that the academic team had carte blanche sanction to do what they wanted or that a token collective consent was granted. Rather, decisions were made together and there was a lot of communication between the academic team, the leadership, and the community to ensure that everyone was continuously working from the same perspective.

Along with collective consent, individual consent was obtained from each person who participated in this research. The research assistants (RAs) received in-depth training about the importance of the consent process, which emphasized that simply giving the participant the form to sign was not a sufficient means by which to obtain such consent. During the training, the RAs were taught to read and explain the consent form with potential respondents, and to go through any questions or comments with the individuals prior to them signing the form.

Copies of the ethics procedures and consent forms that were developed and used for this project are available upon request from any member of the research team.

**Ethics challenges and opportunities**

**Long consent forms:**
The ethics review committees at our academic institutions required a long, legalistic consent form that was sometimes seen as intimidating by community members. Many comments were made during all three phases of the project. Participants felt that the forms were unnecessarily long and should be shortened to be more accommodating to the communities in which the research is taking place.

**Conflicts of interest:** Two academic members of the research team (Bull and Martin) and two community members of the research team (Paul and Wall) are also members of NunatuKavut. While this may be seen as a conflict of interest in some research designs, it is actually a benefit when using community-based participatory methods. This is an ethical dilemma inherent in this research but is also a strength of research conducted with communities.

**Confidentiality and Anonymity:** A common guideline for institutional ethics boards (in this case, MUN HREA and Dal REB) is that participation in research should remain confidential or anonymous. In some cases that is appropriate; for example we kept the responses to the survey component of this project confidential (Phase II). However the team argued that confidentiality or anonymity might not be necessary when participants want to be named in the results and dissemination of the project. Most of the community members who took part in individual in-depth interviews chose to be named in this report; we used their real names and left out the names of others who did not wish to be named.

**Ownership, access and storage of data:** In keeping with the current direction of guidelines for such research, the research agreement for this project sets out that full ownership, access, and control of the research remains with NunatuKavut, even though the data is physically stored at Memorial University of Newfoundland. Again, this is in contrast to the more conventional practice set out by institutional ethics boards, whereby the ownership of data often remains solely with the investigator.

**Multi-site ethics review:** Due to the nature of this project, an ethics review was required from multiple sites. The research team anticipated a complex job in preparing for this multi-site review, as each board would require slightly dif-
Different revisions to the proposed research prior to granting final approval. We worked hard to streamline the process and shared information between all parties in order to satisfy the requirements from all boards.

Methodologies

This section outlines all of the processes that were used to collect the data for the NunatuKavut Community Health Needs Assessment.

Site selection

The NunatuKavut membership runs through both southeast and central Labrador. However, for the purposes of this study we concentrated on only a portion of the territory – the southeast coast.

We chose to focus on the southeast coast for a number of reasons. Among those is the fact that many of the needs of that area are distinct from those in central Labrador. For instance, several southeast coast communities are only accessible by plane, boat (in the summer), or snowmobile (in the winter).

We wanted to gather information on both the needs and assets of NunatuKavut communities. NunatuKavut has dedicated staff and volunteers who are committed to securing a healthier future for their members. Moreover, NunatuKavut is engaged in joint efforts with Labrador-Grenfell Health and the other Aboriginal groups within Labrador (e.g., the Labrador Aboriginal Health Research Committee). It is recognized that these joint efforts are vital to creating a healthier Labrador in general.

Since most NunatuKavut members are located on the southeast coast of Labrador, those communities were considered the best place to conduct the Community Health Needs Assessment.

Field worker training

Research assistants were hired from NunatuKavut communities to carry out the data collection component of the study. In November 2009, the three research assistants (Pye, Pye, and Cumby), project manager (Graham), project coordinator (Paul), quantitative co-investigator (Valcour) and qualitative data consultant (Bull) travelled to Goose Bay for three days of training to prepare them for the various tasks of data collection. The intensive training covered the project background and ethical considerations, as well as discussions about how to conduct a qualitative interview, the role of a surveyor, how to use digital recorders and how to upload and save the audio files, how to manage data and what information to record and report. Participants were given the opportunity to conduct mock interviews and time was spent critiquing the interview skills based on what was learned in the training. This was followed by an introduction to the community health needs assessment survey database (starting the database, entering data, saving data, managing data). The research assistants then conducted mock surveys to practice all of the necessary steps in completing the research process.

Research Process

The study was conducted in three phases. In the first phase, we conducted key informant interviews. These key informant interviews were used to inform the second phase of the study, which was the implementation of a survey. The third phase of the study involved returning to the communities with preliminary results from the key informant interviews and the survey, to
share the information with community members. Their perspectives on this data were collected during focus group sessions. The following section describes this process in more detail.

**Phase I: Key informant interviews**

The first phase of the qualitative component involved recruitment of 12 key informants from the 11 study communities. Key informants were defined as people who live in the community, who are involved in community activities and who, through their employment or volunteer experience, are familiar with some of the key health care and health-related issues facing the community. Possible key informants were identified by employees at NunatuKavut, who work closely with the communities in the study area. They were able to provide names of potential participants who could speak about health care and health-related programs and services in each of the 11 communities included in this study. These individuals were then invited to take part in interviews.

The 12 key informants took part in one-on-one, semi-structured interviews about the health needs and assets in their communities. All of the key informant data collected from these interviews was uploaded into the qualitative data analysis software programme Atlas ti, where it was coded and analysed for themes and sub-themes. These themes and sub-themes were used to identify health care and health-related policy, service and program priorities and helped to shape some of the questions that were asked in the survey.

Phase II: Surveys

The second phase of the study was the administration of the survey. The NunatuKavut Community Health Needs Assessment (CHNA) survey was developed using the First Nation’s Regional Longitudinal Health Survey (RHS) as a template (Assembly of First Nations, 2002). Discussions with NunatuKavut Community Council and the NunatuKavut CHNA Steering Committee, as well as preliminary results from the key informant interviews in Phase I, were used to tailor the CHNA survey to better address the specific needs of the NunatuKavut communities on the south shore of Labrador. The Canadian Community Health Survey (CCHS) was also consulted for potential questions. Survey interviews were conducted in-person with trained interviewers.

The study population for the survey included people who live in one of the 11 NunatuKavut communities and who are 16 years of age or older. Only one member of each household was recruited to participate in the survey. Selection for participation was based on a stratified random selection of participants from each community (11 communities in total). This was to ensure a representation from all communities included in the CHNA. Randomization was performed using a computer generated random number (see below) (Stata, version 10.1, Stata Corp.).

A sampling frame of all individuals, including their current household residence, was obtained from the NunatuKavut Community Council. Households in each community were selected using a stratified random sample using a probability proportional to size methodology¹ (Dohoo et al., 2010). Table 4.1 shows the breakdown of the number of households sampled per community.

The selection of potential survey participants was conducted in the following manner: households in each community were randomly selected from a stratified sample of all households in each community, using a probability proportional to size methodology. A total sample size of 350 households was determined using a precision of 5% to an estimate proportion of 50% for dichotomous outcomes given a power of 80% and a confidence level of 95%. A finite population correction was applied as more than 10% of the population was being surveyed. Adjustment was also made to allow a non-response rate of 25%.

<table>
<thead>
<tr>
<th>Community</th>
<th>Number to Sample</th>
<th>Actual Sampled</th>
<th>Response Rate (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cartwright</td>
<td>84</td>
<td>84</td>
<td>100.00</td>
</tr>
<tr>
<td>Black Tickle</td>
<td>24</td>
<td>20</td>
<td>83.33</td>
</tr>
<tr>
<td>Paradise River</td>
<td>4</td>
<td>2</td>
<td>50.00</td>
</tr>
<tr>
<td>Norman Bay</td>
<td>6</td>
<td>6</td>
<td>100.00</td>
</tr>
<tr>
<td>Charlottetown</td>
<td>46</td>
<td>47</td>
<td>97.87</td>
</tr>
<tr>
<td>Pinsent’s Arm/ William’s Harbour/ Lodge Bay</td>
<td>29</td>
<td>28</td>
<td>96.55</td>
</tr>
<tr>
<td>Port Hope Simpson</td>
<td>68</td>
<td>64</td>
<td>94.12</td>
</tr>
<tr>
<td>St. Lewis</td>
<td>34</td>
<td>34</td>
<td>100.00</td>
</tr>
<tr>
<td>Mary’s Harbour</td>
<td>55</td>
<td>55</td>
<td>100.00</td>
</tr>
<tr>
<td>Total</td>
<td>350</td>
<td>340</td>
<td>97.14</td>
</tr>
</tbody>
</table>

Note: ¹ A total sample size of 350 households was determined using a precision of 5% to an estimate proportion of 50% for dichotomous outcomes given a power of 80% and a confidence level of 95%. A finite population correction was applied as more than 10% of the population was being surveyed. Adjustment was also made to allow a non-response rate of 25%.

Table 4.1. Response rate for communities in the NunatuKavut Community Health Needs Assessment.
selected, and one individual in the household was then randomly selected. These individuals were contacted by telephone and invited to participate in the survey. Persons who declined were removed from the list and a new household was contacted. Attempts were not made to recruit another person in the same household. A total of 447 households were contacted with 340 respondents completing the survey (response rate 76%).

Once the sample was identified, members of NunatuKavut received training in how to conduct a survey. They contacted the selected participants by telephone or in person and set an appointment time for the survey to be administered. When participants were first contacted, they were informed about the purpose and objectives of the study, rationale for the survey, and what would be required of them. The process of informed consent was explained prior to the start of each survey. Due to poor weather conditions, interviewers were not able to travel to the communities of Norman Bay and Black Tickle. In these instances, the survey interviews were conducted over the phone. Consent forms were faxed to the communities and returned to the interviewer prior to the interview. Interviewers entered answers to the survey questions directly into a computerized data entry form. The survey data was analyzed using Stata software (version 10.1; Stata Corp.). Dichotomous (i.e., data that can only be one of two answer, for example yes/no questions) and categorical (i.e., data that can have multiple answers, for example employment status could be unemployed, part-time employment, season employment, or full-time employment) variables were examined and percentages calculated. For chronic disease conditions and ailments (e.g., diabetes, high blood pressure and arthritis) age-sex adjusted risks were estimated using direct standardization and accounted for a stratified sampling design. Results are presented in tables or graphs and are summarize for the entire study area. Only data relevant to this report were analyzed. Data on several other variables was collected, but not necessarily analyzed.

Phase III: Focus Groups

The third phase of the study involved community consultations and five focus group sessions that included between two and thirteen participants and lasted from approximately 50 minutes to two and a half hours. All interested community members were invited to attend the community consultation sessions, which were conducted in five communities: Mary’s Harbour, St. Lewis, Charlottetown, Port Hope Simpson, and Cartwright. A flyer was sent out to all community members inviting them to participate in the community consultation session in a special edition of the “Metis Messenger”.

No data was collected during the community consultations. The purpose of these sessions was to provide community members with information about the preliminary results of the study and to provide them the opportunity to offer comments, feedback and recommendations.

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2 The data entry form was developed using EpiData (version 3.1, Epidata Association). Data was exported from EpiData directly into a Stata data file.

3 Cross tabulations between covariates, such as age, sex, education level and household income, were examined and the appropriate statistical test (e.g., t-test, $\chi^2$). For categorical variables (i.e., greater than 2 categories) where a significant $\chi^2$ was observed, either a Cochran-Armitage test for trend (for order variables) or a series of $2 \times 2$ tables as outlined in Norman and Streiner (2008) were used to determine where significant results occurred in the tables.

4 Direct standardization used the Canadian population estimates from the 2006 Census of Population (Statistics Canada) as the standard.
for future policies, programs and research based on the study results.

After the community consultations, residents were invited to participate in a focus group session. The purpose of the focus groups were two fold: to check the data collected in Phases I and II of the study, and to identify gaps or missing information that was not captured in those phases. The rich discussion at each consultation session transitioned well into focus groups. The data collected for this portion of the analysis included feedback from community members about the results of the key informant interviews and the survey, as well as recommendations from them about how best to create policy, program and service changes that will address the health priorities identified.

For Phase III (focus group sessions), a similar process for data analysis was followed as in Phase I. All of the data from both Phase I and Phase III were analyzed together for themes and sub-themes. However, in this stage of the analysis major themes were constructed based on priority areas that were identified by both the key informant interviews in Phase I and the focus group participants in Phase III. Both sets of data were included as the themes were being written and each transcript was reviewed to ensure that all major concerns were captured in the overall themes. Particular attention was paid to the focus group data, since it was noted that many additional concerns were raised during this set of data collection that were not included in Phase I. This may have been because the research team gave a presentation about the project before the focus group sessions, allowing participants to reflect on additional themes instead of repeating the most common themes. There may also have been a greater degree of comfort for participants speaking in a group setting than in a one-on-one setting.

Using the Inukshuk to understand our findings

Figure 4.2. Image of an Inukshuk, which we used to represent the different aspects of health discussed in the NunatuKavut Community Health Needs Assessment. Image source: http://www.ocanadagear.com/Inukshuks-build.htm.

The Inukshuk (Figure 4.2) is symbolic of Canada’s north and of the Inuit who live there. An Inukshuk is a monument constructed of rock that is used to give direction, to signal a presence in a particular area or to mark a place of respect. For these reasons, we thought it was appropriate to use the Inukshuk as a symbol to guide our research findings, to mark our emerging presence in the world of research and to remind us to respect one another, ourselves and the world around us. Just as the Inukshuk pictured above is divided into seven sections, our research results are also divided into seven sections, each representing a different piece of the research findings. Alone, each segment of the
Inukshuk is nothing more than a piece of rock, just as each section of our findings is nothing more than small piece of a puzzle. When placed together, however, each rock represents a larger symbol of direction, presence and respect. In the same way, when considered together, our findings are puzzle pieces that fit together to tell the story of the health and well-being of our people, the Inuit of NunatuKavut.

4.5 Demographic Profile of Survey Participants

A total of 447 individuals were asked to participate in the NunatuKavut Community Health Needs Assessment survey. There were 107 refusals and a total of 340 completed surveys, giving a response rate of 76%.

**Age and sex distributions**

The survey respondents were 44.4% male and 55.6% female. The age distribution is shown in Table 4.2. A relatively small number of young adults (aged 16-24) responded to the survey. This response rate likely may have an impact on the results since the opinions of those who answered the survey may not reflect the overall opinions of young adults in the community in general. There are several possible reasons for the under-representation of young adults in the survey. Many of the young adults, particularly those of post-secondary school age, may have been located outside the communities during the time frame when the survey was being conducted. There is also the possibility that young adults were not as interested in filling out the survey.

![Table 4.2. Age and gender distribution of respondents to the NunatuKavut Community Health Needs Assessment survey. Percentages represent percent of the column total (e.g., percent of males who are in each age group).](image)

![Table 4.3. Education level and gender of respondents to the NunatuKavut Community Health Needs Assessment survey. Percentages represent the percentage of the column total (e.g., percent within males).](image)
Figure 4.3. Employment status and gender for respondents of the NunatuKavut Community Health Needs survey.

Figure 4.4. Age and employment status of respondents to the NunatuKavut Community Health Needs survey.
**Employment**

Figure 4.3 shows the breakdown of employment status of those who answered the survey. The most common employment reported (40.6%) was that of a seasonal nature. Full-time employment and unemployment were the second and third most common responses, at 26.2% and 22.7%, respectively. Approximately 10.6% of those who responded to the survey were employed on a part-time basis. The majority of seniors (greater than 65 years of age) were unemployed (Figure 4.4). As the survey did not ask about retirement status, it is difficult to ascertain whether individuals in this group are truly unemployed or are retired.

**Education**

Education levels are shown in Table 4.3, and Figure 4.5 shows education levels for participants in different age groups. Thirty-four percent (34.4%) of survey respondents had received a post-secondary education. This includes either college or university level education. The majority of people who did not have a high school education were 65 years of age or older (data not shown). A higher percentage of individuals with post-secondary education were employed full-time; whereas a higher percentage of individuals with less than a high school education were unemployed (older than 65 years of age removed from the analysis).

![Figure 4.5. Education level and employment status for respondents of the NunatuKavut Community Health Needs survey.](image-url)
Household Income

Household income was categorized in $20,000 increments. This was done to protect the privacy of individuals and households in the communities. This unfortunately did not allow us to make comparisons with Statistics Canada information on Low Income Cut-off scores. Approximately 51% of people who answered the survey made less than $40,000 in the past year (Table 4.4). Those with higher levels of education were more likely to live in households with higher incomes (Figure 4.6).

Table 4.4. Household income level distribution of respondents to the NunatuKavut Community Health Needs Assessment survey.

<table>
<thead>
<tr>
<th>Household Income</th>
<th>Total %</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $19,999</td>
<td>17.7</td>
</tr>
<tr>
<td>$20,000 - $39,999</td>
<td>32.9</td>
</tr>
<tr>
<td>$40,000 - $59,999</td>
<td>25.6</td>
</tr>
<tr>
<td>$60,000 - $79,999</td>
<td>12.9</td>
</tr>
<tr>
<td>$80,000 and up</td>
<td>10.8</td>
</tr>
<tr>
<td>Total (n)</td>
<td>(340)</td>
</tr>
</tbody>
</table>

Figure 4.6. Household income and education level for respondents of the NunatuKavut Community Health Needs survey.

4.6 Conclusion

This chapter has introduced the steps that were taken to complete the NunatuKavut Community Health Needs Assessment. It has outlined the timeline for the project, the community-based participatory approach to the research, as well as the ethical guidelines and methods that were used. Finally, this chapter ends with a description of the Inukshuk, which is used to
organize the seven 'results' chapters. The chapters are organized as follows: Chapter 5 examines chronic disease and injury, Chapter 6 looks at oral health care, Chapter 7 looks at mental health, Chapter 8 explores health care and health related services, Chapter 9 examines health practices and personal characteristics, Chapter 10 looks at people and their relationship to the natural world, while Chapter 11 looks at people and their relationship to the social world.

4.7 References


communities. *Association of Educational Psychologists Journal, 18*(6), 507-514.


This chapter describes NunatuKavut’s population in terms of health practices and personal characteristics that are known to influence health. We focus specifically on physical activity and recreation, nutrition and diet, substance misuse, and sexual behaviours. Healthy eating and regular physical activity are shown to reduce the risk of obesity and many other chronic diseases. Other health behaviours that may increase a person’s risk for chronic disease include things like smoking, unsafe sexual practices, and the misuse of alcohol as well as prescription and non-prescription drugs.

5.1 Physical Activity and Recreation

Everyone who responded to the survey indicated that they participate in some form of physical activity. The different types of activities that community members reported are shown in Figure 5.1. Men and women tended to take part in different types of activities, including traditional activi-
ties. For example, more men reported getting their exercise through traditional activities like snowshoeing or hunting, while women were more likely to take part in activities like walking, dancing and berry-picking. These differences are discussed further in section 5.6, Men’s Health.

Table 5.1. Physical activity level in the past 12 months by age category.

<table>
<thead>
<tr>
<th>Age Category</th>
<th>At least once per day</th>
<th>2-3 times per week</th>
<th>Once per week</th>
<th>1-2 times per month</th>
<th>Less than once per month</th>
<th>Never</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24 (n=15)</td>
<td>53.3%</td>
<td>40.0%</td>
<td>6.7%</td>
<td>0.0%</td>
<td>0.0%</td>
<td>0.0%</td>
</tr>
<tr>
<td>25-34 (n=47)</td>
<td>36.2%</td>
<td>34.8%</td>
<td>6.4%</td>
<td>10.6%</td>
<td>8.5%</td>
<td>2.1%</td>
</tr>
<tr>
<td>35-44 (n=92)</td>
<td>33.7%</td>
<td>34.8%</td>
<td>21.7%</td>
<td>4.35%</td>
<td>4.4%</td>
<td>1.1%</td>
</tr>
<tr>
<td>45-54 (n=83)</td>
<td>47.0%</td>
<td>27.7%</td>
<td>10.8%</td>
<td>6.0%</td>
<td>3.6%</td>
<td>4.8%</td>
</tr>
<tr>
<td>55-64 (n=54)</td>
<td>25.9%</td>
<td>29.6%</td>
<td>16.7%</td>
<td>14.8%</td>
<td>5.6%</td>
<td>7.4%</td>
</tr>
<tr>
<td>65+ (n=49)</td>
<td>26.5%</td>
<td>20.4%</td>
<td>10.2%</td>
<td>12.2%</td>
<td>8.2%</td>
<td>22.5%</td>
</tr>
<tr>
<td>Total (n=340)</td>
<td>35.9%</td>
<td>30.6%</td>
<td>13.8%</td>
<td>8.2%</td>
<td>5.3%</td>
<td>6.2%</td>
</tr>
</tbody>
</table>
The Canadian Society for Exercise Physiology (CSEP), supported by the Public Health Agency of Canada (PHAC), recommends that adults aim for 2.5 hours of moderate- to vigorous-intensity aerobic physical activity per week (CSEP, 2011; PHAC, 2011). Only 35.9% of Inuit of south Labrador indicated that they had exercised daily in the past 12 months. A further 30.6% exercised 2-3 times per week. This means that the remaining 34.5% of the Inuit of south Labrador are exercising less than once per week – well below the recommendation that adults should exercise every day. Activity levels in NunatuKavut were highest among the younger age groups and tended to decline with age (Table 5.1). Men and women did not differ significantly with respect to how often they exercised. Sixty-nine percent (68.9%) of males indicated that they exercised at least 2-3 times per week compared to 64.5% of females.

Some participants would like to see a person hired to oversee recreation activities in the community. They argued that this would provide more consistency to the activities, which are currently run by volunteers.

... if they had a recreation director... to help with different kinds of sports... now it’s just either a teacher or recreation committee or something like that is going up and doing

---

**Table 5.2. Duration of physical activity session by sex.**

<table>
<thead>
<tr>
<th></th>
<th>Male (n=140)</th>
<th>Female (n=179)</th>
<th>Total (n=319)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 15 min</td>
<td>4.3%</td>
<td>3.9%</td>
<td>4.1%</td>
</tr>
<tr>
<td>15-30 minutes</td>
<td>17.9%</td>
<td>34.1%</td>
<td>27.0%</td>
</tr>
<tr>
<td>31-60 minutes</td>
<td>29.3%</td>
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<td>61-90 minutes</td>
<td>17.1%</td>
<td>9.5%</td>
<td>12.9%</td>
</tr>
<tr>
<td>91 or more minutes</td>
<td>31.4%</td>
<td>5.6%</td>
<td>16.9%</td>
</tr>
</tbody>
</table>

The majority of people surveyed (69.0%) are meeting CSEP’s recommended 30-60 minutes per activity session, and approximately 39.8% of those individuals are exceeding the recommended length of time. Men generally reported exercising for longer periods of time per session than women (Table 5.2). Despite meeting guidelines for the length of time per session, most people in NunatuKavut are not exercising every day, and therefore may not be getting the full benefits of physical activity. It is important to note that those who reported exercising less frequently also exercised for a shorter period of time.

In the qualitative interviews and focus groups, participants mentioned that they would like to see more opportunities for organized recreation. In some cases, they felt that there were no adequate facilities in their community for such activities. In cases where suitable facilities exist, participants reported that a lack of funds often created problems in keeping the facility open.

Or in an area like this, even if we had like a regional swimming pool or something, you know some sort of an arena or something, that you know, there’s nothing... (Port Hope Simpson focus group)

... if they had a recreation director... to help with different kinds of sports... now it’s just either a teacher or recreation committee or something like that is going up and doing
it voluntarily... but if you had a recreation
director or someone that could spend more
time at it and get people involved into it...
(Ford Rumbolt, Mary’s Harbour)

Participants also felt that the consistency
provided by a recreation director might also
help the communities to develop programming
more tailored and targeted to their own commu-
nity’s needs. For example, the participant below
suggests that some community members are left
out of activities because there is no age-specific
programming.

... I’ve heard people say, like with regards to
floor hockey, they’d like to play floor hockey
but maybe they’re out of shape or they’re
older and that they don’t wanna go down to
the gym with the young people, ‘cause they
figures that they’d just be run over or what-

ever so... rather than going down and play-
ing with the younger people they just don’t
play...(Charlottetown focus group)

A lack of targeted and age-specific activities
can have negative health consequences. People
who have chronic conditions or need additional
support to attend organized recreation pro-
grams are not currently the target of any new
recreation initiatives, and may be missing out on
the benefits of physical activity.

For people like me, and like a lot of other
people that can’t get out and do a lot of
physical things, like a lot of walking... I have
a weight problem, I have diabetes, I have
[high] cholesterol, and I can name it on and
on and on... that puts me back from doing a
lot of walking or doing a lot of things I want
to do, so if I had a fitness centre where I can
go in and work out without a lot of activities on my legs, then I would. That’s what I wants, that’s just what I wants. (Charlottetown focus group)

I know that is very difficult to get the seniors out... They would have a St. Patrick’s Day dance and a Valentine’s supper and those types of things but the seniors just didn’t... they just don’t go. And they offer free rides... but it’s just, I guess it’s just difficult for them to get out, you know go out of their homes and especially winter time... that would be an area that I would like to see improved upon. (Kim Morris, Cartwright)

Organized recreation opportunities were mentioned as an important way to improve health outcomes for both adults and youth. Many participants highlighted that if recreation programming is to improve health, it must include a discussion of the current culture of inactivity that exists among many NunatuKavut residents. Many participants mentioned that people are very dependent on their vehicles (i.e., trucks, cars, snowmobiles, etc.) for transportation, and very few people, including youth, walk anywhere.

Interviewer: Is there a bus for kids to go to school?

Participant: No. Their parents drops them off, or they got their own vehicles or their own Ski-Doos. [If] they had to walk they wouldn’t get there, most of them. (Port Hope Simpson focus group)

You come along by the school there now and the trucks [are] lined right up... parents going down and picking up their youngsters... brings them there and brings them back and the only exercise they get is gym class in school, ‘cause they don’t walk to school and they don’t walk home from school.

They’re only a kilometre away from school. (Charlottetown focus group)

Many study participants emphasized that changing the culture of inactivity must involve adults and youth alike. One study participant noted that too often, discussions about physical activity focus only on young people. As he notes below, adults have a responsibility to also show young people the importance of being physically active, since youth learn through the examples set by adults.

... you have to be a role model for your kids. If you’re active, they see that and your kids will become active, and it goes on down through generations. Personally I believe it, because for my two, that’s how they got involved, is by seeing me being involved. So as a parent you start them off on the right track and usually that trend continues. (Charlottetown focus group)

To begin to address the lack of activities for youth and adults, many participants stressed how important it is to re-introduce traditional forms of recreation and physical activity. In cases where youth have had opportunities to learn about traditional activities from adults, these opportunities have been very successful.

I’d like to see more, Metis stuff on the go, or the cultural stuff like that now, gotta try to get some of our kind of stuff like we used to do; we used to play different kind of games and everything when we was small, learn
to get more into that too. And yes, when we was growing up we’d have a game of football every evening, and when we was going to school and playing tiddly, and I think that children gotta try and get more active instead playing them games all the time, hey. (George Roberts, Norman Bay)

Both of my granddaughters… make slippers, they do caribou tufting, and they do sewing and the quilting, all of that… I think the problem is to get them actually doing it, rather than telling them about it. Not a lot of teenagers wants to sit down and listen to you drilling on them… But getting them actually involved…(Cartwright focus group)

Interviewer: You mentioned boat building, is that something that people, the older people around here have done before?

Participant: Yes, a lot actually, there’s three or four building boats here now, in their sheds

Interviewer: Is it older people or is it younger people?

Participant: Ah the younger people are starting now… two or three years ago they decided now it’s time [because] it’s a tradition that’s going to go… and they won’t know how to do it, so, they, the younger people are being shown now, by their elders. (Cartwright focus group)

A youth/elder event in Charlottetown. Courtesy of Melita Paul.
Participant: One year I taught a course at the school through the Labrador Metis Outdoor Survival… you get a lot of outdoor activity right? We had on snowshoes and chopping wood, building snow shelters and lean-to, things like that. So probably the school can generate some kind of courses like that too. To get the young people outdoors and get them interested in the outdoors and things like that. right.

Participant: Gets them active, get them outdoors. You know an active kid is healthy every way—mentally, physically and all those things, when you’re active. (Charlottetown focus group)

One program that has been very successful in attracting youth along the southeast coast is the Junior Rangers program. It began four years ago in Cartwright and has since expanded into many of the other communities along the coast. Junior Rangers offers opportunities for youth to get involved in traditional community activities like hunting, fishing and trapping, and teaches them important skills for outdoor survival in Labrador.

The Rangers…They’ve done, they’ve done an excellent job…They’re teaching everyday tasks…and they goes off and uses the land and these sorts of things.

That was identified as being a really good thing in the communities…They were, they were out for an outing on Saturday, up the bay. (Mary’s Harbour focus group)

There is a Junior Canadian Ranger Program that is excellent and our kids have won the top patrol for the past four years in row.

That’s ever since the award has been given, so that speaks well of the kids and the leaders and the parent group that are involved with that… the Junior Ranger Program I would say is probably the top program here. I think that there are only three or four kids… that are old enough to be in it that aren’t in it… I think it’s the fifth year that they have Rangers and the enrollment does not drop… they lose very few kids; it’s usually when they are too old to go… (Kim Morris, Cartwright)

Participant: …with the Rangers…they’re doing all kinds of shooting and hunting and building little tents, lean-to’s, whatever… Trying to get back to… the more traditional ways.

Facilitator: And so are a lot of kids from this community involved with that?

Participant: Yeah.

Participant: This is where it started first, and then Mary’s Harbour and Fox Harbour joined last year… (Port Hope Simpson focus group)

In the survey component, slightly more than half of the people surveyed indicated that “community or health programs” (62.7%) or “good leisure or recreational activities” (50.6%) were a strength of their community. Men were more likely to identify leisure and recreational activities as a community strength (60.9% compared to 42.3% of women).

5.2 Nutrition/Diet

The majority (86.5%) of the survey respondents reported that they ate a nutritious bal-
Figure 5.2. Percentage of individuals who reported eating a nutritious, balanced diet, by household income.

Figure 5.3. Percentage of respondents who consume the listed foods on a daily basis.
balanced diet sometimes (53.8%) or (almost) always (32.7%). There were no differences in the percentage of men and women who ate a balanced diet, nor between the different age groups. Individuals from households with higher incomes were more likely to report that they always eat a balanced nutritious diet (Figure 5.2).

Approximately 50 to 60% of participants said that they consume healthy foods such as dairy, protein, fruits and vegetables, and water on a daily basis (Figure 5.3). About 30% indicated that they consume soft drinks on a daily basis. A high proportion (76%) of individuals consumed carbohydrates (breads, pasta, rice and grains) on a regular basis. This could lead to negative health consequences if the carbohydrates people choose are refined, white breads rather than whole grains; breads and pastas made from white flour and white rice have been associated with increased risk for diabetes and coronary heart disease. Traditional foods were consumed several times a week (Figure 5.4). Large game and fish were the most often consumed, with approximately 42% of survey respondents indicating that they consumed either large game or fish more than once a week.

**Availability of Fresh Foods**

Apple trees and orange trees just don’t grow here. (Port Hope Simpson focus group)

![Figure 5.4](image_url)

**Figure 5.4.** Percentage of survey respondents indicating they consumed traditional food types several times a week (2-3 times or more per week).
This section focuses on some of the challenges in southeastern Labrador with respect to accessing fresh store-bought foods. This section is limited to discussions of store-bought foods and excludes mention of traditional foods. A discussion of access to traditional foods is included in Chapter 10: People and the Natural World.

It is important to situate access to store-bought food within an historical context. Prior to the 1970s, there was very inconsistent access to store-bought food, and people depended heavily upon hunting, fishing and trapping for survival. Store-bought foods are remarkably more prevalent and easy to access today than they were years ago.

...with the road opened up, it’s a lot easier to get the fruit and the vegetables, not quite as bad. But years ago it was REALLY, really hard to get. (Marie Rumbolt, Mary’s Harbour)

Even though today the local stores regularly stock fresh meats and produce, these are not always consistently available. In all eleven communities, the reliability of access to fresh fruits and vegetables was mentioned as a concern.

...you can’t go to the store everyday and pick up fresh fruit, we all knows that. You can’t get it every day. (Ford Rumbolt, Mary’s Harbour)

We been here a good week or more without fresh milk. I mean you can usually always buy the pack, “Farmer’s Milk” or “Grand Pre!” ... but that’s preserved milk and it's not fresh... (Unnamed participant, Charlottetown)

Part of the difficulty in accessing fresh, healthy store-bought foods is that it is a risk for store owners to order large amounts and varieties of fresh produce. If they order a large quantity and it does not sell, the stores must take a loss. Furthermore, sometimes store owners receive products that are not fresh, which means that ordering a variety of different types of fresh foods may carry some risk for the business.

... the stores do not take it in, because lots of times they don’t sell a lot of it, especially a lot of the green peppers and all of the fruits that would spoil. They don’t take it in, in big quantities, so lots of times when you go to stores you cannot get it. So it is a problem sometimes. (Jeffrey Penney, Port Hope Simpson)

We usually receive fruits and vegetables once or twice a week, weather pending. But what we often find when fresh fruits and vegetables are brought into the community,
Fresh produce is not consistently available in NunatuKavut communities. Courtesy of Aimee Chaulk.

they are in small quantities... There is no variety provided, it’s just your basic fruits, like apples, oranges, grapes and bananas. Vegetables mainly consist of potato, turnip, carrots and cabbage and sometimes you’ll see some cauliflower, broccoli, lettuce and tomatoes. (Unnamed participant, Charlottetown)

Shipments of fresh foods are weather-dependent, since poor weather can hamper transportation of food. The availability of fresh foods is also related to changes in how foods are shipped during different seasons. During the winter, most foods are typically flown into the communities, and people report receiving high quality fresh fruits and vegetables in winter, when it can be delivered on time. However, at that time of year the weather is at its most variable, and winter storms can sometimes prevent shipment of goods for weeks at a time. This means that foods might not reach the southeast coast at all, or in other cases, delays mean that the quality might be depleted by the time the food arrives.

To attempt to address this issue, over the last two winters (2010-11) the provincial government has introduced a pilot project that provides food delivery via boat for those communities that are connected by road (i.e., William’s Harbour and Black Tickle) continue to receive shipments by air. This pilot project has been shown to be successful, but is still a pilot project and does not offer a long-term solution to problems with food delivery in winter.

In contrast, during the summer months food shipments arrive via transport trucks that travel across the Strait of Belle Isle from Newfoundland. At this time of the year, access to these foods is more reliable, but many people report that food quality is poorer than in the winter, because of the additional time it takes for the food to reach the grocery stores after being driven across Newfoundland, transported by ferry to Labrador, and then driven to its destination along the southeast coast.

...there are times of the year when... the availability is terrible... there are times of the year when... you can get the basics of what
you need… very rarely is it that you can go out and buy extra things… for us it is pretty much the basics. (Fanny Keefe, Black Tickle)

Sometimes during the winter months there are weeks we have no access to fresh fruits and vegetables. In the summer time food items are brought in on transport trucks, and again maybe once or twice a week we’ll receive fresh fruits and vegetables. (Unnamed participant, Charlottetown)

Some study participants felt that there was little that could be done to improve the quality of their store-bought foods, given the isolation and variable weather conditions of their communities. However, other participants pointed out that the island portion of the province also faces many of these same conditions, but residents there seem to have better access to a variety of fruits and vegetables on a consistent basis. (Unnamed participant, Charlottetown)

In 2009, I feel you should be able to walk into any grocery store and purchase fresh fruits and vegetables and not have to settle for frozen. (Unnamed participant, Charlottetown)

The issue of consistently accessing fresh, healthy food options was mentioned as being particularly important for community members with chronic health conditions like diabetes.

My mom, she’s diabetic… she do need fresh fruits and fresh vegetables… but, [it’s] hard to get, even the yogurts and stuff like that… she really got a big problem with her sugars… so I’d like to see her getting more fresh stuff, but we can only get it when they have it [available]. (Bella Burden, Pinsent’s Arm)

…there’s room for improvement in our communities when it comes to food, and especially when it comes to fresh food and fruits… We don’t have a whole lot of varieties here and… in our community… we don’t have a lot of… fresh fruits. And especially with people who’s got health problems like diabetes, for instance, and they needs to eat a lot of vegetables and fresh fruits and so on. I don’t see much of it in the stores… I don’t know why. (Guy Poole, St. Lewis)

In the Mary’s Harbour focus group, participants mentioned that messages promoting healthy eating are being integrated into school curriculum, which many felt was an important step towards making healthy food choices. It is unfortunate that many of the healthy foods that are promoted are simply not available in the students’ communities.

People got the knowledge now… And like in schools too, it is being promoted, like they have this Kids Eat Smart program… But there’s communities that got Eat Smart programs that can’t access the healthy food… and they’re getting funds for that eat-healthy program. (Ford Rumbolt, Mary’s Harbour)
Food Costing and Subsidies

Access to fresh foods was also related to people’s ability to pay for them. With many residents on fixed or low incomes, the cost of foods was also identified as a barrier to eating healthier. Note that exact information on low income cut-off [LICO] score could not be determined due to our methodological issues in collecting income level data. See Chapter 2, section 5.3 for more information.

I finds ah, the food around here is expensive. And ah, like I guess well you buy what you gotta buy, but it’s like, it’s not everybody can afford everything, hey? And like ah, I finds around here like you go up on the island it’s ah, lot of difference in the prices than around here. But like we just got to buy what we got to buy I guess, hey, and make do. (Bella Burden, Pinsent’s Arm)

You can’t always get fresh fruit and vegetables, the kind that you like to have… and it’s so costly anyways… so where a low income family is going to buy pop… instead of milk, well I’ve seen that all over the place where you can buy 2 litres of Pepsi for a dollar or two, and it cost 5 or 6 or 7 or 8 or 9 for the same amount of milk… So that’s a real health issue there, right? (Port Hope Simpson focus group)

The high cost of transporting food by airplane is reduced for some storeowners by means of a provincial government airlift food subsidy, which only includes William’s Harbour and Black Tickle. The idea behind the subsidy is that the cost-savings for the storeowner can be passed on to the customer. A number of interviewees mentioned that the food subsidy should be extended year-round to ensure that foods reach the market while they are still fresh.

There’s four or five stores in our community; lots of times you can visit the four or five stores and you can’t get an apple or an orange. The best time that we can access fresh fruits in our community is when the ferry is stopped and they ah… they gets it come in on plane… And they got subsidies to fly it in, and usually when they got these subsidies on ah, it’s fresh fruits and that, it’s usually in the stores all the time. (Jeffrey Penney, Port Hope Simpson)

5.3 Smoking

According to the Canadian Cancer Society, the rates of smoking in Canada have continued to decline over the past decade; in 2008 the prevalence of smoking was estimated at 18%
Health Practices and Personal Characteristics (Canadian Cancer Society, 2009). By comparison, smoking prevalence in NunatuKavut was considerably higher, at almost 40% for males and almost 23% for females. Nationally, smoking rates for young people (grouped according to ages 15-19 and 20-24) were found to be 15% and 24%, respectively. In NunatuKavut, the highest rates of smoking were seen among the youngest people included in the survey, with almost 43% of young men and women aged 16-24 reporting to be smokers. The lowest rates of smoking were seen amongst those aged 64 and older, at 17%. Table 5.3 on the previous page highlights some of the key findings related to smoking prevalence, according to sex and age.

5.4 Substance Misuse

For the purposes of this report, substance use includes the use and misuse of illegal drugs and the misuse of alcohol. The misuse of prescription drugs was not mentioned during the qualitative interviews. This could mean that prescription drug misuse is not an issue in NunatuKavut. Nurses both write and dispense prescription medications in the communities. Since the nursing station is the only drug dispensary in each community it makes it difficult for people to get enough prescription drugs to abuse them. The misuse of prescription drugs does not appear to be a problem along the southeast coast.

This section focuses on two sub-themes. The first discusses substance misuse among youth, and the second discusses how community members perceive existing resources and supports that are available to help those who are affected by substance misuse. It is important to note here that our survey data did not collect data about youth, and we are simply reporting adults’ perceptions of youth issues, which may or may not accurately reflect whether youth see substance use as a problem in their communities. Additionally, we surmise that substance use among adults may be underreported, since people were asked to self-report their own use, which may not be the best indicator of substance use.

Youth substance misuse

Substance misuse among young people was raised as an issue by both individual interview and focus group participants, particularly with respect to the misuse of alcohol. Many also acknowledged that in recent years there have been increasing reports of illegal drug use in the community as well. We specifically recruited only adults to speak in our focus groups, so it is important to note that the issues raised about youth substance misuse are those that are perceived by adults in the communities. These ideas may not reflect how youth feel.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Male % (n=150)</th>
<th>Female % (n=189)</th>
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</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Male % (n=150)</td>
<td>Female % (n=189)</td>
</tr>
<tr>
<td>Once a day</td>
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<td>0.5</td>
</tr>
<tr>
<td>About 2-3 times a week</td>
<td>22.0</td>
<td>5.8</td>
</tr>
<tr>
<td>About 2-3 times a month</td>
<td>22.0</td>
<td>23.3</td>
</tr>
<tr>
<td>About once a month</td>
<td>8.0</td>
<td>9.5</td>
</tr>
<tr>
<td>About 2-3 times a year</td>
<td>14.0</td>
<td>27.0</td>
</tr>
<tr>
<td>Never</td>
<td>30.0</td>
<td>30.9</td>
</tr>
</tbody>
</table>

Table 5.4. Frequency of alcohol consumption in the past 12 months by males and females.
about substance use and whether it is a problem from their perspective. It is possible that adults in the community see youth substance misuse as a problem because many of the adults interviewed had very little opportunity to be exposed to illegal drugs or even alcohol until the recent past.

I gotta be honest with you here, I think it’s worse now... well I never seen it before because, like I said one time, you know, (laughs) you’d be lucky if you get a bottle of spruce beer eh, and now, ‘tis all kinds of stuff on the go, eh... (Guy Poole, St. Lewis)

Opinions and awareness of youth substance misuse varied widely among participants. In many of the individual interviews, aside from those conducted with health-care workers, participants said that they were unaware of substance misuse in the community. When this finding was reported to people who attended focus group sessions, however, many disagreed, stating that substance misuse is in fact a concern, particularly among youth.

And I worked with youth and... I don’t know if parents got their head in the sand or the community got their head in the sand, but it’s going on, big time... (Charlottetown focus group)

The Charlottetown focus group included a very frank discussion about alcohol use, with many participants stating that alcohol use is a problem among youth in the community, and that they were also concerned about drinking and driving. One focus group participant explained that Charlottetown no longer has a store that sells alcohol, but instead of cutting down on the amount of drinking, it simply means that people are travelling to other communities to access it. This may be a problem if youth (and adults) end up buying alcohol elsewhere and then drinking it while driving back to Charlottetown.

Participant: I did have a small business here that did supply beer, but it was only to anyone over the age of nineteen... I closed my business as of December last year, and there’s more beer bottles and beer cases on the road now than ever.

Participant: It’s still happening.

Participant: So what they are doing is driving to another community and picking up twice as much what they would need, and drink on the way home.

Facilitator: So are they drinking and driving?

Participant: Oh yes.

<table>
<thead>
<tr>
<th>Frequency</th>
<th>Male % (n=150)</th>
<th>Female % (n=189)</th>
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</thead>
<tbody>
<tr>
<td>Never</td>
<td>42.0</td>
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</tr>
<tr>
<td>Less than once a month</td>
<td>16.7</td>
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</tr>
<tr>
<td>Once per month</td>
<td>10.7</td>
<td>7.9</td>
</tr>
<tr>
<td>2-3 times per month</td>
<td>16.0</td>
<td>4.8</td>
</tr>
<tr>
<td>Once per week</td>
<td>10.0</td>
<td>3.2</td>
</tr>
<tr>
<td>More than once per week</td>
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<td>0.5</td>
</tr>
<tr>
<td>Everyday</td>
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<td>0.0</td>
</tr>
</tbody>
</table>

**Table 5.5.** Frequency of binge drinking (greater than 5 drinks in one sitting) in the past 12 months by males and females.
Participant: No doubt about it.
Participant: They’re at it all the time.
Participant: They do it a lot. (Charlottetown focus group)

One of the young adult participants in the Charlottetown focus group explained that drinking has become a social norm for youth. They explained that this was partly because there was little else for youth to do in their free time, but it was also simply ‘what everyone else was doing’.

It was kinda like, at first it was... kinda odd for everyone to be doing it... But like then after a while it’s just like you’re immune to it... (Charlottetown focus group)

Among the focus group participants in Mary’s Harbour, participants suggested that although there was a lot of attention paid to youth, alcohol use is a problem among other family members too.

Participant: I think with the drugs and alcohol, I think most people are looking at teenagers.
Participant: Yeah.
Participant: But I think it’s far beyond that... It’s probably the mothers and fathers, the aunts and uncles, even probably the grandmothers and grandfathers. (Mary’s Harbour focus group)

Figure 5.5. Frequency of binge drinking (greater than 5 drinks in one sitting) per month by age category.
In the survey, on average men reported consuming alcoholic beverages more frequently than women (Table 5.4). Men also reported consuming five or more alcoholic beverages in one sitting more often than women (Table 5.5). Consuming five or more drinks in one sitting may be indicative of binge drinking, which has been associated with a number of adverse health and social outcomes (Flegel et al., 2011). Participants aged 16-24 were more likely to have participated in binge drinking at least once a month, compared to older age groups (Figure 5.5).

Support for substance misuse issues

There appears to be a sense amongst many community members that there are few opportunities for people to learn about substance misuse, aside from Alcoholics Anonymous meetings, or actively seeking assistance from a regular health care provider (e.g., family doctor). A small minority (approximately 1%) indicated that they used cannabis regularly. Interestingly, although the survey results indicated low rates of substance use, participants in the qualitative interviews and focus groups reported that use of illegal substances such as hashish, marijuana and even some ‘harder’ drugs like Ecstasy were becoming more common, which was seen as problematic in their communities.

Yes, there is an Alcoholics Anonymous group in town, and other than that I would say they probably, people just go to the clinic and then they probably just get referred out. But as for drug abuse, there is nothing available in this community... and there is drugs here, there is no doubt about that, yeah. (Kim Morris, Cartwright)

Many stated that if there were opportunities for community members to discuss substance use issues, there would be more awareness about how to make responsible decisions regarding drugs and alcohol, and how to seek help if drugs or alcohol use becomes problematic.

I would like to be able to talk to [youth] about it... tell them our experience and what happened... or something to show what can happen... [like] videos to show... what can happen... Nothing good comes out of it, hey. (Bella Burden, Pinsent’s Arm)

There’s an awful lot of drugs now in our communities... we say it because everybody knows it, eh ... It’s not ... just black and white, I’m sure of that... If you don’t talk about it, it will never go away... the key is to talk about it... (Guy Poole, St. Lewis)

5.5 Sexual and Reproductive Health

Sexual health behaviours can impact a person’s physical and mental wellbeing. Approximately 70.9% of the survey respondents reported being sexually active in the previous 12 months. The majority of the respondents reported that their sexual activity was with one partner only (see Table 5.6). A small propor-

Table 5.6. Number of sexual partners for sexually active males and females in the past 12 months.

<table>
<thead>
<tr>
<th>Number of partners</th>
<th>Male % (n=96)</th>
<th>Female % (n=140)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 partner</td>
<td>91.7</td>
<td>97.1</td>
</tr>
<tr>
<td>2 partners</td>
<td>0.0</td>
<td>2.9</td>
</tr>
<tr>
<td>3 partners</td>
<td>5.2</td>
<td>0.0</td>
</tr>
<tr>
<td>4 or more partners</td>
<td>2.1</td>
<td>0.0</td>
</tr>
<tr>
<td>Refused</td>
<td>1.0</td>
<td>0.0</td>
</tr>
</tbody>
</table>
The reported use of several different methods of birth control. Surgical methods of birth control (e.g., tubal ligation or vasectomy) were the most prevalent method of birth control used; the majority of these individuals were married or living in common-law relationships. Condoms were the most widely used form of birth control among individuals who were not married or in common-law relationships. Birth control pills and withdrawal were the next most com-

<table>
<thead>
<tr>
<th>Birth Control Method</th>
<th>Single (never married), separated or divorced</th>
<th>Married or living common-law</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>20.0 (9)</td>
<td>53.1 (104)</td>
</tr>
<tr>
<td>Condoms</td>
<td>53.3 (24)</td>
<td>8.7 (17)</td>
</tr>
<tr>
<td>Birth control pills</td>
<td>26.7 (12)</td>
<td>11.2 (22)</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>17.8 (8)</td>
<td>7.7 (15)</td>
</tr>
<tr>
<td>Depo Provera (injection)</td>
<td>6.7 (3)</td>
<td>1.5 (3)</td>
</tr>
<tr>
<td>Rhythm</td>
<td>0.0 (0)</td>
<td>1.0 (2)</td>
</tr>
<tr>
<td>Other</td>
<td>(2)</td>
<td>3.1 (6)</td>
</tr>
</tbody>
</table>

* Rows will not add to 100% as values are based on answering yes/no to that particular method and individuals could have answered yes to more than one method

Table 5.7. Birth control methods among married (including common-law) and single individuals among sexually active individuals.

<table>
<thead>
<tr>
<th>Birth Control Method</th>
<th>1 partner</th>
<th>2 or more partners</th>
</tr>
</thead>
<tbody>
<tr>
<td>Surgery</td>
<td>48.2 (108)</td>
<td>16.7 (2)</td>
</tr>
<tr>
<td>Condoms</td>
<td>13.8 (31)</td>
<td>75.0 (9)</td>
</tr>
<tr>
<td>Birth control pills</td>
<td>13.8 (31)</td>
<td>25.0 (3)</td>
</tr>
<tr>
<td>Withdrawal</td>
<td>9.4 (21)</td>
<td>16.7 (2)</td>
</tr>
<tr>
<td>Depo Provera (injection)</td>
<td>2.2 (5)</td>
<td>8.3 (1)</td>
</tr>
<tr>
<td>Rhythm</td>
<td>0.9 (2)</td>
<td>0.0 (0)</td>
</tr>
<tr>
<td>Other</td>
<td>3.6 (8)</td>
<td>0.0 (0)</td>
</tr>
</tbody>
</table>

* Rows will not add to 100% as values are based on answering yes/no to that particular method and individuals could have answered yes to more than one method

Table 5.8. Birth control method used by sexually active individuals based on the number of sexual partners in the past 12 months.

The men surveyed reported having 3 or more sexual partners within the past year (5.2% compared to 0% among women). Younger age groups were not significantly more likely to have a larger number of partners than older participants.

Different methods of birth control may help people to prevent unwanted pregnancy or reduce the risk of contracting a sexually transmitted infection (STI). Table 5.7 summarizes the use of birth control methods among married (including common-law) and single individuals among sexually active individuals.
mon methods of birth control, respectively, for all sexually active individuals. Other forms of birth control reported by participants included menopause (not a true method of birth control), intra-uterine devices (IUD) and the birth control patch. Among individuals who had more than one partner, condoms were the most utilized form of birth control, although birth control pills, Depo Provera and withdrawal were also used (Table 5.8). These values should be interpreted cautiously as they are based on a very small number of individuals (17 in total). Only 58.3% of the individuals that reported 2 or more partners in the past year had been tested for STIs. Although this finding represents only a small number of individuals, it may be important in terms of the spread of STIs in NunatuKavut.

5.6 Men’s Health

The majority of the participants in the focus groups were women, but in St. Lewis and Charlottetown, a number of men also participated. In these two focus groups, participants raised issues related to men’s health, even though gender was not specifically raised by the focus group facilitators. In one community, for example, participants mentioned that men are less comfortable talking about issues related to healthy sexuality or sexual health problems than women. In many cases, a man’s partner or wife would have to ask the clinic nurse about his sexual health problems, because the men did not feel comfortable doing so. This may be partly explained by the fact that most of the clinic nurses are female, and there are very few male nurses available to talk to.
The sexual health section of the survey focused on issues of safe sex and pregnancy, and did not address sexual health problems. As sexual health issues can have far reaching implications on an individual or couple’s mental and physical well being, it would be well worth including measures of sexual health and healthy sexual relationships in future studies.

Aside from sexual health, concerns were also raised about men’s physical activity levels. In years past, men were generally very active, since they were often outdoors hunting, fishing, cutting wood or doing something that involved physical labour. These activities were done for the benefit of one’s family or household, and therefore were not thought of as exercise for the purpose of fitness. For most families today, many of these formerly ‘essential’ activities are now optional, or are engaged in intermittently or with the help of gas-powered tools or motorized vehicles. This physical work has not been replaced with physical activities done for the sake of being healthy and active. As an older man from Charlottetown states, ...

...I think as a man my age and a little older... I think we have to change our attitude towards exercise. I think our attitude is ‘ah we’re ok, we don’t need to walk, we don’t need to exercise’ and things like that. (Charlottetown focus group)

Similarly, in the quote below, the same man explains that it is so unusual for a man to be seen out walking for exercise, that it is often difficult to do so without being stopped by cars and offered a ride.

... A little more education for us guys... for instance I went into a garage a while ago and dropped off the truck. I had three invitations for a ride as I walked out (laughing). “What happened? Your truck broke down?”... It was almost a sin I was walking. (Charlottetown focus group)

In the survey, a large percentage of both men and women identified the loss of cultural identity as a problem currently facing their community. It would appear that the loss of cultural identity affects males disproportionally with respect to physical activity levels, as the physical activities that men tend to take part in are linked with cultural roles traditionally filled by men within these communities. This might include activities such as cutting wood, hunting, and fishing; all activities that would require physical activity and a certain level of fitness. Because
exercise is associated with positive health outcomes, this loss of culture impacts men’s health, as they may not be replacing traditional forms of exercise with alternatives.

At one point during the focus group discussion, a number of people speculated as to why men might not like to do exercise for the sake of exercise. The same older man quoted previously mentioned that this may in part be the result of the traditional roles of men in the community. He suggested that there are many expectations attached to what it means to ‘be a man’ in a small fishing community, and many of these expectations do not include ‘going out for a walk’ or doing other activities that might be perceived as less masculine. He suggests that this argument might extend beyond men’s willingness to engage in physical activities, to include other aspects of their lives, like getting an education. These things may not fit within the social norms that were constructed when men’s roles in the community were considered ‘set in stone’ – that is, they were fishermen and they were hunters.

At my age, 40 and 43, [education] wasn’t the thing to do, we were fishermen and that’s what [you’re] kind of expected to do, to be a man, to be a fisherman, not to go away and do college or things like that… (Charlottetown focus group)

The women who took part in the Charlottetown focus group seemed to agree with this analysis. In fact, one woman said that even when she and her children make a point of being active and getting fit, it is still very difficult to persuade her husband to follow suit. She sug-

suggests that this is the case for many of the women she knows.

... I hear a lot of people say, ‘finally I’m fit, [or] I’m trying to get fit, and my kids, but I can’t get my husband up’. (Charlottetown focus group)

Interestingly, the results from the survey suggest that both women and men are equally physically active, but they engage in very different types of physical activity, which might help to explain why women feel that men are not as active as they should be. As was suggested by the qualitative data, many men do not exercise ‘for the sake of exercise’, but many of them do still take part in more traditional physical activities, like cutting wood, hunting and fishing, even though it may not be as frequent as in previous years. Specific physical activities are listed in Figure 5.1. Men were more likely to be involved in traditional forms of physical activity such as hunting and trapping, fishing, and snowshoeing. They also identified a number of other activities such as wood collecting/chopping and snow removal. However, men were less likely than women to participate in more ‘modern’ types of physical activity such as walking, dancing or aerobics classes. Men were also more likely than women to report that a typical workday for them included moderate or strenuous physical activity, and a typical session
of physical activity for men was significantly longer than the average for women. Conversely, men were more likely to indicate that they spend more time doing sedentary leisure activities such as watching television, playing computer games or using the computer.

5.7 Conclusion

This chapter has focused on a variety of individual health behaviours, including physical activity, nutrition, and substance use. It is important to acknowledge that although the decision to eat healthily, exercise regularly and use drugs and alcohol ‘responsibly’, these decisions are also set within a context of social pressures and norms, and barriers such as cost and infrastructure that make it easier to make certain (positive or negative) health choices than others. As such, it is important to emphasize here that even though individuals may make choices regarding their health that may be viewed as ‘healthy’ or ‘unhealthy’, communities play a large role in providing information to individuals about the choices they make. It is hoped that by shedding light on what kinds of individual level health behaviours people are engaging in, resources and supports can be put in place to support those activities that are health promoting.

Brook running out of Gull Lake, a popular ice fishing location. Courtesy of Melita Paul.
5.8 References


6.1 Direct and indirect costs of health care

Ten percent of survey respondents reported not being able to afford the direct cost of health care services (i.e., the cost of tests, treatments and medications) in the past year. There were no significant differences between respondents with respect to sex and education level, but significant differences were observed with employment status. Individuals who were unemployed or who worked part-time were more likely to report that they could not afford the direct costs of health care (see Table 6.1). One in 10 respondents reported that they had difficulty affording prescription drug costs. Individuals on lower incomes were significantly more likely to have trouble paying for prescription drugs, while there were no observed differences between males and females, education levels or with employment status.
Participants in the interviews and focus group sessions also noted that pharmacies’ dispensing fees had increased in the past year, which they argued had made prescription medications much less affordable. In the past, individuals paid one dispensing fee regardless of the number of prescriptions being filled. Now, there is a charge of $8.50 per prescription, which many people argued is making prescriptions unaffordable, particularly for the elderly and those on fixed incomes, who may have multiple prescriptions.

Participant: I got to have my drugs to keep myself healthy, I got to have the heat to keep myself warm and we got to put food on the table... I heard people say they gave up the cholesterol pills because they can’t afford them... The money goes to something else – either food, heat, whatever, and they’re just not going to get their medications that they require.

Participant: And it started happening after the dispensing fees went up.

Participant: That, that affected a lot of people too.

Participant: Yeah.

Participant: He’s right.

Participant: He’s right. (Mary’s Harbour focus group)

For patients along the southeast coast who have to travel to attend medical appointments, the government subsidizes their flights to make them more affordable. Currently the cost of a return flight from the southeast coast to St. Anthony is approximately $40 if one is travelling for medical reasons. This cost was not considered prohibitive for most people who have necessary appointments. However, the additional costs one must incur in order to attend an appointment were identified as problematic. For example, in addition to the cost of the flight, a person must also pay for accommodation while waiting for the appointment, and since most flights only travel two or three times per week, the minimum stay for an appointment is two nights. The hostel in St. Anthony offers rates of $45-50 per night, but in some cases, residents report that the rooms are not available when they need them and they end up staying in hotels, which can be very costly.

I went over last week and I called a week in advance for our hostel room and she said we’re really, really booked up so I had to go get a hotel room. (Ford Rumbolt, Mary’s Harbour)

In addition, people must pay for food and other expenses while they are away from home. Sometimes the travel means lost wages for the patient and anyone who must travel with them, as well as paying for childcare. Depending on

<table>
<thead>
<tr>
<th>Employment Level</th>
<th>Could not afford direct cost of care or services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed (n=77)</td>
<td>22.8%</td>
</tr>
<tr>
<td>Seasonal (n=136)</td>
<td>5.8%</td>
</tr>
<tr>
<td>Part-time (n=36)</td>
<td>13.9%</td>
</tr>
<tr>
<td>Full-time (n=89)</td>
<td>4.5%</td>
</tr>
</tbody>
</table>

*Table 6.1. Ability to afford direct healthcare costs by employment status.*
these factors and the length of time one has to stay to attend appointments, a routine medical appointment might incur over $200 in additional costs.

Cause if you go over on the plane well then you get over on a voucher which is $40.00, but when you get to St. Anthony then you have to ... stay somewhere for probably two nights and you’re paying forty or fifty dollars there for a hostel so it is... it is costly just to access basic services... in a little town. ~ Jeffrey Penney, Port Hope Simpson

Interviewer: Are there services that are being addressed but are inadequate or inappropriate?

Participant: ... I don’t know about the majority, but a high percent of people that I talk to, here in our community… it’s the cost to them of attending a doctor’s appointment and the time it takes even to go to St. Anthony. It’s costly for some, and some people really can’t afford it... and there’s been times when even the people in the community would have to do some fundraising for people to go to some of these appointments, or if they had to stay a long time, to just help some of these people out...(Jeffrey Penney, Port Hope Simpson)

In addition to the expenses associated with attending routine appointments, there is also the chance that appointments might be re-scheduled or cancelled without notice, particularly if a person is unable to get on a scheduled flight to attend their appointment. This can be very problematic, both in terms of cost and in terms of coordinating travel and accommodations for new appointments.

...we were over there in March and this lady was there from [town], and she is an elderly lady, she went over prepared to have surgery... it was probably late the next day when she found out she wasn’t gonna have surgery... they should have called her and told her before she left [town]... So she ended up not getting to the plane right... she was over there for five days with her and her daughter in a hostel, and no surgery, and she gotta come back in July for the surgery... She said all her money is gone, she gotta come back in July, her daughter will be working... I just felt so bad that here she is out all this money, stuck over there the whole week and for nothing, you know, and that happens every day... go over in the hospital, you will see people from all over the coast, tell you their story, you know, one
more horrific story after another… (St. Lewis focus group)

One suggestion participants had for overcoming these scheduling difficulties is for the hospital to work with the air service provider to coordinate medical appointments for the people of the coast. This would not only ensure that medical appointments would take priority on certain flights, but would also ensure that patients travelling for appointments would not have to wait for days to return home after their appointment is over.

I know they can't have a plane of their own and takin' everybody back and forth but I, I’m wondering if ah, people from the coast could have different appointment days? Because ah, if you’re in St. Anthony or around there it’s only to jump in your car and go, but if you’re here and you’re in the same lot of appointments as they have over there it’s different. So I think people from the coast should be looked, their appointments should be looked at a little bit differently from where you can get in your car and go. (Marie Rumbolt, Mary’s Harbour)

An additional concern for residents are the costs associated with air ambulance flights – although there is no cost to be air-lifted out of the community for an emergency, the patient must pay for accommodations, meals, and the return flight back to their community. Depending on the severity of the health issue, this can be quite expensive.

That’s like being medevac-ed out of here, I mean you leave here you never know like... what it’s going cost you before you get back. (Ford Rumbolt, Mary’s Harbour)

Many participants were also concerned about the costs associated with other health care appointments for which many people along the coast do not have insurance, such as dental appointments. Dental care can be very costly, particularly if the procedure goes above and beyond a regular dental cleaning. Along with this are the costs of travelling to attend a dental appointment if there are no upcoming scheduled dental visits for the community.

…when it comes to dental I think it’s a chore for you to have to go to get it done and then there’s the stress of, ‘well ok how am I am I supposed to pay for this when it is done?’ (Marie Rumbolt, Mary’s Harbour)

6.2 Weather and Isolation

Communities in southeastern Labrador vary widely in terms of the availability of health services in the community and how easy it is to access services when they are needed. For example, although all of the communities along the southeast coast could be considered isolated, the towns of Mary’s Harbour, St. Lewis, Port Hope Simpson, Cartwright and Charlotte-town are accessible by road and by water; they each have a community clinic with at least one full-time nurse and an airstrip for transporting patients or supplies. In contrast, people who live in Pinsent’s Arm, Lodge Bay, William’s Harbour and Paradise River must travel to other communities to receive services. In Black Tickle, there is no road access but the community does have an airstrip and clinic. In Norman Bay there is only seasonal access to the community, by boat or snowmobile, and there is no permanent medical staff based there. As such, the length of time it takes to travel to appointments and the acces-
sibility of emergency services vary considerably between the different communities on the coast.

The weather is also an important factor in residents’ ability to travel to medical appointments, and medical professionals’ ability to travel into isolated communities. The winter of 2010 was unusually warm along the coast of Labrador. The lack of ice made it very difficult for people in the more isolated communities to receive health care, since they had no way of leaving the community, and medical personnel had no way of getting there. The same issue arises each spring and fall when the snow, ice, and bad weather leave the towns isolated until the weather improves. In Norman Bay, the people have lobbied the government for a road connection, but to date their efforts have not been successful.

Participant: We wrote the minister, we wrote everybody, nobody don’t want to help us... it wouldn’t cost a big lot to put [in] a road... but government won’t look at it. They are gonna extend the ferry [service] again... for another five years... that is no good for in the fall... when it starts to freeze up sometimes you [are] two weeks... completely isolated. We got no airport... we got nothing; the ferry in summer time and skidoo in the winter time.

Interviewer: And has the transportation been an issue this winter?

Participant: Yeah, an awful issue this winter because ice haven’t been thick enough to get in, and then we had a lot of mild weather and they have had the chopper on couple of weeks bringing people back and forth, people going into the clinic for blood work and everything. ’Tis been a hard issue this year especially. (George Roberts, Norman Bay)
6.3 Trans Labrador Highway and the Reduction in Medical Services

In 2000, communities along the coast of Labrador welcomed the opening of the Trans Labrador Highway, which, for the first time, connected them by road to the world outside of the southeast coast. This provided residents with the opportunity to travel to other communities and towns on the island portion of the province, and allowed freight to be delivered by road. The new road connection has brought significant changes to southeast coast communities, which have impacted health care delivery, including the ability to drive to medical appointments in Newfoundland, and the ability to travel by ambulance to clinics outside of one’s immediate community for medical emergencies.

The difficulty with the new road, however, is that it cannot be relied upon during harsh winter months when it is impassable due to heavy snow accumulation. Also, the road itself is often very rough, making travel in an ambulance difficult for someone who might be in pain. Although the option of driving to medical appointments makes it easier for those with vehicles to travel on their own schedule, this does not diminish the extensive travel time required to attend a medical appointment. Nor does it address the problems of driving during poor weather conditions (i.e., when high winds close the ferry service to the island or prohibit air travel). In the fall of 2009, the last phase of the highway was opened, which now connects the southeast coast of Labrador to Happy Valley-Goose Bay. Although by and large, the residents...
The road has made it easier to leave the coast by vehicle, as a result, there has also been a reduction in air travel and air services in the last five to ten years. Before the road, most travel, freight and mail delivery to and from NunatuKavut was by airplane, particularly during the winter months. It is now more common for residents to use their vehicles to pick up materials themselves, or they rely upon freight delivery via transport trucks. This has resulted in a significant reduction in air travel services.

A number of study participants talked about the reduced schedule of flights into and out of their communities. Previously, services were provided by competing companies – Air Labrador and Provincial Airlines – but in the past few years services are only provided by Air Labrador. Currently, most communities along the coast have flights dropping off mail and freight two to three times per week.

Most major medical appointments require air travel to either St. Anthony or St. John’s. More recently, since the opening of the road connection to Goose Bay some residents are also driving to Goose Bay to access health-care services. The provincial government subsidizes flights out of the coastal communities to attend regular medical appointments, and seats are reserved for community members based on a ‘triage’ list that allows patients to board flights based on priority and the severity of their health needs. With a limited number of flights leaving the community at any given time, there is no guarantee that a person will be able to attend a scheduled medical appointment.

I know of some people have lost their appointments because the plane didn’t come.

(Marie Rumbolt, Mary’s Harbour)
... if you’re going for a medical appointment... if you got a dental emergency you’re not going be looked at until all medical appointments are taken in account and if there’s space for you after. (Ford Rumbolt, Mary’s Harbour)

Many residents spoke about the difficulties of leaving home to attend medical appointments. Often the appointments were quick follow-up visits that might only last ten or fifteen minutes. However, the preparation, planning and travel needed to attend these medical appointments take much more time, especially given the reduced flight schedules. The work associated with coordinating a medical appointment, booking accommodations and travel, and dealing with work and family commitments has made some residents reluctant to book appointments unless they feel they are absolutely necessary.

And now look at the air service that we do have, like my appointment was booked for the 29th of March, so I would have had to travel over on a Wednesday to get a Friday appointment, and I wouldn’t be able to return home until that next Monday... I would have missed Wednesday, Thursday, Friday and Monday of work. Plus I had two kids home. And my husband works ‘til five or whenever he gets home... He’s working in Voisey’s Bay... and I just, you know, you can’t just go with something so unreliable as that... And for a fifteen minute appointment. (Mary’s Harbour focus group)

Seems like, I know I’ve heard talk of people who had to go for, for an x-ray and they wanted, they went to St. Anthony for like a few-minute appointment – they’d be gone all week. Like they’d have to be sent over on plane and wait around for their appointment and if they missed the plane that day they might have to wait till Friday to go over on Monday, and it’d be Friday until they’d get back... (Shane Bridle, Port Hope Simpson)
Attending medical appointments is particularly problematic for the elderly, or others who need intensive medical care. Often they need a family member or friend to accompany them to their medical appointments, meaning that flights, accommodations and other travel arrangements must be made for two people rather than just one.

Mom would leave here, and I would take Mom and would drag all of her bags everything she had to use for her dialysis. We’d muck all that all over St. Anthony, you know, heaviest stuff to get around, and getting her up early in the morning and doing all and getting everything done before she had to go to the hospital and everything. And we’d go in and she would step on the machine and he’d look at her and he’d look at her pills and he’d say ‘alright Mrs. [name] you got no problems now; everything is fine’. He’d take her blood pressure and he’d go and he’d say ‘okay’. She’d get down, she’d put her clothes on, we’re gone. (Mary’s Harbour focus group)

Coordinating appointments and accessing needed health care may be even more problematic if the health issue is of a sensitive or private nature. In the quote below, a mental health counselor notes that mental health issues are sometimes difficult to diagnose, particularly if people are reluctant to seek medical attention in the first place. With additional barriers to accessing needed services, it is more likely that people will simply not receive the treatment they need.

...I do mental health counseling and [person’s name] is the mental health nurse, but right now in these communities there’s no other services. Usually you’ve got to access it through St. Anthony, which is a bit of an issue for some people, especially with the stigma associated with mental health. Um, a lot of people don’t wanna fly over to St. Anthony to see a psychologist or to see a psychiatrist or whatever... in bigger centres too, there’s maybe self help groups or... groups to deal with different aspects of mental illness. That’s not available here. (Shane Bridle, Port Hope Simpson)

6.4 Emergency Services

The above section has shown that it can be difficult for people along the southeast coast to coordinate scheduled doctor’s appointments. The situation is exacerbated during a medical crisis, since the coordination is very time-sensitive. In the quote below, Guy Poole reflects that with so many factors at play, it is sometimes difficult to ensure that the patient gets the best care.

… One could say we got it pretty good here. We got an airport eh, that’s less than five minutes away... one could say we got a clinic here that’s, you know, less than two or three minutes away... all this eh, is good. But having said that, when an emergency happens, and someone is brought to the clinic ... and they’re in dire straits... like in a skidoo accident or whatever the case might be, then there’s a whole lot of factors that, if it don’t mesh together, somebody is gonna be in trouble. (Guy Poole, St. Lewis)

During a crisis many factors, such as weather, distance, and severity of the injury, are beyond the immediate control of any one individual or group. Therefore it is important that all of
the things that can be controlled are put in place, in case an emergency arises. But in some cases, it takes an emergency for changes to happen. Guy Poole notes that before his wife died of complications related to diabetes, there was an incident where she was being taken by ambulance to the local airstrip to be airlifted to the hospital. But when they arrived at the airstrip, there was a gate blocking the entrance.

There was one instance eh that stuck, it sticks in my mind that should never have happened. Liz got sick as she did many, many times. We took her to the clinic... I couldn’t even take her in my truck... The ambulance had to come from probably Port Hope, so she was put on the stretcher, she was took out of the clinic, put in the ambulance, the ambulance had to go ‘bout 1000 feet... When we got to the airstrip the plane was on the... strip waitin’, waitin’ for Liz to go out... and it was rainin’ like you’ll never see it before.... and here was this big gate across eh, this yellow gate... the airstrip was barred off and there was a lock on it... And I mean she was a sick woman, and I was upset that day eh, I was upset because my woman was so sick. But anyway, I took it on me hands to damage some equipment and I didn’t care that day what it belonged to - I took the axe eh, and I beat the lock off the [gate]... and I come home and I phoned the RCMP and I told ‘em what I done... A week after that I got on the interview, ah Crosstalk [program on CBC Radio] with the minister responsible for that kind of stuff and told him eh. And that made a difference then after that, then the ambulance driver, the clinics... and the people looking out for the airstrip had a universal key... they changed it eh... that’s never gonna happen no more in our small communities, what happened to my wife that time... it should never have happened. (Guy Poole, St. Lewis)

When there is an emergency in any of the coastal communities, the local nurse assesses the situation and consults with a doctor to determine if the patient needs medical attention at a hospital. If necessary, the patient is transported to hospital with use of the local cargo plane. In some cases, this can work very efficiently, with patients arriving in hospital as quickly as possible. However, many residents expressed concern about relying upon the local planes for emergencies. These small planes are not specifically designed to handle emergencies, they are not always available, and small cargo planes cannot land unless weather conditions are optimal. Currently, all
of the airstrips located along the southeast coast of Labrador have short, dirt runways. Medevac planes, which are administered by Newfoundland and Labrador Government Services, need a long runway to land, and cannot land on dirt airstrips because of the low undercarriage, and so they are currently unavailable to residents who live on the southeast coast.

When my, our brother died and they came in for him, [it] was 1 o’clock, 2 o’clock in the morning. That plane couldn’t land here on the airstrip, neither one until daylight, but it was a critical situation and we couldn’t get any help, we had to wait. (St. Lewis focus group)

We’ve had problems here, we had ah young [man]... broke his leg here in the afternoon and the chopper never come till next day, close on dinner time before the helicopter got in to pick him up. (George Roberts, Norman Bay)

In early spring of 2010, the provincial government made the decision to move one of two provincial Medevac planes from its base in St. Anthony to Goose Bay in Labrador. The move generated a lot of opposition from residents of St. Anthony and along the northeast coast of Newfoundland, since they would be losing a very important service from their local hospital. But to residents of Labrador’s southeast coast, Medevac’s location is of little interest, because the plane is unable to service their communities. Many residents expressed frustration over the amount of media attention paid to the Medevac’s changing location, while the people along the southeast coast of Labrador continue to rely on cargo planes for medical emergencies.

Participant: … He had a problem there last year, so he went down to the clinic and I guess they talked to a doctor in St. Anthony, they suggested he go down to Forteau… Two hours over a dirt road, five hundred thousand pot holes, bedrock sticking up three and four inches… So they hemmed and hawed at that for ten to fifteen minutes, then one of his friends volunteered to take him down so they hemmed and hawed at that for another eight to ten minutes. That was cancelled. Then they were gonna get the ambulance from Port Hope Simpson to come pick him up. So they poked around at that for another five or six minutes or ten minutes. That was postponed. And that’s when… they were gonna get the plane to come from St. Anthony, the Air Ambulance. It was about ten minutes and the nurse come to us and said, ‘No, they can’t land on a dirt airstrip’, so that was called off. So that was three vehicles and a plane. And then they called Labrador Airways [sic] and gone about ten minutes and came out again she said Labrador Airways don’t fly after 12 o’clock… now we said ‘who you gonna go to now?’, ‘gonna try [the pilot who flies a cargo plane]’…and [he] said, ‘I be there in 25 minutes’, so roughly around 45 minutes after [the pilot] turned up, now that was three vehicles and three planes.

Participant: And this man ended up going out on cargo…

Participant: … ended up going out on a cargo plane with no facilities to handle an emergency if it was required. So we have this beautiful new Medevac and that is useless to us, we need a four thousand foot paved strip
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for that to land on, so what benefit is that to us? When I hear all these stories on television every day it makes me puke, because no consideration is being given to the people on the south coast of Labrador, it’s all Goose Bay, Labrador City, or St. Anthony or the West Coast but not about us… we still have to depend on our cargo plane and hopefully that they can get you in through their door. (St. Lewis focus group)

One of the participants in the focus group in St. Lewis pointed out that it might be less costly and more efficient for the government to invest in at least one standard-size, paved runway along the southeast coast of Labrador, because then they would be able to use their existing air ambulance during medical emergencies, instead of having to contract out the service to someone who is ill-equipped to deal with a medical emergency.

To me it’s a double expense for Grenfell, or for the government or somebody, you know they got a state-of-the-art aircraft there sitting in the hangar, they gets the call to take someone down Mary’s Harbour or Port Hope Simpson, they got to turn right around charter another air plane, with their own aircrafts, pilots and mechanics and everything on a salary every day… so to me it is a double expense for the government. (Guy Poole, St. Lewis)

6.5 Policing Services

Participants also expressed concern over problems in accessing police services during an emergency. Even calling for help can be difficult and frustrating. Currently, there is a system in place which directs all policing calls to a central operator in St. John’s. Similar systems exist all over the country when calling the RCMP – calls get directed to a dispatcher, who will then connect you with the local RCMP detachment in your area. The first problem raised is that the dispatcher in St. John’s is often unaware of the geographic distances between communities in southeastern Labrador and the length of time it takes to travel between communities. If there is an emergency and a call is forwarded to the detachment in Mary’s Harbour and there is no one on duty, then the person calling must hang up, call the dispatcher in St. John’s again, and repeat the request for a detachment in Cartwright or Forteau, which might be a significant distance from where the emergency has occurred. The additional time it takes to track down a detachment to deal with an emergency wastes valuable time. Many participants saw this as unacceptable – in these communities the RCMP know everyone in the community and where they live, and could respond very quickly if the individual was allowed to speak directly to the detachment in their area.

… you call the police now you’d get someone in St. John’s … So even though the station is up here… you make a call, you get through to St. John’s… That’s a pet peeve of mine because you know, the police know the people in Cartwright right?… And they know who’s, like if I called over there now, they’d know who I was… But if I called that number and I get someone in St. John’s I have to explain who I was, where I lived… (Cartwright focus group)

Participants also expressed serious concerns over the length of time it can take for police to
respond to emergencies in such a geographically dispersed area. Although nothing can be done to shorten the distance between communities, it is important to reflect on the measures that are put in place to ensure the best possible response in the event of an emergency. This includes ensuring that emergency vehicles are always serviced and ready to respond, and ensuring that various parts of the coast always have someone on-duty who is able to respond in a timely manner. In the story below, a woman in Pinsent’s Arm recounts the horrifying ordeal her family faced when her son was killed by a drunk driver over the Christmas holidays.

..the night this happened to [our son], ah, they had Forteau on call… there was no one on call in Mary’s Harbour… so [we] tried calling Mary’s Harbour... and [we] couldn’t get through… you would get St. John’s… and so then you had to wait for an RCMP officer to come… all the way from Forteau… they left from Forteau, they couldn’t get down ‘cause the, you know how bad the weather is and the roads, so they couldn’t… so then [the police from] Mary’s Harbour came. Then Mary’s Harbour had to go to Port Hope Simpson to gas up. So you imagine having an emergency vehicle not gassed up? … This happened to [our son], twenty after one in the morning. And the cops came down here to this site… it was the next day. Sometime before dinner the next day… it took ‘em like five and six hours like that… If we left [our son] up there... he would’ve been snowed over before the cops got here… they needs more cops on Christmas time cause you knows there’s more people on the go… (Bella Burden, Pinsent’s Arm) The police’s inability to arrive in a timely manner hindered the investigation, and no one was charged in connection to the young man’s death. This issue also speaks to the difficulty of enforcing laws in remote communities, where police response times are slow and evidence may be time-sensitive.

Participant: There was charges but they was all dropped… [the person] was charged for impaired driving causing death, and driving while under the influence, but everything was all dropped because if you don’t get the blood results in, within three hours, the courts won’t look at it. So, [the police] were way over the three hours by the time they got to the clinic and took [the person’s] blood right, it was too long… Like I said it’s not gonna bring him back, but at least it would have been some justice… I don’t want another parent to be going through what we’re going through. (Bella Burden, Pinsent’s Arm)

6.6 Satisfaction with Health Care Providers

The majority of survey respondents (69.6%) felt that they have less access to local health care services than other Canadians. There were no differences in this response between men and women. Despite the low availability, the majority (66.2%) of people surveyed felt that community and health care programs were strengths of their community. There were slight (p-value 0.056) differences between men and women – men (71.8%) were more likely to feel that community and health programs were strengths of their community than women (61.7%).

It may seem contradictory that people
believe they have fewer services than other Canadians, but that they also feel their health care services are among their communities’ strengths. It is critical to make the distinction between the amount of services that are available and the quality of care provided. Although the majority of people felt that they receive fewer services than the average Canadian, there is great satisfaction with the services that are provided, and in particular with the health care workers who provide the services. In all of the interviews and focus groups, participants showed a tremendous degree of respect for the local health care providers. They recognized their hard work and long hours, and described a dedication to their jobs that often goes above and beyond the call of duty.

You come to a coastal community, you’re not only a nurse, you’re everything, whatever is required at the time. (Guy Poole, St. Lewis)

Participant: The nurses are as good as doctors.

Participant: ...we have been blessed with the quality of nurses that we’ve got. (Ford Rumbolt, Mary’s Harbour)

They’re over-worked and under-paid. It’s like they say you know... my daughter... when she’s on call that girl is never in the house... Never says a word, never complains... she’ll say, ‘it’s part of my job’.... when you’re called, you go... don’t hesitate...(Charlottetown focus group)
For many, an important element of good quality health care was having access to health care providers who have lived in the community for a while and know their patients’ names and medical histories.

The nurses are good, they know your history (Lydia Penney, Port Hope Simpson)

I think that we’re very fortunate here in this community, we have three nurses that are permanently stationed here and there are three nurses that have been here long term, and ahh, so that keeps the consistency. Like there is nothing worse than going to the hospital and they ask you who your family doctor is and you have to say well it’s… whatever doctor happens to come in, but you know these three nurses up here are well trained and, and good, you know… they provide a very good service for our community. (Kim Morris, Cartwright)

In addition to the quality of care provided by health care workers, the interview participants agreed that information provided to the staff was kept confidential and that patients were treated with a great degree of professionalism. Although it should not be surprising that nurses and other health care providers would take care to keep personal health information confidential, this was seen as particularly important in a small community where ‘everyone knows everyone’.

Well I’m ah, part of the town council and other organizations within town… I’ve never had, ah, any complaints or heard of any complaints where confidentiality was a problem. I think the ah, nurses that we have and the health staff are trained good and

I’ve… I haven’t heard of any complaints or problems with confidentiality. (Jeffrey Penney, Port Hope Simpson)

Participants’ only concerns about confidentiality related to the layout and infrastructure of many of the clinics. In cases where the clinics are very small, it is sometimes possible to overhear discussions between patients and health care providers, which can be problematic for people if they are visiting the clinic for issues of a personal nature.

… if you’re in one of the rooms and you have someone sitting out in the waiting room, sometimes they can hear what’s being said... so like that’s not always good… it’s very difficult to keep it confidential when you have somebody that’s sitting two feet away from you… it’s only two or three feet between those seats and where you’re getting your medication to. So and the same thing… if the nurse happens to speak loudly, and she’s on the phone… or she picks up the phone when she’s in her office and you’re sitting there, you can hear what’s being said. She mightn’t say the patient’s name but… sometimes you know who she’s talking to by just what she’s saying. So, you know I think that could be addressed better… that is a fairly ah (laughs) big problem in the community... everybody around town talks so, you know, small community. (Lydia Penney, Port Hope Simpson)

Although there appears to be tremendous dedication on the part of local health care providers, and a sense of great satisfaction with the quality of care they provide, participants also recognized the difficulty that many communities face in recruiting and retaining qualified staff for
the local clinics.

‘Cause right now we got five clinics here in Port Hope Simpson, Mary’s Harbour, Charlottetown, St. Lewis and Cartwright. And we have a shortage of seven nurses, in those five clinics. (Ford Rumbolt, Mary’s Harbour)

Problems in recruiting and retaining health-care workers mean that patients will see their health-care provider change, which can make it difficult to build a relationship. Also, attending appointments outside of the community often means attending ‘when one is available’ as opposed to ‘with your usual health care provider’. This means that many people reported frequent changes in who provides their health care services. In the survey, over 60% of respondents indicated their service provider has changed in the past 12 months. There was a significant difference between males and females with respect to this change, with females (64.0%) being 1.46 times more likely than males (43.7%) to have had their doctor change within the past 12 months.

Because many of the communities along the coast are short-staffed, participants in the study recognized that this often leads to existing health care workers being very over-worked.

Some of the communities only just have at times one nurse on, even though I think each one is supposed to [have] two nurses stationed, but there’s often issues with retaining nurses. So in a one-nurse station I guess that person can be easily overwhelmed if there’s critical emergencies. (Shane Bridle, Port Hope Simpson)

These ongoing staffing shortages raise questions about how much support is available to health care providers when dealing with difficult medical issues. Collaborating with other health care providers would provide an opportunity to de-brief about particularly difficult issues, and to seek and share advice with others who may...
be facing, or may have faced, similar situations. These encounters would not only be learning opportunities, but also a way of dealing with the stressors that accompany this difficult work. It is not clear whether this sort of opportunity is currently available for health care providers.

6.7 Health Care Service Utilization

Eye Examinations
In the past 12 months, 34.3% of south Labradorians had an eye examination. There were no significant differences between respondents based on age or sex. Income was associated with having had an eye exam – people with lower incomes were less likely to have had an eye exam in the past year. Individuals with some post secondary education were more likely to have had an eye exam in the past 12 months compared to those with high school or less (45.6% versus 26.0%). In comparison, results from the First Nation’s RHS reported (2007) that 57.6% of the respondents had an eye examination in the past 12 months, and older individuals were increasingly more likely to have had an eye examination (up to 72.1%). The opposite trend was observed in NunatuKavut’s community needs assessment, where older individuals were less likely to have had an eye exam in the past 12 months (20.4%).

Blood Pressure Testing
Eighty-two percent (82.0%) of survey respondents had their blood pressure tested in the past 12 months. Women were more likely to have had their blood pressure tested than men (86.7% vs. 75.1%). The proportion of individuals who had their blood pressure tested was not associated with education, age, or household income level.

Blood Sugar Testing
Approximately 60.4% of survey respondents had their blood sugar level tested in the past year. Women (64.7%) were marginally more likely to have their blood sugar levels tested.
compared to men (54.0%). Education level, age, and household income were not associated with being more likely to have had a blood sugar test.

**Physical Examination by a Physician**

About half of the people surveyed had a complete physical examination in the past 12 months. Women were more than twice (2.27) as likely to have had a complete physical examination compared to men. The percentage of individuals getting a complete physical examination decreased significantly with an increase in age. There were no significant difference between education level or household income and having a complete physical examination in the past year.

### 6.8 Wait Times

Participants were generally very satisfied with wait times for medical care. In most cases, residents reported that local health care providers were virtually ‘always’ on-call and prepared to handle most medical issues.

The positive experience in the small community like this – if you got some problems, you can go to the clinic and within a half hour or so you can be seen. And you have these nurses there that would attend to you, and I guess they got access to a doctor for advice. So that would be the positive thing about ...ah livin’ in a small community like that, with some good qualified nurses. (Jeffrey Penney, Port Hope Simpson)

Path from Flagstaff Hill, Cartwright. Courtesy of Margaret Pardy.

They got bigger facilities, they got doctors, but they got more people to see, right? (Ford Rumbolt, Mary’s Harbour)

We can’t complain with what we have here for a small town. How many towns do you see in Newfoundland with 300 people [that have] two or three nurses in their community, within a kilometer? (Female, Charlotte-town)
6.9 Long-term & Palliative care

NunatuKavut communities have always persevered and survived through hard work, and through the reciprocity and sharing that have characterized the communities along the coast. In the St. Lewis focus group, participants discussed how family and neighbours have always been integral to one’s survival. They reported that still today, as people in the community reach the later stages of life, family and neighbours are an essential part of maintaining mental, physical, emotional and spiritual well-being. In the CHNA survey, 19.1% of respondents indicated that they help a family member or friend with home health care, and 14.7% reported that they had an immediate family member in long-term care. Statistics were not collected regarding palliative care, although palliative care was mentioned as an issue in the focus group discussions.

Currently, there is one long-term care facility located along the southeast coast, in Mary’s Harbour. It is a ‘level-one and level-two facility’, meaning it houses people who are mainly able-bodied, but might need additional assistance with certain aspects of daily living. There is currently limited space available at southeast coast facilities equipped to house the sick or elderly who need assistance beyond what level-one and level-two care can provide. As such, if an elderly person requires more care than this facility or their family members can provide, they must move to St. John’s, St. Anthony or Goose Bay. It is very difficult for family members to visit frequently, due to the high cost of travel. Participants highlighted that taking elderly people away from their familiar surroundings can have devastating effects, for those who leave and those who are left behind.

Like when they’ve lived here, like most of them, a lot of them have never went to school so this is their world. And then all of a sudden they become sick, they are uprooted from their families, their traditional foods, their traditional way of life, and they are off to [an] institution, I guess, in St. John’s somewhere, where they are just waiting to die. (Cartwright focus group)

One woman in Cartwright described how her family had suffered when her parents had to move to St. John’s to seek palliative care for her ailing mother. Her mother passed away not long after they moved.

And it’s like for me, you know, a double death in a way, because they died inside of them when they left home... And a part of us went with them. So, I think there should...
be somewhere in Labrador, even if it’s one community where we can have all of these people where we can go visit them... it takes thousands of dollars for us to go out there and visit them... Dollars we don’t have, and we have income that we have to give up in order to go out there, so it costs thousands of dollars. I made one trip out to visit my mom, one year and that was the year before she died, and I got to see her once in that year and my mom is like, you know, my best friend and all. It’s so sad... It was like, to me, it was like she was gone already because I knew that she would not survive in that place anyway. She wasn’t at home, where she could see the water and see familiar things and familiar people. It was a whole world of strangers locked in a facility. (Cartwright focus group)

Another woman from Cartwright explained that even though she was able to spend a great deal of time with her mother in St. John’s while she was dying of cancer, she had argued with the doctors that her mother needed to be brought home so she could die in familiar surroundings. She says that when her mother was finally able to move home after six months of cancer treatment, she finally found peace once she could see the water and receive visits from old friends.

Participant: ...my mom was dying with cancer four years ago, I stayed with her, ... they knew mom wasn’t going to get better, and they kept her there, and kept her there... she wanted to be at home and she was suffering... I had to say right at the hospital and say ‘look she’s going home’... Because she knows she’s not getting better, I know she’s not getting better, they know she’s not getting better. And so once she got home she just livened right up, until she got bedridden and she was at home, and she was quite happy.

Facilitator: Yeah, so how long was she in St. John’s before that happened?

Participant: Ah, we were there what? Five months, six months or so, six months... and really no need of it. You know, she wasn’t happy there, she wasn’t eating, and she really wanted to be at home, and she had

Courtesy of John Graham.
somebody to look after her, because I was there looking after my mom, and plus the other family members as well... you know I always say ‘let them die with dignity, let them come home’. (Cartwright focus group)

Although many family members are reluctant to send their loved ones to St. John’s for palliative care, there are currently very few other options. As a woman explains below, it is often difficult to fund palliative care at home, because the Newfoundland and Labrador policy on home care services stipulation that family members cannot be paid for caring for their relatives. This can be a problem in small communities comprised of few families, because it is often difficult to find someone qualified to care for the sick and elderly, and if the qualified person is related to the patient they cannot be hired to provide that care.

Participant: …there is quite a number of people that need home care, and it’s not there, and they won’t pay a family member or a relative to care for them. They have to pay someone they don’t know. So, let’s say if that’s your mom… they say no you can’t have this person, you got to have a total stranger come in and take care of your mom... And they will pay a stranger to come in and take care of her mom, but they won’t pay her. (Kim Morris, Cartwright)

6.10 Conclusion

As highlighted in Chapter 5: Chronic Disease and Injury, over 49% of survey respondents reported having more than one chronic condition. As the population ages, it can be expected that there will be a rise in these co-morbidities
and a subsequent growing need for patients to seek access to long-term, continuing and palliative care. Again, this situation is not unique to NunatuKavut, and it would be helpful to look towards other remote places experiencing an aging population for ideas and solutions about how to deal with impending health-care crises.

There seems to be a dire need for provincial health-care policies to fundamentally change if health care workers along the southeast coast are to respond to the needs of their aging patients. The current health-care system on the southeast coast is designed to accommodate only acute, episodic care, and not those who have several complex issues. As a result, it will be increasingly difficult to keep pace with the growing need for the different kinds of complex care that will be needed as NunatuKavut’s population ages. As efforts are made to improve the quality and accessibility of health care along the southeast coast, it is important to consider the complexity of care required for multiple chronic conditions.

### 6.11 References

The results related to chronic disease and injury are divided into two sections: quantitative and qualitative findings. The quantitative section of this chapter offers a broad look at survey results related to high blood pressure, high cholesterol, asthma, arthritis, obesity, diabetes and other chronic conditions. Because Aboriginal populations have been seriously affected by diabetes (Assembly of First Nations, 2007), this section provides a closer examination of the issues around diabetes. The quantitative section also examines co-morbidities (i.e., being affected by more than one condition), as well as the role that age, gender, income, and education play as risk factors for chronic disease. This section also makes comparisons to related data on First Nations, Métis and non-Aboriginal peoples, to
help to understand the health of people in NunatuKavut as compared to other Aboriginal and non-Aboriginal peoples across Canada.

The qualitative section of this chapter focuses solely on diabetes as it was understood by key informants and focus group participants. We have devoted much of this chapter to diabetes rather than other chronic conditions because participants in the interviews and focus groups talked most about diabetes as a major health concern. As well, many other chronic conditions are associated with diabetes, including heart disease, high cholesterol and obesity. A more

<table>
<thead>
<tr>
<th>Chronic Health Condition</th>
<th>% Prevalence (SE)</th>
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<tbody>
<tr>
<td>High Blood Pressure</td>
<td>23.95 (1.98)</td>
</tr>
<tr>
<td>Allergies</td>
<td>23.13 (2.49)</td>
</tr>
<tr>
<td>High Cholesterol</td>
<td>21.00 (1.98)</td>
</tr>
<tr>
<td>Arthritis</td>
<td>20.89 (1.92)</td>
</tr>
<tr>
<td>Stomach/Intestinal Disorder</td>
<td>14.81 (2.02)</td>
</tr>
<tr>
<td>Thyroid Problems</td>
<td>13.80 (2.37)</td>
</tr>
<tr>
<td>Chronic Back Pain</td>
<td>13.24 (1.80)</td>
</tr>
<tr>
<td>Hearing Impairment</td>
<td>11.93 (1.71)</td>
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<tr>
<td>Asthma</td>
<td>10.84 (1.67)</td>
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<tr>
<td>Diabetes</td>
<td>10.36 (1.51)</td>
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<tr>
<td>Heart Disease</td>
<td>6.79 (1.18)</td>
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<tr>
<td>Cancer</td>
<td>4.95 (1.10)</td>
</tr>
<tr>
<td>Autoimmune Disease</td>
<td>4.77 (1.20)</td>
</tr>
<tr>
<td>Cataracts</td>
<td>4.61 (1.05)</td>
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<tr>
<td>Osteoporosis</td>
<td>4.22 (0.94)</td>
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<tr>
<td>Blindness/Serious Vision Impairment</td>
<td>3.52 (1.13)</td>
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<tr>
<td>Learning Disability</td>
<td>3.21 (1.07)</td>
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<td>Psychological/Nervous Disorders</td>
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<tr>
<td>Chronic Bronchitis</td>
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<tr>
<td>Glaucoma</td>
<td>1.97 (0.73)</td>
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<td>Epilepsy</td>
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<td>Uncorrectable Vision Problems</td>
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<td>Tuberculosis</td>
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<td>ADD/ADHD</td>
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<td>Sexually Transmitted Infection</td>
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<tr>
<td>Liver Disease</td>
<td>0.85 (0.59)</td>
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<tr>
<td>Stroke Related Illness</td>
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<tr>
<td>Emphysema</td>
<td>0.49 (0.31)</td>
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<td><strong>Table 7.1.</strong> Prevalence of chronic health conditions.</td>
<td></td>
</tr>
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Table 7.2. Prevalence of chronic ailments by sex.

<table>
<thead>
<tr>
<th>Condition</th>
<th>Male</th>
<th>Female</th>
<th>*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergies</td>
<td>17.01 (3.69)</td>
<td>29.17 (3.40)</td>
<td>*</td>
</tr>
<tr>
<td>Arthritis</td>
<td>14.53 (2.29)</td>
<td>27.40 (3.10)</td>
<td></td>
</tr>
<tr>
<td>High blood pressure</td>
<td>23.37 (2.82)</td>
<td>24.36 (2.78)</td>
<td></td>
</tr>
<tr>
<td>High cholesterol</td>
<td>20.63 (2.69)</td>
<td>21.46 (2.79)</td>
<td></td>
</tr>
<tr>
<td>Thyroid problems</td>
<td>6.81 (3.07)</td>
<td>20.52 (3.58)</td>
<td>*</td>
</tr>
<tr>
<td>Asthma</td>
<td>3.78 (1.27)</td>
<td>17.82 (3.11)</td>
<td>*</td>
</tr>
<tr>
<td>Stomach and/or intestinal problems</td>
<td>12.99 (2.91)</td>
<td>16.54 (2.80)</td>
<td></td>
</tr>
<tr>
<td>Chronic back pain, excluding arthritis</td>
<td>15.52 (2.92)</td>
<td>10.84 (2.01)</td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td>11.10 (2.18)</td>
<td>9.79 (2.09)</td>
<td></td>
</tr>
<tr>
<td>Osteoporosis</td>
<td>1.20 (0.80)</td>
<td>7.00 (1.66)</td>
<td>*</td>
</tr>
<tr>
<td>Autoimmune disease (Rheumatoid Arthritis, Lupus)</td>
<td>4.15 (1.77)</td>
<td>5.55 (1.72)</td>
<td></td>
</tr>
<tr>
<td>Hearing impairment</td>
<td>20.27 (3.24)</td>
<td>4.65 (1.33)</td>
<td>*</td>
</tr>
<tr>
<td>Psychological or nervous disorders</td>
<td>1.51 (0.83)</td>
<td>4.45 (1.29)</td>
<td>*</td>
</tr>
<tr>
<td>Heart disease</td>
<td>9.57 (1.97)</td>
<td>4.38 (1.36)</td>
<td>*</td>
</tr>
<tr>
<td>Cancer</td>
<td>6.73 (1.92)</td>
<td>3.30 (1.16)</td>
<td></td>
</tr>
<tr>
<td>Chronic bronchitis</td>
<td>2.35 (0.94)</td>
<td>3.28 (1.04)</td>
<td></td>
</tr>
<tr>
<td>Cataracts</td>
<td>6.82 (1.83)</td>
<td>2.77 (1.13)</td>
<td>*</td>
</tr>
<tr>
<td>Glaucoma</td>
<td>1.35 (0.72)</td>
<td>2.72 (1.29)</td>
<td></td>
</tr>
<tr>
<td>Vision problems that can’t be corrected with glasses</td>
<td>0.95 (0.60)</td>
<td>1.80 (1.12)</td>
<td></td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1.08 (0.96)</td>
<td>1.62 (.83)</td>
<td></td>
</tr>
<tr>
<td>Blindness or serious vision impairment</td>
<td>5.63 (2.13)</td>
<td>1.58 (.80)</td>
<td></td>
</tr>
<tr>
<td>Learning disability</td>
<td>4.90 (2.02)</td>
<td>1.53 (.67)</td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td>0.80 (0.70)</td>
<td>1.33 (.66)</td>
<td></td>
</tr>
<tr>
<td>Emphysema</td>
<td>0.56 (0.49)</td>
<td>0.38 (0.34)</td>
<td></td>
</tr>
<tr>
<td>Effects of stroke (brain hemorrhage)</td>
<td>0.74 (0.52)</td>
<td>0.34 (0.30)</td>
<td></td>
</tr>
<tr>
<td>Liver disease (excluding hepatitis)</td>
<td>1.71 (1.19)</td>
<td>0.00 (0.00)</td>
<td></td>
</tr>
<tr>
<td>Attention Deficit Disorder/Attention Deficit-Hyperactivity Disorder (ADD/ADHD)</td>
<td>1.98 (1.75)</td>
<td>0.00 (0.00)</td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infection</td>
<td>1.98 (1.75)</td>
<td>0.00 (0.00)</td>
<td></td>
</tr>
</tbody>
</table>

* indicates a significant difference, p-value <0.05 using Sidak’s adjustment for multiple tests.
complete understanding of how diabetes influences NunatuKavut communities may therefore help with the prevention of associated conditions. The qualitative section of this chapter explores the need for more access to nurses and other health-care workers who specialize in the treatment of diabetes, as well as the need for culturally appropriate diabetes education programming focusing on diet and exercise.

7.2 Quantitative

Prevalence of conditions

Table 7.1 lists common chronic conditions and their prevalence in southeast Labrador communities. The most prevalent health ailments reported were high blood pressure (24%), allergies (23%), high cholesterol (21%) and arthritis (21%). Approximately 1 in 10 individuals reported having being diagnosed with asthma, and roughly the same proportion had diabetes. Table 7.2 shows the prevalence of chronic conditions by sex.

High Blood Pressure

High blood pressure (hypertension) relates to an elevated pressure in the arteries. Long term exposure to high blood pressure can result in scarring of the artery walls, leading to the promotion of fatty plaque buildup and the narrowing of the blood vessel (Heart and Stroke Foundation, 2010). High blood pressure also puts an increased strain on the heart. Chronic high blood pressure increases the risk of developing other illnesses including heart disease, stroke, kidney disease and damage to the blood vessels in the eyes (medicinenet.com, 2010a). There are multiple causes of high blood pressure, including genetics, dietary factors (e.g., high salt intake), obesity and age.

The survey of coastal communities of southeast Labrador found a prevalence of high blood pressure of 23.95%, which is higher than estimated Canadian average of 16.4%, and marginally higher than the estimate from the First Nations’ RHS (20.4%) (Assembly of First Nations, 2007). There was no significant difference between males and females with respect to high blood pressure. The prevalence of high blood pressure is higher in older age groups (>55 years of age). While the numbers are not directly comparable due to different age group ranges being utilized, the prevalence of high blood pressure in older age groups was higher than what was reported in the RHS and the CCHS (Assembly of First Nations, 2007).

High Cholesterol

Cholesterol is a fatty-like substance required for the normal maintenance of the body and used in the production of Vitamin D and some digestive components. There are two different types of cholesterol, low density lipoproteins (LDL) and high density lipoproteins (HDL). LDL are often referred to as “bad” cholesterol, as high concentration of LDL in the blood can result in build-up in the arteries and increase the risk for heart disease (medicinenet.com, 2010). Factors that can lead to high “bad” cholesterol include age, sex, genetics, diet, weight and physical exercise levels (medicinenet.com, 2010b). In the survey, 59.4% of respondents had had a cholesterol test in the past year. Women (67.4%) were significantly more likely than men (47.5%) to have had a cholesterol test. Income and educational level did not play a role in cholesterol testing rates. A fairly linear relationship was found between age and cholesterol testing, with
The prevalence of high cholesterol in southeast Labrador communities was 21.0%. This figure is similar to estimates observed in northern Inuit populations (Egeland, 2010). There were no differences observed between males and females. The prevalence of high cholesterol increased with age (data not shown). Estimates in older age groups were lower than those observed for the general Canadian population (Grace et al., 2004), but higher than observed in northern Inuit populations (Egeland, 2010). Estimates for the prevalence of high cholesterol from the First Nation’s RHS were unavailable.

**Allergies**

Allergy is an extreme immune response to what would otherwise be a harmless foreign substance (referred to as an allergen) (medicinenet.com, 2010c). Allergens can include such things as moulds, pollens, animal dander and certain types of foods. When the allergen is introduced to the body, the immune system mounts a response beyond what would normally be expected. The allergic response can include symptoms of a runny or stuffy nose, sneezing, itching, redness of the eyes, watery eyes, shortness of breath, wheezing, coughing and tightness in the chest. Allergic reactions can also occur on the skin, such as red itchy skin in the exposed area, hives (raised red welts), or a rash on the face or around eyes, elbows and knees. In extreme cases a person may have an anaphylactic reaction (allergic shock), in which several organ systems are affected. Anaphylaxis results in shortness of breath, nausea, vomiting and low blood pressure. Treatment for allergies includes allergen avoidance, prophylactic (drug) treatment of symptoms, and allergen desensitization through exposure to the allergen (Holgate and Polosa, 2008).

Approximately 1 in 4 (25%) participants indicated that they had been diagnosed with some type of allergy. There was a marked difference in the prevalence between males (17.0%) and females (29.2%). Allergy was significantly more prevalent in individuals younger than 35 years of age (41.6% versus 19.6% for 35 years or older). The estimated prevalence is higher than what has been estimated for First Nation’s populations (19.9%), but lower than what has been estimated for the Canadian population in general (30.3%) (Assembly of First Nations, 2007).

**Asthma**

Asthma is the result of inflammation in the lungs and upper respiratory tract that results in shortness of breath and difficulty breathing. It can be caused by various triggers, such as allergens, irritants, and exercise. The most prevalent chronic health conditions in southeast Labrador communities were high blood pressure, allergies, high cholesterol, diabetes, and arthritis. Photo courtesy of Aimee Chaulk.
in swelling and narrowing of the airways and difficulty breathing. Common triggers include allergens, chemical and physical irritants (e.g., cigarette smoke), medications, environmental factors, mental state and hormonal factors. Treatment can reduce inflammation and reverse airway narrowing, but severe attacks may require medical intervention.

The prevalence of asthma in south Labrador communities was approximately 10%. This figure is similar to estimated prevalence from the Regional Health Survey and Canadian Community Health Survey (Assembly of First Nations, 2007), but lower than what was estimated for Manitoba Métis populations (Martens et al., 2010). There was a marked significant difference between the prevalence of asthma in males and females, at 3.8% and 17.9%, respectively. Age did not seem to have influenced the prevalence of asthma. This mirrors similar finding from the First Nations RHS (Assembly of First Nations, 2007).

**Arthritis**

Arthritis is typified by inflammation and pain in the joints. It can arise from wear and tear on the joints (Osteoarthritis) or can be due to an autoimmune disorder (Rheumatoid Arthritis). Arthritis has many potential causes depending on the specific type of arthritis. Osteoarthritis can arise from natural wear and tear on the joints, genetics or other ailments.

**Figure 7.1.** Prevalence of diabetes by BMI categorization.
(e.g., gout) and usually results in mild disability. Rheumatoid arthritis, on the other hand, is a progressive disease where the body’s immune system attacks its own healthy tissue, and can result in severe disability. Osteoarthritis is more commonly diagnosed compared to rheumatoid arthritis.

The prevalence of arthritis in southeast Labrador coastal communities was approximately 20% (roughly 1 in 5 persons). Unfortunately this study did not distinguish between osteo- and rheumatoid arthritis types; therefore it is not possible to estimate the prevalence of each. Some misclassification may have also occurred as some rheumatoid arthritis may have been classified under “Autoimmune Disease” (see Table 7.1). The prevalence of osteoarthritis/rheumatoid arthritis in First Nation’s populations and the general Canadian population is 25.3% and 18.0%, respectively (Gariepy et al., 2010; Assembly of First Nations, 2007). The prevalence in this study was similar to that reported for the Canadian population and lower than that estimated for First Nations communities. There was no significant difference between the prevalence in males and females. Not surprisingly, there was a higher prevalence in older individuals, with large increases being observed after 55 years of age.

Diabetes

Diabetes is a chronic condition where the body is unable to produce or properly use insulin. Insulin plays a role in the regulation of glucose, which is used by cells as an energy source. There are three different types of diabetes, denoted as Type I, Type II and gestational diabetes. Type I diabetes usually develops in childhood or early adolescence; the cells of the pancreas are no longer able to produce insulin. Type I diabetes is typically controlled through injection of external insulin. Type II diabetes tends to be diagnosed later in life, although younger adults and children are now being diagnosed with Type II diabetes more frequently (Canadian Diabetes Association Clinical Practice Guidelines Expert Committee, 2008). With Type II diabetes the body does not make enough insulin, or the body no longer responds to the insulin that is produced. Type II diabetes is often associated with lifestyle factors such as a poor diet and a lack of exercise. Gestational diabetes appears during pregnancy and typically will resolve within four months, post-partum. However, it has been linked with an increased

<table>
<thead>
<tr>
<th>Has your diabetes:</th>
<th>Percentage responding “yes”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prompted you to adopt a healthier lifestyle</td>
<td>85.57</td>
</tr>
<tr>
<td>Affected your vision</td>
<td>18.69</td>
</tr>
<tr>
<td>Affected your kidney function</td>
<td>22.20</td>
</tr>
<tr>
<td>Affected your circulation</td>
<td>22.84</td>
</tr>
<tr>
<td>Affected the feeling in your hands and feet</td>
<td>21.08</td>
</tr>
<tr>
<td>Affected your lower limbs</td>
<td>15.25</td>
</tr>
<tr>
<td>Resulted in infections</td>
<td>16.51</td>
</tr>
<tr>
<td>Resulted in amputation</td>
<td>0.00</td>
</tr>
</tbody>
</table>

Table 7.3. Impact of diabetes on lifestyle and associated ailments.
risk of developing Type II diabetes.

The overall prevalence of diabetes in south Labrador communities is 10.4%. This represents an increase since the ‘Learning for Life: Preventing Diabetes’ data collected by NunatuKavut in 2003, which showed a prevalence of 6.6%. Approximately two thirds (67%) of those with diabetes reported Type II diabetes. The average age of diagnosis was 39.9 years of age. There were no significant differences between sexes, but there was an observable linear trend that increased with age. A trend was also observed with respect to income: respondents with lower household incomes had a high prevalence of diabetes (data not shown). The risk of diabetes increases in individuals classified as overweight or obese. Figure 7.1 shows the percentage of individuals with certain BMI classifications who have diabetes. The graph shows that as weight increases, so does the proportion of individuals diagnosed with diabetes.

The estimated prevalence of diabetes in southeast Labrador communities (10.4%) is lower than that reported for First Nations peoples (19.7%) (Assembly of First Nations, 2007) and Manitoba Métis (11.8%) (Martens et al., 2010). However, it is higher than the Canadian prevalence (3.6%), and the estimated prevalence among Inuit populations (8.0%) (Inuvialuit Settlement Region, 2009; Martens et al., 2010; Assembly of First Nations, 2007). The proportion of all diabetes cases in NunatuKavut communities that are classified as Type II diabetes (67%) was lower than that estimated for First Nations populations, which was 78.2% (RHS, 2007). The patterns of diabetes among the different age, sex and BMI groups were similar to previously reported trends (Assembly of First Nations, 2007).

There was a problem with the data entry program with respect to the diabetes section of the survey. This resulted in several values not being recorded for whether individuals had diabetes or not. These values were subsequently coded as “no”. As a consequence, the estimate of the prevalence of diabetes in southeast Labrador is a conservative estimate of the true prevalence of diabetes.

Table 7.3 shows the reported consequences of diabetes. Roughly 1 in 5 individuals report that their diabetes has negatively impacted their vision, kidney function, circulation or sensation in their hands and feet. While fewer reported experiencing problems with lower limb function or infections, the percentage was still relatively high at 15.3% and 16.5% respectively. On a positive note, 85% of survey respondents indicated that their diabetes has encouraged them to adopt a healthier lifestyle.

Diet and exercise are the most common methods employed by individuals to treat their diabetes (Table 7.4). Insulin and pills are used in 57.6% and 24.6% of the cases, respectively. Traditional medicines are used by about 2.4% of the individuals, and 18.9% reported not using any method of treatment.

<table>
<thead>
<tr>
<th>Diabetes Treatment</th>
<th>Percentage (n=42)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Diet</td>
<td>95.76</td>
</tr>
<tr>
<td>Exercise</td>
<td>74.51</td>
</tr>
<tr>
<td>Insulin</td>
<td>24.61</td>
</tr>
<tr>
<td>Pills</td>
<td>57.58</td>
</tr>
<tr>
<td>Traditional Medicines</td>
<td>2.38</td>
</tr>
<tr>
<td>No Treatment/Medicines</td>
<td>18.93</td>
</tr>
</tbody>
</table>
Approximately 37.4% of the diabetic respondents reported checking their blood sugar levels at least once per day. Among the 62.6% who did not check their blood sugar levels daily, the most cited reason for not checking was that they didn’t think they needed to (73.2%), followed by forgetting (18.2%). One person reported that they did not check their blood sugar levels daily because they could not afford enough testing strips.

The majority of survey respondents who had diabetes either agreed or strongly agreed with the statement that “a diabetes clinic is available in my area”. All diabetic participants were receiving some kind of diabetes education, with the exception of 10 participants. For these 10 people, Table 7.5 shows the reasons they identified to explain why they were not receiving diabetes education. The statistics in this section should be interpreted with caution, because the sample size is too small to generalize. Forty percent of the community members with diabetes who were not receiving diabetes education felt that the diabetes education currently offered was culturally inappropriate. A majority of the respondents (60.0%) felt that health services for diabetes in the area were inadequate, and agreed that “a diabetes health specialist is not available in my area”. Other reasons for not receiving diabetes education included no longer requiring diabetes education (50.0%), insufficient information about where to seek education (22.2%), costs of travel (30.0%) and costs of childcare (10.0%).

7.3 Qualitative

When asked about their concerns related to chronic diseases in the community, diabetes was mentioned as the biggest health concern during both the key informant interviews and focus groups. Although diabetes does not appear to be the most prevalent chronic disease according to the survey results, it is also important to remember that many people who do not have diabetes might be experiencing symptoms related to pre-

**Table 7.5.** Reasons for not using diabetes educational services available (total n = 10; percentages should be interpreted with caution).

<table>
<thead>
<tr>
<th>Reason</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>I already have the information I need and no longer require diabetes education</td>
<td>50.00</td>
</tr>
<tr>
<td>I don’t have sufficient information about where to go to get diabetes education</td>
<td>22.22</td>
</tr>
<tr>
<td>A diabetes clinic is available in my area</td>
<td>60.00</td>
</tr>
<tr>
<td>I cannot afford the transportation cost to go where diabetes education is available</td>
<td>30.00</td>
</tr>
<tr>
<td>I cannot afford to pay for childcare while I’m away for diabetes education</td>
<td>10.00</td>
</tr>
<tr>
<td>I feel that the health service for diabetes is inadequate</td>
<td>60.00</td>
</tr>
<tr>
<td>A diabetes health specialist is not available in my area</td>
<td>60.00</td>
</tr>
<tr>
<td>I feel the health services offered for diabetes education is culturally inappropriate</td>
<td>40.00</td>
</tr>
</tbody>
</table>

*a Percentage of respondents that strongly agreed or agreed with the statement.
diabetes (American Diabetes Association, 2009; Zamora-Giménez et al., 2012), which may help to explain why high blood pressure and high cholesterol (both risk factors for diabetes) are mentioned as occurring more frequently than diabetes. It is also possible that diabetes rates are underreported because people have not been diagnosed. Although many people reported knowing about diabetes awareness programs offered through Labrador-Grenfell Health and through NunatuKavut, participants felt that these programs need to reach more people, particularly the elderly and others who may not be able to access information about nutrition and exercise through reading or the internet.

Diet control. But how do you diet control if you don’t really know what the diet is? (Charlottetown focus group)

Many participants thought that education programs and resources are important. However, given the high prevalence of diabetes in the community, this information needs to be continuously available, not only when a specific diabetes awareness program is being offered. Although the information acquired through doctors and nurses in the hospital is important, there is currently no way for people along the coast to have frequent follow-up appointments because of the difficulties associated with travelling. As such, it was felt that a full-time dietician or nutritionist permanently stationed along the coast is warranted.

Dietary teaching would help to address the health issues in our community. Some of the health issues include type II diabetes, high cholesterol, obesity, high blood pressure and heart disease. Obesity is definitely on the rise, not only in the adult population but the children as well. Diet and lifestyle are the key contributing factors. However, if you are not able to purchase healthy food choices at your local supermarket it’s difficult for people to make the necessary changes... In my personal opinion the health care system would benefit from having a dietician or nutritionist located on the coast to carry out the necessary teaching required. (unnamed, Charlottetown)

... seems to be high incident of diabetes in the community, and obesity... it seems like a genuine need for more work on nutrition services, ah, more need for a nutritionist to come and maybe do education. (Shane Bridle, Port Hope Simpson)

Participants also thought it was important for educational resources about diabetes to be culturally appropriate. Many of the elderly people in NunatuKavut are more familiar with eating land-based foods rather than those purchased at grocery stores. As a result, many are unaware of which grocery store foods are healthier than others. Even if people know
which foods are healthy, it does not mean that these foods are affordable or always available.

My mom, she’s diabetic and stuff and she do need fresh fruits and fresh vegetables and different things but, it’s ah, a bit hard to get, even the yogurts and stuff like that. ‘Cause ah, she really got to big problem with her sugars and stuff hey so like ah, I’d like to see her getting more fresh stuff. But like ah, we can only get, hey, when they has it coming up there, and I finds getting’ it flied in and stuff is ah, expensive anyway, right? In the summers it’s not so bad ‘cause it comes on the ferry or whatever. (Bella Burden, PinSENT’s Arm)

Many participants felt that returning to the traditional diet of land-based foods was an important means of preventing diabetes, and that this approach should be incorporated into diabetes prevention programming.

… a lot of Aboriginal people… we’re getting type II diabetes. I think there’s two reasons behind it... I’m no expert on it, but I thinks this eh, that our lifestyle is changing, we don’t get enough exercise anymore, we don’t walk anymore, we got wheels to take us wherever we wanna go. Even just short distance eh... so people is not getting exercise enough eh, and, and we’re not eatin’ traditional foods enough... But having said that, I can’t say that the foods in the stores is not safe... people would be getting food poi-
soning, but I, what I am trying to say is that I think we should be eating more foods eh, from the land versus off the shelves in the stores... The business people would be upset with me for saying that but... I am speaking the truth here as I see it [laughs] (Guy Poole, St. Lewis)

In addition to ensuring that information about diet and exercise is culturally appropriate, participants also want to see efforts made to ensure that youth continue to take part in traditional activities, as a way to protect their health. It was noted by one person in Norman Bay that even though many of the older people in the community may be preventing diabetes by going out on the land to access traditional foods, many of the youth are beginning to choose store-bought foods over land foods.

A lot of people around here now lives, oh lives on the land most of the time like us, our crowd lives on the rabbits, partridge and seal meat whenever we can get it... me and [spouse] goes for rabbits, partridge, beaver and seal, lives more on wild meat, hey? I say the younger crowd now, they goes more for the store-bought food like burgers and fries and that kind of stuff. Almost all the older people goes for the ducks, partridges, rabbits and stuff, hey? (George Roberts, Norman Bay)

No discussion about diabetes in Labrador would be complete without mentioning the efforts of one man in St. Lewis, Guy Poole, whose wife died from complications related to diabetes a number of years ago. After she died, he was determined to raise awareness about diabetes
in NunatuKavut communities, and challenged himself to walk across Labrador. Since his efforts began in 2005 he has walked approximately 1000 km to raise awareness and money for diabetes research.

I set out, you know, four or five years ago to walk across the, this province eh, and ah, and I’m gonna do it and I’m hopin’ that if I change one person’s life eh, and they get out there and walk and be healthy, then I won. And I think I’ve done that already eh - I’ve seen a lot of people walk eh, and a lot of people comment on the walk and that’s a good thing, that’s all, you know. I’m hopin’ it will raise a little bit of money eh, and maybe one day we find a cure for diabetes, eh? (Guy Poole, St. Lewis)

7.4 Conclusions

The rates of chronic disease and injury discussed in this chapter provide important insight into which chronic conditions deserve increased attention by health care practitioners, and point out the need to understand why certain diseases seem to be more prevalent in southeastern Labrador than in other places in Canada. As well, the chapter provides important data that can help target health services to those in our communities who most need it (i.e., higher rates of asthma among women than men, and higher rates of allergies among younger versus older populations).
7.5 References


8.1 Introduction

Dental service delivery varies between the different communities along the southeast coast. There are six dental clinics in total each of them located in the community medical clinic. The dental clinics are located in Mary’s Harbour, St. Lewis, Port Hope Simpson, Charlottetown, Black Tickle and Cartwright. These clinics are not open at all times, but; instead dentists visit on a regular schedule. Mary’s Harbour and St. Lewis have scheduled visits by a dentist approximately once every three weeks, for a one-week period. Port Hope Simpson and Charlottetown have dental visits once every six weeks, for a one-week period. Cartwright and Black Tickle currently have dental services seven times per year. Each visit there lasts two weeks. Routine services provided include regular examinations,
restorative and prosthetic care, minor oral surgery, endodontics (e.g., root canals), radiographs and periodontal care. Children and adults who require procedures under general anesthesia or medical supervision—such as patients with other medical or mental health issues—must travel outside of NunatuKavut for these services. This also applies to patients requiring more complex procedures such as removal of impacted wisdom teeth (Hornett, P., 2011, personal communication).

People in NunatuKavut face challenges in accessing oral health care (as well as other health care services—see Chapter 6), often related to the ‘hidden costs’ of accessing such services. One important difference with oral health care, compared to other forms of health care, is that dental services are generally not publicly funded. Only children under age 12, people on social assistance, and low-income families are eligible for government-subsidized dental services. However, these subsidies are often not enough to cover additional food and lodging for appointments that must take place outside of NunatuKavut. This makes oral health services unaffordable for many community members.

In this chapter, we discuss dental care costs and insurance, travel and other costs associated with accessing dental care outside of NunatuKavut, the frequency of ‘home remedies’ for those unable to access a dentist, and patterns of oral health care within NunatuKavut. It should be noted here that no data has been collected regarding the oral health status of the population. No data currently exists regarding the oral health status of NunatuKavut residents, although anecdotally we know that oral health issues exist for many residents.

8.2 Dental care costs and insurance

Well, I said to the dentist, I said, ‘now I got my teeth, I can’t afford to eat!’ (Cartwright focus group)

Only 25% of Labradors on the southeast coast have insurance that covers dental expens-

<table>
<thead>
<tr>
<th>Table 8.1. Factors affecting dental coverage.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Primary</td>
</tr>
<tr>
<td>Some High School</td>
</tr>
<tr>
<td>High School</td>
</tr>
<tr>
<td>Some College/University</td>
</tr>
<tr>
<td>Obtained College/University Degree</td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
</tr>
<tr>
<td>$0 - $19,999</td>
</tr>
<tr>
<td>$20,000 – $39,999</td>
</tr>
<tr>
<td>$40,000 – $59,999</td>
</tr>
<tr>
<td>$60,000 – $79,999</td>
</tr>
<tr>
<td>$80,000+</td>
</tr>
<tr>
<td><strong>Employment Type</strong></td>
</tr>
<tr>
<td>Unemployed</td>
</tr>
<tr>
<td>Seasonal</td>
</tr>
<tr>
<td>Part-time</td>
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<tr>
<td>Full-time</td>
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</tbody>
</table>
There was no significant difference between males and females, but respondents with at least high school education were more likely to have dental insurance, as were respondents with a household income of $40,000 or greater (see Table 8.1). In addition, people working full-time were more likely to have coverage than people working part-time.

Thirty-two percent of respondents reported that they were unable to afford dental care. Women were more likely to say that they could not afford dental services (38.6% vs 25.2% of men). Not surprisingly, household income was significantly associated with being unable to afford dental care costs. Individuals who lived in a household that made less than $40,000 in the past year were more likely to report that they could not afford dental care. Education and employment status were not significantly associated with being able to afford dental services.

Participants in the qualitative interviews also spoke about the high cost of dental treatment and dental coverage. For people who cannot afford a dental plan for their families, any dental expenses must be paid out-of-pocket.

I do know that ah, a lot of the people don’t have their dental plan… because I guess it’s too expensive for some people to get it. (Marie Rumbolt, Mary’s Harbour)

...somebody phoned while I was [at the dentist’s office] and asked how much it costs for an extraction and she said, between, about $160 minimum, and she said a filling is between $100 and $200. And then she was there, ‘Hello? Hello?’, and the dentist said ‘they must have fainted’... (laughing)... because she couldn’t, didn’t want it or what-ever, I mean they can’t afford it, right? Who can? (St Lewis focus group)

Some participants mentioned that needing dental care sometimes forces people to make tough choices between paying for those dental services and paying other household bills. Often, the other needs come first and people end up forgoing the dental care they need.

Participant: What it comes down to really... your hydro bill or your phone bill or your food bill or you, you either see or eat... You can’t do both... And you see so many going around with teeth gone and it’s a shame.

Participant: ...they just can’t afford to [go to the dentist].

Participant: ...they should be able to. (Cartwright focus group)

...I think the cost of it is what’s keepin’ people from goin’... ‘cause ‘tis awful expensive... if you needs dentures... just a top denture is now $700, and that might not seem like a lot to some people, but if you’re on a fixed income... $700 out of your monthly income, it means a lot and I think this is why a lot of people is not even goin’. Like fillings, I mean it’s a lot of people not goin’ to get their teeth filled because they just can’t afford it [sympathy in voice]. (Marie Rumbolt, Mary’s Harbour)

8.3 Travel

As noted above, nearly one third of survey respondents said that they were unable to afford dental care. Participants in the focus groups and key informant interviews pointed out that even if a person can afford the dental care itself, other
Table 8.2. Respondents who agreed or strongly agreed with the statement “the cost of travelling to where dental services are offered has affected my decision to obtain dental services”.

<table>
<thead>
<tr>
<th></th>
<th>Agreed or strongly agreed %</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
<td></td>
</tr>
<tr>
<td>Male</td>
<td>51.0</td>
</tr>
<tr>
<td>Female</td>
<td>43.4</td>
</tr>
<tr>
<td><strong>Age</strong></td>
<td></td>
</tr>
<tr>
<td>16-24</td>
<td>53.3</td>
</tr>
<tr>
<td>25-34</td>
<td>53.2</td>
</tr>
<tr>
<td>35-44</td>
<td>46.7</td>
</tr>
<tr>
<td>45-54</td>
<td>49.4</td>
</tr>
<tr>
<td>55-64</td>
<td>42.6</td>
</tr>
<tr>
<td>65+</td>
<td>38.8</td>
</tr>
<tr>
<td><strong>Education</strong></td>
<td></td>
</tr>
<tr>
<td>Primary</td>
<td>48.7</td>
</tr>
<tr>
<td>Some High School</td>
<td>40.9</td>
</tr>
<tr>
<td>High School</td>
<td>42.9</td>
</tr>
<tr>
<td>Some College/University</td>
<td>44.4</td>
</tr>
<tr>
<td>Obtained College/University Degree</td>
<td>51.3</td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
<td></td>
</tr>
<tr>
<td>$0 - $19,999</td>
<td>44.6</td>
</tr>
<tr>
<td>$20,000 – $39,999</td>
<td>53.9</td>
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<td>$40,000 – $59,999</td>
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<td>48.8</td>
</tr>
<tr>
<td>$80,000+</td>
<td>20.6</td>
</tr>
<tr>
<td><strong>Employment Type</strong></td>
<td></td>
</tr>
<tr>
<td>Unemployed</td>
<td>45.5</td>
</tr>
<tr>
<td>Seasonal</td>
<td>48.6</td>
</tr>
<tr>
<td>Part-time</td>
<td>66.7</td>
</tr>
<tr>
<td>Full-time</td>
<td>37.1</td>
</tr>
</tbody>
</table>
costs associated with receiving that care may
prevent them from seeking dental services un-
less the matter is urgent. For example, although
many communities have regular visits from a
dentist, some dental procedures still require
residents to travel to a different community. For
residents who live on a low or fixed income, the
cost of travel can be an important concern. This
focus group participant explained how the high
cost of travel makes already expensive dental
treatments even more difficult to access:

Like my daughter and her husband works in
the fish plant when the plant is open in the
summer time, and they go on EI in the win-
ter which is all there is. They’ve got to take
their daughter to St. John’s in July to get...
four teeth removed, at a cost of $2500. Just
for the dental work alone. And then some-
one’s got to go out with her, and it’s going to
cost them somewhere around $6000. That’s
her whole income for the summer in the fish
plant. (Cartwright focus group)

Approximately 47% of the survey respon-
dents reported that the cost of travel affected
their decision to obtain dental services. There
were no significant differences in this finding
based on sex, age group, education or employ-
ment status (Table 8.2). However, participants
with a household income greater than $80,000
per year were significantly less likely to report
that the cost of travel affected decisions about
dental services (Table 8.2).

8.4 Home remedies

The survey revealed relatively high rates of
‘home remedies’ used to relieve dental pain and
discomfort. Thirteen percent (13%) of survey
respondents indicated that they had attempted
dental home remedy, with more males than
females indicating that they had used a home
remedy. Although this could be related to the
high cost of accessing dental services, respon-
dents’ use of home remedies did not appear
to be related to income, insurance availability,
ability to afford dental services, availability of
services, wait times or travel to obtain services.

In this quotation, one participant describes
a dental procedure that had been conducted at
home:

Participant: I got a gentleman over there at
my house that removes his own teeth.

Facilitator: Really, removes his own teeth?
Like how?

Participant: Don’t ask... (Cartwright focus
group)

8.5 Frequency of visits and wait times

As mentioned at the start of this chapter,
dentists visit the communities of NunatuKa-
vut on a set schedule. Of course, this schedule
may vary due to weather, and/or emergencies
that might arise. Given that cost is a barrier for
many people to receive dental treatment – par-
ticularly preventative treatment like regular
cleanings and check-ups – many residents report
that much of dentists’ time in the communities
seems to be spent dealing with urgent issues or
emergencies. This seems to indicate that people
might not be accessing preventive dental ser-
dices that could prevent the need for extensive
restorative or emergency care. It is unclear from
the data gathered how often those with low
incomes or on social assistance actually access
dental care; it is possible that even with government-subsidized dental care there may be additional barriers such as travel (even within communities) preventing some people from accessing dental care. More research is needed to uncover the complexity of oral health care and service delivery in NunatuKavut.

When asked about when the last time they had visited the dentist, approximately 40% of survey respondents indicated that they had been to see the dentist within the past 12 months. Still, a large percentage (27.4%) had not been to see the dentist in 2 or more years (including some who may never have gone to the dentist). Significantly more women (51.3%) had been to see the dentist within the past year than men (26.5%). Those with higher household incomes and higher levels of education attainment were more likely to have had dental care within the past year (Table 8.3). Younger respondents were also more likely to have had dental care in the past year. Unfortunately we did not ask about the reason for seeking dental care, so it is hard to know how much of the care actually delivered was preventative care or maintenance versus treatment or emergency services.

When asked about the availability of dental services in their communities, 69.4% of respondents felt that services were not available. There were no differences with respect age, sex, income level and employment type, but respondents with higher levels of education were more likely to indicate that there was a lack of dental services in the community (see Table 8.4).

<table>
<thead>
<tr>
<th>Table 8.3. Survey respondents who have had dental care within the past 12 months, by age, education level and household income.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Gender</strong></td>
</tr>
<tr>
<td>Male</td>
</tr>
<tr>
<td>Female</td>
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<tr>
<td><strong>Age</strong></td>
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<tr>
<td>16-24</td>
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<tr>
<td>25-34</td>
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<tr>
<td>35-44</td>
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<td>45-54</td>
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<tr>
<td>55-64</td>
</tr>
<tr>
<td>65+</td>
</tr>
<tr>
<td><strong>Education</strong></td>
</tr>
<tr>
<td>Primary</td>
</tr>
<tr>
<td>Some High School</td>
</tr>
<tr>
<td>High School</td>
</tr>
<tr>
<td>Some College/University</td>
</tr>
<tr>
<td>Obtained College/University Degree</td>
</tr>
<tr>
<td><strong>Household Income</strong></td>
</tr>
<tr>
<td>$0 - $19,999</td>
</tr>
<tr>
<td>$20,000 - $39,999</td>
</tr>
<tr>
<td>$40,000 - $59,999</td>
</tr>
<tr>
<td>$60,000 - $79,999</td>
</tr>
<tr>
<td>$80,000+</td>
</tr>
</tbody>
</table>
Table 8.4. Respondents who agreed or strongly agreed with the statement “I feel that dental services are not available in my area,” by highest level of education.

<table>
<thead>
<tr>
<th>Education</th>
<th>% agreed or strongly agreed:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>59.0</td>
</tr>
<tr>
<td>Some High School</td>
<td>73.2</td>
</tr>
<tr>
<td>High School</td>
<td>60.7</td>
</tr>
<tr>
<td>Some College/University</td>
<td>83.3</td>
</tr>
<tr>
<td>Obtained College/University Degree</td>
<td>75.2</td>
</tr>
</tbody>
</table>

Approximately 36.7% of participants in south Labrador coastal communities felt that dental services in their area were adequate. There was no significant difference in this finding based on sex, employment status, age group or household income (see Table 8.5). However, participants with lower education levels were more likely to indicate that dental services provided in their communities were adequate (see Table 8.5).

Forty-one percent (41.1%) of respondents agreed or strongly agreed that long wait lists were a factor in not receiving dental care. This finding did not appear to be related to sex, age, education level, employment status or household income level.

In the qualitative interviews, many participants reported that it is sometimes hard to book a regular dental appointment. It was mentioned that the schedule of when a dentist would be available and able to accept appointments was unclear, but it may be that people are unaware of the dentists’ scheduled visits because they are

Table 8.5. Respondents who felt that dental services in their area were adequate.

<table>
<thead>
<tr>
<th>Gender</th>
<th>% agreed or strongly agreed: “dental services in my area are adequate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>36.4</td>
</tr>
<tr>
<td>Female</td>
<td>37.6</td>
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</table>

<table>
<thead>
<tr>
<th>Age</th>
<th>% agreed or strongly agreed: “dental services in my area are adequate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>16-24</td>
<td>26.7</td>
</tr>
<tr>
<td>25-34</td>
<td>51.1</td>
</tr>
<tr>
<td>35-44</td>
<td>32.6</td>
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<tr>
<td>45-54</td>
<td>32.5</td>
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<tr>
<td>55-64</td>
<td>46.3</td>
</tr>
<tr>
<td>65+</td>
<td>32.7</td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Education</th>
<th>% agreed or strongly agreed: “dental services in my area are adequate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary</td>
<td>51.3</td>
</tr>
<tr>
<td>Some High School</td>
<td>33.8</td>
</tr>
<tr>
<td>High School</td>
<td>51.8</td>
</tr>
<tr>
<td>Some College/University</td>
<td>27.8</td>
</tr>
<tr>
<td>Obtained College/University Degree</td>
<td>23.9</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Household Income</th>
<th>% agreed or strongly agreed: “dental services in my area are adequate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>$0 - $19,999</td>
<td>46.4</td>
</tr>
<tr>
<td>$20,000 – $39,999</td>
<td>44.2</td>
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<tr>
<td>$40,000 – $59,999</td>
<td>24.7</td>
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<tr>
<td>$60,000 – $79,999</td>
<td>34.2</td>
</tr>
<tr>
<td>$80,000+</td>
<td>38.2</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Employment Type</th>
<th>% agreed or strongly agreed: “dental services in my area are adequate”</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unemployed</td>
<td>37.7</td>
</tr>
<tr>
<td>Seasonal</td>
<td>39.9</td>
</tr>
<tr>
<td>Part-time</td>
<td>38.9</td>
</tr>
<tr>
<td>Full-time</td>
<td>31.5</td>
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</tbody>
</table>
not attempting to access his/her services. Participants in the key informant interviews and focus groups reported that because dentists are not always present, it seems that when they do arrive, they have to deal mainly with urgent cases before they can attend to regular appointments.

The dentist… only comes in about every six weeks, right, and like he’ll only see like, sort of emergencies, like you can’t get a cleaning, ah, and he’s all booked up. (Port Hope Simpson focus group)

I think they come in on an average of... once a month? Or every six weeks? I’m not sure... but they’re pretty full when they do come. Because um... like it’s lots of times you’d like to go in just to get a cleaning done, but you can’t get it done because ah, they’re really busy... they’re taking care of fillings and extractions and those type of things right?... ‘Cause I was supposed to have gone back to the dentist to get a filling, at least three months ago, and they were going to call me when they get in but because... like my filling is not very... it’s not too bad so, you know, it was no big deal – it’s not an emergency... so I get pushed back because they have some other things that are more impor-

One participant from Port Hope Simpson observed that because dentists sometimes visit the communities sporadically, most of their time may be spent doing rehabilitative work like extractions or fillings. This means they may not have much time available to educate patients or the general population about preventative dental care and hygiene.

...it seems to me and I don’t know if I am correct in this, um, is that the services being provided are pretty much emergency services. They can’t...they don’t have time like for much education, that type of thing, like basically what they’re doing is, as far

Regular dentist visits are an important part of oral health, yet people in NunatuKavut report they often see dentists for rehabilitative work instead of preventative care. Courtesy of Aimee Chaulk.
as I know is like fillings and extractions and root canals and a few things like that right. (Lydia Penney, Port Hope Simpson)

Residents of the more isolated communities like Norman Bay must travel to other towns for dental care, so it is even more important that they know the dentist’s schedule well in advance. Given that these dentists are treating patients from multiple towns during a single visit, many participants felt that they should visit more frequently.

… they could visit the Charlottetown clinic more often… seems like a long wait… she was in there in January; I think it’s March she is coming again. Every couple of months before you sees her, could be more visits probably, frequent visits. (George Roberts, Norman Bay)

In the following quotation, one participant argues that more frequent visits by the dentist could also make dental care more affordable, because the cost could be spread out over a number of months, rather than paying for several treatments at one time.

8.6 Conclusions

Oral health is about more than simply healthy teeth and gums. Without a proper diet or the knowledge and ability to take care of one’s teeth and gums, it is difficult to have optimal oral health. There are a variety of issues that make achieving oral health difficult for people who live in NunatuKavut communities. These include the high cost, difficulty of accessing healthy foods that might protect against oral disease, and the increased consumption of foods that contain sugar (discussed in Chapters 5 & 10), as well as the loss of traditional practices such as chewing bone marrow, which might

Nearly one-third of survey respondents reported they were unable to afford dental care. Women were more likely than men to say they couldn’t afford dental care. Courtesy of Aimee Chaulk.
have historically strengthened teeth and protected against oral disease and decay. These issues reinforce the importance of reviving traditional southeast Labrador Inuit activities, as well as the importance of being able to maintain access to traditional foods.

An important part of one’s overall oral health regime should also include regular visits to a dental professional for check-ups and cleanings. As noted above, only a quarter (25%) of residents have dental insurance, and even for those who do, the additional costs of travelling to attend appointments can make dental appointments unaffordable. The result is that dental care seems to be mainly reserved for emergency and rehabilitation services – such as fillings, extractions, and root canals. The importance of maintaining healthy teeth and gums becomes even more important when the high cost of treatment services makes them unaffordable for many community members.

Unfortunately, due to the infrequent schedule of visits by dental professionals, it was reported by community members that much of the dentists’ time seems to be spent doing emergency procedures, which leaves little time to carry out preventive activities like regular check-ups. If community members are unable to even afford the costs associated with regular check-ups, then it is more likely they will eventually face very expensive dental procedures associated with oral disease. Of course, these expensive treatments also often require costly travel, since more invasive dental procedures require facilities and resources not available on the coast.

Oral health promotion and disease prevention interventions are needed along the coast. Such initiatives must address the difficulties of accessing health care services, education programs and even healthy food choices that might protect against oral disease. It is not known how many people take advantage of publicly funded dental coverage (available to those on social assistance, low-income families, and children up to age 12). More detailed information is needed on oral health in the communities, as well as information about the challenges in accessing oral health services. This information could be used to develop more specific recommendations.

8.7 References
Within NunatuKavut communities, when someone is experiencing mental health problems it is often said that they have ‘lost their colour’. Losing one’s colour can affect all aspects of one’s life and health – emotional, mental, physical and spiritual. Given the small, close-knit and collective nature of NunatuKavut communities, when one person loses their colour, those around them often experience a loss of colour as well. As a result, it is important to understand mental health within this broad context where every individual constantly influences, and is influenced by, the collective. Supports and services to address the mental health of individuals must also account for this collective perspective.
… my father-in-law is not well; he has a series of health issues and he is nearly 80; my mother-in-law just turned 73. They live alone and I tell you before Christmas I thought we were gonna have to send her somewhere for help. I mean he wasn’t sleeping, so she wasn’t sleeping. He was up wandering around in pain and so she was up, and I mean the weight she had lost, and like she lost her color, you know, didn’t she? And it was, it was just stressful… (St. Lewis focus group)

In the following section, we report on issues directly related to mental health. We begin with a discussion of the prevalence of mental health issues in NunatuKavut. We then move on to describe the community context and availability of existing informal support systems that are perceived to be available within NunatuKavut communities, as well as some of the barriers that might prevent community members from seeking either formal or informal supports for mental health issues. From there, we discuss the availability of formal support for mental health issues as well as the challenges faced by people accessing those services.

9.2 Mental Health Statistics

With the NunatuKavut CHNA, we wanted to find out how common depression is in the south coast communities. Survey respondents were asked if they had felt sad, blue or depressed for more than two weeks in the past 12 months – if so they were to be classified as “depressed” (Assembly of First Nations, 2007). Twenty-two percent of individuals reported being depressed (i.e., feeling sad, blue or depressed) in the past 12 months, which is higher

Moonrise over William’s Harbour. Courtesy of Billy Larkham.
than what has been reported for other First Nation communities (20.1%) (Assembly of First Nations, 2007). The estimated prevalence for the general Canadian population ranges from only 4.3% to 7.3% (Satyanarayana et al., 2009, Schmitz et al., 2007; Tjepkema, 2002).

5.4% of survey respondents reported having seriously contemplated suicide. This value is higher than the proportion estimated for Canadian and Newfoundland and Labrador populations, 3.7% and 2.1% respectively (Statistics Canada, 2003). Sex, age category, income level, education level or BMI categorization were not significantly associated with serious contemplation of suicide. The proportion of depressed individuals who contemplated suicide in NunatuKavut communities (16.5%) was lower than that reported in the First Nations’ RHS (50.5%) (Assembly of First Nation’s, 2007). Of those who had contemplated suicide, approximately 44% reported that they had actually attempted suicide, which is almost twice as high as what was reported for First Nation’s Communities (26.0%) (Assembly of First Nations, 2007). It is important to note that all of the numbers related to suicide in NunatuKavut communities should be interpreted with caution as they were based a small number of individuals.

Persons who were classified as depressed were less likely to report that they had a good balance between the physical, emotional, mental and spiritual aspects of their lives (Figure 9.1). They felt they had less control over things that happened to them, and that they were less able to solve problems (Figure 9.1). They were also more likely to agree with the statement “I often

Figure 9.1. Self-evaluation of coping skills for individuals identified as either “depressed” or “not depressed”.

* Indicates a significant difference p<0.05)
feel helpless in dealing with the problems in life” and “There is little I can do to change many of the important things in my life” (Figure 9.1).

### 9.3 Informal mental health support systems

People with mental health problems may seek or receive help from people outside of the health care system. We asked about informal mental health supports, which we define as individuals or groups of people, outside of a formal health care setting, that a person can count on for friendship, emotional, and practical support. These support systems might include family, friends, and neighbours. Small communities like those found on the southeast coast of Labrador are often seen as very close-knit, meaning that everyone knows everyone and many residents are related. There is a sense of community and a sense of security in knowing that everyone ‘looks out for’ everyone else. Participants considered this a very important aspect of living in a small town, and many of our study participants mentioned that ‘knowing everyone’ was a very positive thing about their local community.

We asked a number of questions about people’s access to various informal social supports. Figure 9.2 shows the responses of individuals who were classified as “depressed” and “not depressed”. Individuals who reported feeling depressed were less likely to say that they had somebody they could count on when they needed help, somebody to take them to the doctor when they need to go, or somebody that they could do something enjoyable with (see Figure 9.2).

Respondents’ use of family and community supports is shown in Figure 9.3, again broken

**Figure 9.2.** Evaluation of access to informal supports for individuals classified as either “depressed” or “not depressed”.

* Indicates a significant difference ($p < 0.05$)
down by whether they were depressed in the past 12 months. Most participants reported talking to immediate family members or friends for support, followed by nurses and their family doctors. People who reported feeling depressed in the past 12 months were more likely to seek help from family members, friends, nurses, family doctors and counselors than people who had not reported feelings of depression (see Figure 9.3).

Informal support was often mentioned as one characteristic of NunatuKavut communities that has been maintained throughout history. Although many aspects of the community have changed in recent years along with changing technology and transportation, participants repeatedly said that people still look out for one another and are always there in times of need, particularly if there is a sickness or death in someone’s family. In St. Lewis, one of the elderly women who took part in the focus group discussion had recently lost her husband. As she notes below, she relied heavily on the emotional support of a neighbour to help her through the grief and loss she was experiencing.

Participant: I don’t know what I would have done only for [neighbour].

Neighbour: Thank you.

Participant: She brought me down books, she come down, she sat down for hours on end, talking to me. I just thank God for

**Figure 9.3.** Use of family and community support by person identified as depressed or not depressed
her tonight, ‘cause I don’t know, there was
days I felt like cracking up. (St. Lewis focus
group)

There seems to be a great deal of informal support for people dealing with certain mental health issues, particularly those related to the grief and loss associated with the sickness or death of a family member. However, there are other, often chronic, mental health issues in the communities that have little to do with physical sickness or death. A number of participants, particularly health professionals, described systemic factors that may contribute to chronic mental health problems in NunatuKavut communities. These factors include the shift away from traditional activities and knowledge, concerns about finding employment, persistent out-migration (particularly of young people), and few opportunities for organized social events. In most cases, community members have little direct control over these systemic factors, but they are nevertheless influenced by them. One healthcare worker noted that she sees a direct link between high unemployment and many of the social problems facing NunatuKavut communities, including violence and abuse in families as well as substance abuse and addiction.

Many study participants argued that pervasive mental health stressors are very common, but so daunting that community members may not even know how to begin to talk about them. As a result, there seems to be a ‘culture of silence’ regarding mental health issues, which makes it very difficult for those experiencing mental health problems to seek support from within their community.

Participant: It’s getting better but ah, there still a lot of ‘hush hush’.

Participant: Oh Yeah.

Participant: It shouldn’t be that way.

Facilitator: Where does the ‘hush hush’ come from?

Participant: Well the stigma of mental illness.

Participant: They’re ashamed.

Participant: It’s embarrassment …

Participant: They’re ashamed to talk about ‘well my sister or my daughter or my son got a mental illness’…you know and they’re kinda ‘hush hush’ about it. (Charlottetown focus group)

This persistent silence may lead some community members to attempt to hide what they are feeling and experiencing. Without the social support of family and friends, the experience of having a mental illness can be exacerbated, and the person may feel stigmatized by their fellow community members.

I am just saying that there is still a stigma; people don’t want to let people know that they have depression or they feel down or whatever. (Charlottetown focus group)

In the focus group in Mary’s Harbour, participants pointed out that sometimes people do not feel comfortable talking to family members or friends about certain mental health problems. This might be because of sensitivity or stigma, or in some cases family and friends are simply not equipped or properly trained to identify and deal with severe mental health issues.

Participant: People don’t want to talk about certain things.
Facilitator: So but I guess what I’m interested in understanding a bit more is why do you think people are not willing to talk about it?

Participant: ...A lot of people may not have, I know, yes, there’s a lot of support in families around here, but some people just don’t feel comfortable talking about that stuff.

(Mary’s Harbour focus group)

9.4 Formal mental health support systems

Although participants saw support from family and friends as important for good mental health, they also acknowledged that their family and friends are generally not trained professionals and are not equipped to handle serious mental health issues. In the focus group in St. Lewis, a number of people strongly felt that their communities need better access to professional mental health care.

Participant: We do not have the proper facilities on this coast... We do not have anybody in Southern Labrador to help anybody with the situation. Most people do not want to go to that clinic to discuss their problems; it’s a small place and you don’t want other people to know what you’re going through. I noticed that out there that [Dr. Valcour during community presentation] said that sometimes people go to their families. Well a lot of times you can’t go to your family. They’re not equipped to help you, you have to be a special person who is trained in this field to handle this problem, and we need that desperately. (St. Lewis Focus Group)

Currently, there is only one mental health counselor, one mental health nurse and one addictions counselor for all of the southeast Labrador communities, and patients must travel to St. Anthony or Goose Bay to receive the specialized services of a psychologist or psychiatrist. Additionally, as the mental health worker notes below, unless specialists are specifically referred to a community, they do not go there. This worker feels that a greater presence of mental health workers in the various communities would make it easier for clients to attend appointments. Although it may appear contradictory to suggest that more mental health workers would benefit southeast coast communities when many would refuse to take advantage of services within their own communities due to confidentiality issues, this may be interpreted to indicate that significant works needs to be done to break down barriers that exist with respect to dealing with mental health issues, which ultimately points to the significant need for additional mental health personnel and resources, not less.

...I know there’s some regional mental health positions, although I heard criticism
that even though they are regional, these positions never leave St. Anthony. Um, so again more presence I guess in the different communities. Like right now [we] do some prevention work and education work in different communities but for the most part if we don’t have a referral in a community we don’t go there. But there’s been ... people have said that if you do go there, if your presence is seen there then the services, then the clients will come. (Shane Bridle, Port Hope Simpson)

Part of the challenge of offering additional mental health services is that it is difficult to get a clear picture of how widespread many mental health issues are, given that many people are unwilling to talk about them. Without the voice of community members to lobby for additional services or even to seek out treatment, many of the needs of people with mental health issues are going unmet.

Campfire Legends, Lisa Learning

### 9.5 Challenges in accessing care

#### Confidentiality and stigma

Given the stigma attached to mental health issues within many of the communities, people who want to seek help may find it difficult to do so. As the mental health worker notes below, he has sometimes encouraged patients to travel to other communities to access his services because they felt uncomfortable doing so in their own community. Other times patients use the back door of the clinic so that no one can see who is entering. Although this does not remove or address issues of stigma, it does permit those seeking help to do so with fewer concerns about confidentiality.

Participant: I’ve heard clients say before that this person wanted to access mental services, but they don’t want to be seen as someone accessing mental health services. They didn’t want to come in and be in the clinic and people know the reasons they were there – to see the addictions worker
or see the mental health nurse or whatever... we try to work around that, but that seems to be an issue for a lot of people in smaller communities.

Interviewer: Yeah. So how do you think those issues could be addressed?

Participant: I know for some people, like if I have some clients in another community, they might drive... like I go to each clinic – they might drive to another clinic to see me just because they don’t want to be seen with the addictions worker or with the mental health nurse in their community. And I know there’s clients who don’t want to be out in the waiting room with clients who have to see the nurse so they’ll access the back door... I try and tell them it’s an option if they want to do that, and then they come and use the back door so no one sees that they’re accessing addiction services or mental health services. (Shane Bridle, Port Hope Simpson)

Many of the health workers are from the local area and therefore know many of their clients personally. This might be an advantage insofar as the health-care worker is familiar with the patient’s file and does not have to review a patient’s medical history each time he or she enters the clinic. However, this situation provides little in terms of confidentiality. Furthermore, a personal relationship can present problems if the patient is seeking help related to a legal issue such as violence or abuse; the health-care worker might be related to, or close friends with, others who are involved in the situation. Although the health-care worker below says that in such cases he will simply remove himself and refer the patient to someone else, this might mean that the patient has to seek medical attention outside of the community.

The other thing, the other issue was that... like I have lots of family and friends in the community and surrounding communities so it’s probably not a good idea for family to access ah, for a person to be counseling family members or whatever. So in sensitive issues like that we usually refer to the [other] mental health nurse, [but] there’s also some concerns with um, especially like issues with spousal abuse, domestic violence, um, rape, those kind of things where women only want to deal with, they don’t wanna deal with men, so then I would refer out to other people... (Shane Bridle, Port Hope Simpson)

Travel

Anybody that has mental health issues here – you’re in a hard spot, because to send you out to the counselor, you go out on a Monday and come back on a Wednesday. And you know, if you’re doing that once a month that’s not a solution, I don’t think. Mental health is probably one of the biggest issues for improvement. (Kim Morris, Cartwright)

Travel can be problematic for anyone who needs specialized medical services within NunatuKavut communities, as the only way to access a hospital is by travelling long distances to St. Anthony or Goose Bay. Sometimes the prospect of travelling while ill is enough to deter some people from seeking medical attention unless it is absolutely necessary. For those with mental illnesses, a proper diagnosis often entails repeat visits with multiple health-care practitioners, meaning a great deal of travel. A further complication is that many people with undiag-
nosed mental health issues may be reluctant to seek out health-care advice.

A lot of people don’t wanna fly over to St. Anthony to see a psychologist or to see a psychiatrist or whatever. (Shane Bridle, Port Hope Simpson)

We’ve had kids who should be seeing a counselor but they just, it’s not often enough and it’s you know, too far away and you know they don’t have the opportunity to build a rapport. So you know, that’s a difficulty. (Kim Morris, Cartwright)

Similarly, the participant below suggests that if someone with a severe mental illness has sought mental health support in St. Anthony, it should be a requirement that there is someone qualified to care for them when they return home again, should they need it. Currently, patients leave the hospital in St. Anthony and return home with limited capacity to follow-up with doctor’s appointments or ongoing counseling.

Participant: I experienced a woman taking an overdose.

Interviewer: Ok.

Participant: Back quite a few years ago and um, they did, they did take her to St. Anthony and ah I, I think that she did see somebody over there, but then after she come back here she was here for months and months and months and didn’t see anybody after that, because there was no one around (Marie Rumbolt, Mary’s Harbour)

It [needs] to be addressed through Labrador-Grenfell Health with psychiatrists – make sure they got a psychiatrist that goes into the [communities]. They [should] know they got

Figure 9.4. Barriers to access to health care for individuals classified as either “depressed” or “not depressed”.

![Bar chart showing barriers to access to health care](image-url)
people [with mental illness] and they send them back home to somebody that’s going to be able to look after them and help them with their problems, right? Those things is not bein’ done... they haven’t got the staff to do it. (Marie Rumbolt, Mary’s Harbour)

The results of the survey also reflected the challenges involved accessing health care for people experiencing mental health problems. Although participants were not asked specifically about challenges to accessing mental health services, important differences were observed between people who were classified as either “depressed” or “not depressed” in terms of access to health care in general. Figure 9.4 summarizes the barriers to accessing health care according to the respondents’ mental health status. Barriers were determined by the percentage that answered yes to the question of “During the past 12 months, have you experienced any of the following barriers to receiving health care?” with respect to the categories provided. Survey respondents who had experienced a depressive episode in the past 12 months were more likely than other respondents to indicate that waiting times to see a specialist were too long, that they were unable to arrange transportation to receive health care, that they were unable to afford health care costs, and that services were not available in their area.

9.6 Mental health awareness and knowledge

Appropriately preventing, addressing and responding to mental health issues in NunatuKavut communities will require better understanding of mental health, on the part of both health service providers and other community members. A number of participants suggested that one way to begin addressing some of the identified challenges is to improve opportunities for people to learn about mental health issues, with the idea that enhanced knowledge may better prepare them to support one another. Participants mentioned a wide range of specific mental health issues that they saw as serious problems in their communities. These included support for people grieving the loss of a child or other loved one; people facing addictions, abuse and violence; and people with chronic mental health issues such as depression, schizophrenia and bipolar disorder. Some participants suggested that support groups for specific mental health-related issues would be helpful.

I know in bigger centres too, there’s maybe help, self-help groups or groups for survivors of trauma or for, um, I don’t know, groups to deal with different aspects of mental illness that’s not available here. (Shane Bridle, Port Hope Simpson)

Other participants mentioned seminars and courses where community members can learn about different mental health topics. Some such programs have been offered by NunatuKavut and Violence Prevention Labrador.

There seems to be some education programs going on about spousal abuse, domestic violence that kind of stuff with Violence Prevention Labrador, with the Metis Nation, I know myself I do some... more so geared towards schools, [they] do some, ah, presentations on bullying prevention, healthier relationships, that kind of stuff. So there’s education, education sessions going on. (Shane Bridle, Port Hope Simpson)
Participants suggested that these programs should be renewed, expanded upon and promoted to reach a wider audience. They also mentioned that it would be helpful to have opportunities to learn from mental health professionals, who could help them to identify and address mental illness in loved ones. These professionals could also provide ideas on how to seek out support, which is particularly important given the isolation of these communities and the difficulties people reported in accessing services.

I think there should be more professionals in that field coming into places like this, and doing more presentations in schools and communities... [several people talking at once]... most especially in schools... all age groups... (St. Lewis focus group)

...a lot of people don’t understand mental Illness, so we don’t, and the people is not made aware. It’s not talked about and it’s sad, you know... I think people should be more aware of it. (Charlottetown focus group)

9.7 Conclusion

This chapter has discussed the prevalence of mental health issues, as well as some of the barriers to receiving the support needed to deal with or overcome these issues. Many of the barriers relate to the high cost of travel to get to medical appointments and the limited resources available for mental health workers to travel to the coast to deliver specialized mental health care. Support from family and friends is an important part of mental health care in Nunatu-Kavut, but the communities need multi-faceted approaches that involve health professionals as well as family and friends. Mental health issues were identified as a key priority needing immediate attention by many of the key informants and focus group participants.

9.8 References


10.1 Introduction

This chapter discusses the important relationship between the people of NunatuKavut and their local, natural environment. The majority (93.5%) of survey respondents identified the natural environment (such as clean air, pristine wilderness or scenery) as one of their community’s strengths. Nonetheless, they also expressed concerns over the state of the natural environment, and they saw protecting the lands and waters as essential to maintaining and strengthening the health of the NunatuKavut people. NunatuKavut elders see the health of people as closely related to the health of the environment. Without a healthy environment, a community cannot raise healthy children. Thus, it is in the best interest of the community to protect the environment and promote respect for it, so that
it can continue to provide for future generations.

You know our children deserve it, eh... they
deserve to live in a healthy, clean and safe
environment and one can’t go without the
other... You got to have a clean, safe and
healthy environment... that goes for the
schools, the building, the public buildings,
it goes for the land... take either one of those
away and you are in trouble. ~ Guy Poole, St. Lewis

The first section of this chapter highlights
the findings related to pollution of local lands
and waters. The second section focuses on ac-
cess to, and quality of, drinking water. The final
section emphasizes the importance of protect-
ing the environment as a source of traditional
foods, and describes some of the restrictions that
currently govern how and when residents can
gather and share those foods.

10.2 Land and Water Pollution

Commercial waste

For the most part, participants in the study
seemed satisfied with the low amount of pol-
lution and contaminants to which they are
exposed in their coastal communities. They felt
that communities along the southeast coast have
very little exposure to major pollutants com-
pared to larger cities and towns.

Interviewer: How do you feel about pollut-
ants or contaminants in the air, soil or water
in your local area?

Participant: In our community I don’t think
there’s any big problem with any of that,
don’t seem to be. I never heard talk of any-
thing, and I would’ve cause with a small
community you hear, hey? You know.

Interviewer: So why do you think that’s not
an issue for this area?

Participant: Well I guess we don’t have any

Bear near the Cartwright dump. Courtesy of Margaret Pardy.
of those smogs, you knows, the smoke and it’s only just the bit of smoke or, whatever we got it’s only from furnaces and it’s no... big companies or industries or anything like that so, I guess that’s it I s’pose. (Bella Burden, Pinsent’s Arm)

Participants did raise some concerns over other aspects of the local physical environment, particularly with respect to waste disposal – both residential and commercial. Some participants mentioned that local industries (such as fish plants) are such an integral part of community life that many local residents do not think about their impact on the surrounding natural environment, or about ways to minimize this impact.

For communities depending on these industries, seeing businesses thrive and continue to operate locally is an important consideration. In the quote below, Guy Poole notes that it in the past, industries have left the community before people began to question their environmental impact.

In the 1950s, 1960s the Americans come and they built a, a gap-filler site up here on Fox Harbour hill and when they went out... they just turned the keys and went away. And then the building was tore down and ah...In my opinion, the site was never cleaned up proper and back in those days, you know, they had transformers, they had stuff that was... ah PCBs was in it eh, you know, some people say PCBs is cancer-causing agents, I don’t know a big lot about it but... if it’s any possibility it’s up there, then how come the governments haven’t come in and cleaned up our site eh? ... It was a good thing that the site come in here; not saying it was, you know, it was a good thing... people got work. The first time they ever seen real money in this community was when the Americans come in here, so that was a good thing eh, but you just wonder, you know, over the long haul was, is it good?... We gets water from Fox Harbour pond ... any pollutants drains downhill and Fox Harbour pond is down under the hill... any pollutants would drain out into the water system. (Guy Poole, St. Lewis)

Today, there are no longer radar stations or a military presence in southeastern Labrador. The fishery is the main industry, and many communities rely upon fish plants as a main source of employment. The following participant notes that even though the local fish plants are important for employment, it is also important to keep the local, natural environment as healthy as possible.

Participant: Before the shrimp plant was established in our community, the harbour was clean. As children we would swim in those waters, but I wouldn’t encourage any child to swim in those waters anymore. As you walk along the beaches now there are shrimp shells and by-products washing up on the shoreline, which is definitely an eyesore and the smell is not pleasant at all. The shrimp shells are being barged and dumped in the harbour waters, and with the wind and tide changes, the shells and remaining by-products are blowing back into the community, polluting our beaches and waters.

Interviewer: So when they take it... you said that they take it out in a barge?

Participant: Mm hmm.

Interviewer: Does it sink...once they dump
the barge, does it sink to the bottom or does it kind of stay on the top?

Participant: Shrimp shells are not heavy, and with the right winds and tides it’ll move.

Interviewer: But how far does the barge go out? Do you know roughly?

Participant: Not very far, approximately 2 km but I am not exactly sure. I would assume an environmental assessment would have been completed before the shrimp plant was started but surely goodness there must be a better way of disposing of the shrimp shells. Why not truck them out and dispose of them in a proper burial site? Or another possibility is to process the shrimp shells into a form of fertilizer, rather than pollute our waters and shorelines. (Unnamed participant, Charlottetown)

More than two thirds of the survey participants (67.5%) identified environmental concerns such as water quality issues and fish by-product dumping as problems in their community. Most people didn’t feel that there had been any change in the past 12 months, positive or negative, with respect to environmental issues, while about 10% thought the situation had gotten worse (see Table 10.1).

### Table 10.1. Perception of changes in community environmental issues.

<table>
<thead>
<tr>
<th>Change from 12 months ago</th>
<th>Percent (n=340)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Much improved</td>
<td>0.3</td>
</tr>
<tr>
<td>Somewhat improved</td>
<td>3.5</td>
</tr>
<tr>
<td>About the same</td>
<td>80.7</td>
</tr>
<tr>
<td>Somewhat worse</td>
<td>8.8</td>
</tr>
<tr>
<td>Much Worse</td>
<td>2.1</td>
</tr>
</tbody>
</table>

Residential waste

Historically, residential waste removal and disposal were not major concerns in Nunatu-Kavut communities, as the local culture placed great value on using and reusing all materials, foods and resources without wasting anything. What was no longer useable was often burned as fuel to heat homes. In more recent years, the amount of clothing, furniture, store-bought foods and other commercial goods that enter these communities has increased considerably, as has the packaging associated with these items. The amount of waste generated by communities has increased dramatically, and there is much more garbage to be disposed of than in years past. Participants expressed concern that garbage thrown into local dump sites will eventually end up in the water supply.

They could probably find a better location for the dump, um, than right by the river. And it seems like if you go up in that area, like I said, it’s not well contained; there seems to be garbage everywhere. ~ Shane Bridle, Port Hope Simpson

Participant: Another thing about it too the dump is ah, I forgot to mention, I think it’s probably too close to the water supply.

Interviewer: Too close to your pond?

Participant: Mm hmm.

Interviewer: So about how close is it, with like in miles or kilometres?

Participant: Oh it’s not that, it’s not far away... it wouldn’t even be a half a mile, I wouldn’t say (Vera Russell, William’s Harbour)
In many ways, residents continue the traditions of re-using materials and trying to cut down on waste – these ideas are still valued. But the sheer amount of commercial goods now entering the communities creates a lot of garbage. There are no recycling programs available, so all kinds of waste go into local landfills. Many residents still burn their garbage rather than sending it to the landfill. Part of the rationale for burning waste stems from the knowledge that garbage disposed of at the landfill will only be buried or burned there, rather than being recycled.

The waste in our community, in our local dump is not controlled at all, ahh there is a fence, ahhh, at the local dump, however, it has little to no effect on how it controls things. On days when it’s windy there is garbage flying around there, you know; it’s just it’s not upheld the way that it should be... it’s never been any real effort put into ahh, cleaning up the dump site, not in terms of any kind of long term thing put in place (Fanny Keefe, Black Tickle)

Interviewer: Do you have garbage collection services in your community?

Participant: No, everybody... we used to, but that just went by the wayside and everybody burns their own or brings their own to the dump. I burn it... we have got the dump but, you know, you bring it over there and burn it, and every year it gets, ah, bulldozed over or whatever. And other than that, you know, it’s, not much gets done.

Interviewer: ...what do you do with like, you know, paint cans, ah aerosol spray cans...?

Participant: Everything goes to the dump. ~ (Vera Russell, William’s Harbour)

In some cases, reusing materials like people did in the past may not be the safest or healthiest option. For example, the tradition of burning waste can provide heat and reduce waste that would otherwise end up in the landfill. However the practice might actually be harmful to people’s health, since many of the materials that are burned this way are synthetic and may be toxic or unsafe to burn.

There’s also some concerns now about a lot of people burning wood, and not only wood, but they burn a lot of their garbage and all that kind of stuff, and apparently there’s a lot of risk involved with that. (Shane Bridle, Port Hope Simpson)

Throughout the summer and fall, ah the dump, the burning of the dump. Because they burns it and you don’t know what’s in it. Now I am quite a ways away from the dump but I am sure the people that’s livin’ over in the cove, when that dump is going, I think it must be awful for them because I mean you can even smell it... you smell the rubber, you can smell whatever they’re burnin’ there... and it is definitely coming out to the houses and whatever. (Marie Rumbolt, Mary’s Harbour)

10.3 Drinking Water

The availability of drinking water systems along the southeast coast of Labrador varies considerably from household to household and from community to community. Most communities along the coast have access to a municipal water supply. There are three communities
(Black Tickle, William’s Harbour and Norman Bay) that do not have municipal water system, although they each have a water treatment plant where residents collect treated water and transport it to their own homes. In communities that do have municipal water, not all households are hooked up to the water supply system. In some cases, municipal water is not available in certain sections of town. In other cases, some residents have chosen not to be hooked up to the water supply or are unable to afford it. The majority of survey participants are serviced by piped-in water (74.9%). Other individual households collect water from wells, rivers, lakes or ponds (23.4%). The rest either purchase bottled water that has been flown into local grocery stores, or collect it themselves from local water treatment facilities.

Many participants expressed concern over the quality of water available in their communities. Only 26.0% of people surveyed felt that their tap water was safe for drinking year-round. A large proportion of households use other sources of drinking water, as shown in Table 10.2. For at least one participant, although having running water was very convenient, he preferred to drink untreated local water in order to avoid the chemicals and additives that are put into the municipal water.

Most of the water I drinks it comes from Round Hill Pond, and there’s a big pond eh... [I] goes in and gets a bucket of water and comes and puts it in the fridge and I drinks it, eh, for the most part. I am 66 years old and I haven’t had much health problems so far, so … I mean one time a long time ago we drink water from wells, from ponds and there was no chlorine into it and, and nowadays it seems like there’s more people getting sick than there ever was, eh, and you know sometimes you wonder if the water that we’re drinkin’ is safe... You know and I guess we listens to the experts out there.

Only 26% of people surveyed felt their tap water was safe for drinking year-round.
who’s… knows a lot more about water probably then we do, eh… Should we be drinking more water from the natural surroundings like ponds and rivers and stuff like that? Without the chlorine into it? I wonders about it. (Guy Poole, St. Lewis)

There seemed to be some disagreement among participants about which type of water was the safest and healthiest to drink. Although some people have doubts about the quality of municipal water, other participants in the study relied upon municipal water, because they could be sure that the water was regularly tested and deemed safe. However, relying upon municipal water entirely is not always possible, given the frequency of boil water orders within many of the communities. Even among communities and residents that do have access to municipal water, some raised concerns over the number of boil water orders that are introduced each year. In communities such as Charlottetown, residents claimed that they are on a boil water order for as many as six or seven months of the year. In most cases, these long boil orders are related to the waste leaving local fish plants – boil orders are often issued simultaneously with a fish plant’s annual opening. Similar issues were reported in Port Hope Simpson and Mary’s Harbour.

With such frequent boil water orders, some participants in the focus groups and key informant interviews reported that they do not rely upon tap water for drinking, even when there is no boil water order. Instead, they either carry water from neighbours’ wells, get it from local water sources like ponds and streams, or in some cases, they purchase drinking water from the local stores.
Personally my family and I do not drink town water; we carry water from others in the community who have artesian wells. So I feel for a service being paid for, it’s inconvenient and unfair. (Unnamed participant, Charlottetown)

Table 10.2. Sources of drinking water used as alternatives to tap water.

<table>
<thead>
<tr>
<th>Drinking water source</th>
<th>Percent* (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Boiled tap water</td>
<td>10.3 (29)</td>
</tr>
<tr>
<td>Bottled water</td>
<td>60.9 (171)</td>
</tr>
<tr>
<td>Rivers, stream, lake or pond water</td>
<td>27.4 (77)</td>
</tr>
</tbody>
</table>

*Percentages will not add to 100% as all categories are not represented

One participant was concerned about needing to rely upon their neighbours to access fresh water. Although she is very grateful for the generosity of their neighbours, she still sometimes feels like she is imposing when she has to knock on their door and ask for water.

Well, thank God for good friends and neighbours who allow us to access good drinking water through their own private artesian wells. This is a small community, and those who have artesian wells are always there to offer. However with that being said, you always feel like you’re invading someone else’s space and privacy when you have to go knock on someone’s door asking for drinking water. (Unnamed participant, Charlottetown)

In some cases, households are able to run a pipeline to the local water supply to bring water into their homes. This is convenient for the summer months, but during the winter, the pipes have to be drained to prevent them from freezing. This means that during the winter these residents must go back to fetching water themselves.

Interviewer: There’s no time in the year when you have running hot and cold water?

Participant: Ah, yeah well we got a hook-up from a pump house, and that only happened lately, in the summertime... and that’s all on top of the ground so once the fall comes we let that go.

Interviewer: And then you go back to collecting it yourself?

Participant: Yeah. (Vera Russell, William’s Harbour)

As a result of the inconvenience of fetching water from other places or continuously boiling their water, study participants reported that many residents simply purchase their water from the local grocery stores.

Water quality in our community is... it is a big problem, because we do have a town system, lots of time it’s not working, we have a boil order after boil order. And I think most all of this past fall it was boil orders on the water. Government did approach us and they would put ah, ah system in for us, which would cost us $130,000 dollars, but with a small town we just could not afford it. So most of the water that we have here at this school and most of the water that we have at home is bottled water for drinking (Jeffrey Penney, Port Hope Simpson)

There are a number of issues with relying on water supplied from the grocery stores, notwithstanding issues of quality control. Prior to the in-
At the bridges, Lodge Bay. Courtesy of Leila Coates.
whereas now it seems like every single drop has to be accounted for before you can actually use it. (Fanny Keefe, Black Tickle)

The same person from Black Tickle also pointed out that since the water treatment plant was installed, the local store began stocking less water. Now that the treatment plant is no longer working, there has sometimes been a shortage of water in the community.

They been buying water at the store but... in the past few years with the water treatment plant running they haven’t been putting, having as much water come in. And so now this year since the water treatment plant is not running, the stores are starting to run out of water and so therefore it’s not going to be much longer, if something isn’t done, before there is no clean water to give to the babies to mix bottles ahh, for anything. (Fanny Keefe, Black Tickle)

Despite residents’ concerns over water quality, they generally felt that there was little that could be done to improve the system – the water treatment plants in their communities were relatively new, and the current services were seen as a great improvement over a few years before, when running water was simply not an option.

One study participant from Charlottetown suggested that a solution to issues of water quality might be to have a number of community wells dug throughout the community, which could be used by a number of households.

[An] alternative could involve the town investing in several artesian wells throughout the community and running the water-lines through these artesian wells. This would provide us with good drinking water. Another possibility is to invest in one artesian well in the community with outside access 24/7 for those of us who have to carry drinking water. (Unnamed participant, Charlottetown)

10.4  The Natural Environment and Traditional Food Use

Connecting environmental issues, health and traditional foods

Many participants stressed the importance of being able to access foods from the natural world, because these foods are an important part of how they express their relationship to the world around them. This relationship was highlighted as being important for both emotional and spiritual health.
A lot of people, a lot of the older people are used to it... and they’ll gather their berries and they’ll go out and get their fish or their seal meat, or the rabbit and partridge, because it’s a traditional thing to do and I think a lot of people is used to doing that and hopefully it’s gonna stay that way. (Marie Rumbolt, Mary’s Harbour)

It is also important to community members to pass on traditional food gathering skills to future generations. When asked if they planned to teach their children traditional food gathering skills such as hunting and fishing, 75.8% and 82.8%, respectively, indicated that they intended to do so.

Sharing foods gathered from the natural world is also an important tradition in the community. Food-sharing was mentioned as important for ensuring that elders continue to have access to traditional foods, even when they no longer get out on the land to hunt and fish themselves due to physical ailments.

A lot of people ah, hunt. And people that hunt are, are usually fairly successful and they’re very generous as well – you know, a lot of them take care of the seniors, who of course grew up on that and may not have family members of their own. And people tend to share it out amongst people so that is a good thing. (Kim Morris, Cartwright)

Aside from the importance of maintaining cultural traditions through these foods, participants also highlighted that many of these foods are important for nutritional health – both in terms of the types of foods and traditional preparation methods (e.g., raw or prepared in ways that preserve nutrients).

I know there’s people who catch rabbits just for, I guess the cultural aspect of it. It’s something that, that they’ve always done or their parents done, they want to keep up that tradition. But at the same time there’s, they do it for nutritional aspects as well I guess. (Jeffrey Penney, Port Hope Simpson)

We grew up living off the land, like we eat everything... we’ve eaten the leaves from dogberry trees and caribou moss, and ah grass roots and Alexander and that. We didn’t bother to cook a lot of the things we hauling out of the water... When you’re hungry, you just go haul it up and eat it... leaves
a lot of nutrients when you don’t cook it, right? (Port Hope Simpson focus group)

Many participants also mentioned that they believe locally harvested traditional foods, particularly meats, are healthier options than what is sold in local grocery stores. Many were skeptical about where store-bought meats ‘come from’ and what chemicals and hormones they are exposed to before being sold to the consumer. Participants were less concerned about exposure to additives and chemicals when eating foods that are gathered, hunted or trapped locally.

Interviewer: Why do you think people access traditional foods?

Participant: I think we enjoy them, and we believe that they’re better for us than the cow or the chicken, which is pumped full of all kinds of um, you know… stuff (laughs)… to make them grow… we’re hoping that our traditional foods are a lot better for us and won’t do us much harm to our bodies as ah, as some of these, um pumped-up chickens. (Lydia Penney, Port Hope Simpson)

You hear the news about, you know, what they feeds the chickens with and so on and so forth, and I’m there thinking, you know, man if I had a good ol’ healthy duck there to put in the oven for Christmas dinner or whatever, like I had years ago, I think you know it would be a lot better. So I’m not saying there’s anything wrong with the food, I’m just saying that … I’m used to eating traditional foods...(Guy Poole, St. Lewis)
Economics may also be a factor in choosing traditional foods. One participant in Norman Bay mentioned that in some cases people prefer to rely on traditional foods, simply because they cannot afford to buy all of their food from the grocery store.

Oh I suppose, maid, nobody starving, but ‘tis a guaranteed great difficulty. Sometimes you’re only just living from cheque to cheque, just getting money enough for your groceries and ‘tis hard going... food is expensive, really, really expensive... Most of the people, I say 80% of the people, just depends on more or less ah, traditional food yeah, land food. (George Roberts, Norman Bay)

Table 10.3 shows the percentage of survey respondents who had participated in activities such as hunting, fishing, berry gathering and gardening within the past 12 months to supplement food they bought at the grocery store. The majority of participants had used hunting, fishing and berry gathering to supplement their food, but only 22.5% indicated that they kept gardens to supplement their food. When asked how they felt about the statement “The food we bought just didn’t last and we didn’t have the money to get more”, about 1 in 5 (21.9%) indicated that purchased foods were not lasting long enough. About the same percentage (22.2%) said they couldn’t afford to buy balanced meals (i.e., combining proteins, vegetables and fruits, and dairy products). A small percentage of individuals indicated that they had either cut down on the size of their meals (5.8%) or were going hungry because there was not enough to eat (2.9%).

<table>
<thead>
<tr>
<th>In the past 12 months have you supplemented your food with:</th>
<th>Percentage (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hunting</td>
<td>63.0% (216)</td>
</tr>
<tr>
<td>Fishing</td>
<td>77.8% (267)</td>
</tr>
<tr>
<td>Gardening</td>
<td>22.5% (77)</td>
</tr>
<tr>
<td>Gathering berries</td>
<td>77.8% (267)</td>
</tr>
</tbody>
</table>

**Restrictions on access to traditional foods**

Many people in the study mentioned the importance of being able to access traditional foods. However, they also described challenges with accessing these foods when they are needed and in the amounts that people need to feed their families. These challenges were mainly due to increasing restrictions on when, how often and how much people in the local area are allowed to hunt and fish. There was also some concern about the increasing costs associated with acquiring licenses to hunt and fish.

There’s all kinds of regulations that we’re under now ... in the last few years, especially since the fishery closed, we got a food fishery... with the cod fish... only so many you can catch and you got to have a license for everything. With some people now it, it could be a problem because it’s even expensive just buying a license...(Jeffrey Penney, Port Hope Simpson)

For many, the restricted access to traditional foods has a direct impact on health, since the food choices available through the local grocery stores were often seen as less nutritious than foods caught or gathered locally. Survey participants generally believed that the fresh foods available at their local grocery store were adequate, but 19.2% felt that grocery store foods were only “fair”.
So it’s all limited, so when [traditional] food sources run out that you are allowed to have, what do you turn to then? The stores. The foods that are being provided in local stores is all fat, cholesterol, salts, sugars whatever, so now you’re right back to an uncontrolled diet again. (Charlottetown focus group)

Participants also highlighted that community members’ health may have been affected by the loss of the more active lifestyle associated with acquiring traditional foods.

Where we’re living in Labrador and we’ve taken on a more modern type of living, that we have done away with a lot of the things that are good for us and that’s why we are all so overweight and obese or whatever, because we don’t get to exercise. You know those rights that we had back then, and now we’re eating more differently, like more fry foods that are not good for us and not eating like wild meats and fishes and you know different types of fish...(Port Hope Simpson focus group)

Even though many residents feel that traditional foods are superior to grocery store foods, the ever-tightening restrictions placed on when, how much and how often they can hunt and fish have made it more difficult to choose to eat traditional foods. In many situations, if a person strictly obeyed hunting and fishing laws, they would not be able to acquire enough healthy foods to feed their families.

Being able to hunt and fish is also viewed as a fundamental part of expressing one’s identity.
and heritage, which is also crucial to health and well-being.

Interviewer: What do you perceive to be some of the barriers or constraints for people eating more healthfully?

Participant: Well, I guess one of things as I just mentioned like you know as, as Aboriginal people we [are] used to, to eatin’ traditional foods, traditional food being the rabbits, the ducks, the partridges, the seals... we all know that seals is awful hard to get when it comes to shootin’ them with a rifle, you have to be pretty good at it you know… there was times when we was allowed to set out a net... and I knows the wildlife act activists would be upset about what I am gonna... but I’ll tell the truth here and it’s just my opinion. That I think as Aboriginal people here in Labrador, as the Metis Nation people, that we should be allowed to go out and set out a net to get a seal to eat for our families and for our dogs... the Inuit people is allowed to set out a net to get a seal to eat or for their dogs or whatever, and south of [Bolster’s Rock] we’re not. And I think that that’s unacceptable as Aboriginal people... they live no different than people in the south... and if we’re gonna get traditional foods to eat then we have to catch them the traditional ways... like we’ve always caught ‘em... if not, then we are not gonna get enough of traditional foods, eh. And my opinion on it - if we don’t eat traditional foods and drink traditional waters then I don’t think we’re gonna stay healthy. (Guy Poole, St. Lewis)
One participant in the Cartwright focus group pointed out that despite a lack of health-care workers and police officers in the community, there always seems to be an over-abundance of conservation officers on the lookout for people who may be breaking the law by over-hunting or over-fishing.

It’s only a few years back... when they took the police, the policemen from town... Like there was no doctor in Cartwright, there was no dentist, there was no police. Um there was no services whatsoever... I remember saying we don’t have a doctor or a nurse or a police officer, but we had eight conservation officers...You can’t even go and cut a load of firewood without someone following you in there ‘do you have your license?’, ‘you’re not supposed to be cutting here,’ ‘you’re supposed to cut over there.’ And then, to go out and get a meal like a fish or a bird for a meal, you go out in your boat and they’re there down at the dock to see what you have down in your boat. (Kim Morris, Cartwright)

The tradition of food-sharing, mentioned previously, was also seen as being negatively influenced by hunting and fishing regulations. These regulations often assume that one is hunting or fishing for oneself, and not for others in the community. As such, it is difficult to legally acquire traditional foods for elderly or disabled people who cannot gather them for themselves.

...you’re only supposed say, to get so many ducks a day, and the regulations that they got as far as I’m concerned is just bogus, eh. Like if I can go out in boat today... if I went out say and I got 50 ducks, well I am probably not allowed, so if I’m caught then I am charged, I gotta go to court and then I got to pay a fine and all that... I go out and get 50 ducks then why can’t I come home and put them in me freezer and share it with me family members and share it with the older people in the community like I’ve always done? And I don’t have to go out the next day and get another 50, I got enough in there for the whole winter... but the law states that you’re only allowed so many birds, so you know... when it comes to the government it’s just not doing justice to us eh, as Aboriginal people. (Guy Poole, St. Lewis)

10.5 Conclusion

This chapter has focused on the importance of traditional foods, both in terms of their nutritional value and their importance for cultural wellbeing. Participants expressed great concern about the increasing restrictions that are placed on when, how much and how often traditional foods can be collected. Given the linkages between expressions of culture and overall health and wellbeing (Loppie-Reading & Wien, 2009), it is important that supports and resources are put in place that emphasize these traditional activities, rather than detract from them.

10.6 Reference

11.1 Introduction

The current Canadian health-care system is designed to accept patients upon presentation of symptoms, rather than looking at why it is that those symptoms appeared in the first place. The first five findings chapters (Health Practices and Personal Characteristics; Health Care and Health Related Services; Chronic Disease and Injury; Oral Health Care; Mental Health; People and the Natural World) have detailed and described a range of prevalent health conditions and concerns that are all currently treated through the health-care system. However we have not yet explored why it is that we are dealing with such high rates of chronic disease, or why it is that many people do not have secure employment, access to running water or healthy foods. An important aspect of responding to
chronic disease and illness requires recognizing the root causes of these sicknesses. We must also recognize that some of the root causes of disease – poverty, unemployment, access to fresh food and water – are simply not seen as healthcare issues – in general, not just in Labrador. As southern Labrador Inuit people, it is important that health is defined as being about more than health-care. It is also about the health of communities and the natural environment. For without healthy surroundings, people cannot be healthy.

This final findings chapter highlights some of the ways that the social world influences the health and well-being of NunatuKavut communities and their residents. Ultimately, human health, health services and the health of the natural world are all influenced by the actions and choices of NunatuKavut people, and those who influence NunatuKavut (e.g., government policy-makers, health-care administrators, educators, etc.). As such, this chapter is meant to raise questions about how and why it is that rates of certain chronic diseases are so high (like diabetes and heart disease), and how this relates more broadly to NunatuKavut’s history and rich culture. How can NunatuKavut culture be used to improve health? How is it that NunatuKavut culture was not integrated into health services in the first place?

This chapter begins by presenting some final data about community supportiveness and suggestions from research participants about ways to improve social support within NunatuKavut communities. Supporting one another through difficult times is what has made NunatuKavut people strong, and continuing this support in the face of new challenges – health-related challenges – will only make NunatuKavut people stronger. This is followed by a general discussion of what the writers of this report see as some of the ‘root causes’ of health problems in NunatuKavut communities. None of these root problems have easy solutions. By writing about them here, we are naming these issues as areas for health-related change. We hope this will be the part of a dialogue that will help NunatuKavut people move towards addressing these issues as a community.

### 11.2 Community Supportiveness

In many respects, NunatuKavut communities boast a tremendous degree of social connection and interpersonal support in times of need. Family members and friends can be counted on for many different kinds of support. For example, if there is a death in the community or if someone is suffering from an illness, the community rallies to ensure that people have the comfort and practical support they need. As the focus group in Charlottetown suggested, ‘everybody is family’.

Facilitator: What is it that brings you back here?

Participant: The family. The closeness.

Participant: It’s home.

Participant: Everybody is family. (Charlottetown focus group)

Community members also provide a great deal of support for one another at other times, when there is no crisis. There is always someone available to provide a ride to a doctor’s appointment, pick up groceries, fix a leaky roof, or help with any other errands.
Participant: And it’s not everybody got vehicles here... you got to get a ride or whatever, hey?

Interviewer: So if someone doesn’t have a vehicle, what do they do in that instance?

Participant: Well, they call a family member or friend and they’ll bring them into the clinic. (Bella Burden, Pinsent’s Arm)

In the Port Hope Simpson focus group, one of the women noted that she and her children have all had serious health problems, which have required them to travel to St. John’s often for medical appointments. She credits the community with helping her family to pay for the travel associated with these appointments by holding multiple fundraising events. She argues that without community fundraising, her family would have been unable to afford to attend these appointments, as her family income was mostly from employment insurance.

Participant: I’ve had to go often, I had to go myself and [my two children]... You got unemployment, you can’t come up with two or three thousand dollars every trip. You know what I mean?

Participant: But one thing, the community is very supportive here, a lot of help, they give you a lot of help.

Participant: I can guarantee you that the community here, and I knows, cause I’m one of them.

Bonfire in William’s Harbour. Courtesy of Billy Larkham.
Participant: Very supportive community people in time…

Participant: You’ll come down here, down here to the old fire hall, if you say, you know someone in the community has cancer now… let’s go down and have a fundraiser for [this person]. (Port Hope Simpson focus group)

In virtually every community, fundraising was mentioned as an important source of money for people who need to attend medical appointments outside of their community. Community fundraising was also mentioned as a way to assist people who have had their homes damaged as a result of fire.

Participant: There’s a community spirit that when someone is in need... everybody is there to help.

Participant: Right.

Facilitator: So what, what kind of need, is there like...

Participant: Like somebody, and like for instance last week when the lady needed the money go to St. John’s, in a matter of two days we had a couple of thousand dollars raised.

Participant: Yeah, and then there is someone else lost a house, and you know, [in] a couple of months we had bought them a house. (Cartwright focus group)

Knowing that community members are always looking out for one another seemed to be an important reason why many people choose to stay in their communities, even when employment opportunities are scarce.

And then ah, your children is going out running around somewhere, everybody knows where they’re at…like they say, it takes a community to raise a child, that’s how it is. (Cartwright focus group)

These same ideas are supported by the survey results. When asked to name the strengths

<table>
<thead>
<tr>
<th>“Which of the following do you consider to be strengths of your community?”</th>
<th>Percent (n=340)</th>
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<tbody>
<tr>
<td>Natural Environment</td>
<td>93.3 %</td>
</tr>
<tr>
<td>Awareness of Labrador Culture</td>
<td>91.2 %</td>
</tr>
<tr>
<td>Family Values</td>
<td>90.3 %</td>
</tr>
<tr>
<td>Elders</td>
<td>84.1 %</td>
</tr>
<tr>
<td>Churches or Religious Beliefs</td>
<td>83.5 %</td>
</tr>
<tr>
<td>Social Connection (community working together)</td>
<td>79.7 %</td>
</tr>
<tr>
<td>Strong Leadership</td>
<td>62.7 %</td>
</tr>
<tr>
<td>Community and/or Health Programs</td>
<td>62.7 %</td>
</tr>
<tr>
<td>Educational and Training Opportunities</td>
<td>50.9 %</td>
</tr>
<tr>
<td>Good Leisure or Recreational Facilities</td>
<td>50.6 %</td>
</tr>
<tr>
<td>Strong Economy</td>
<td>44.1 %</td>
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</tbody>
</table>
of their communities, respondents identified “family values” (90.3%), “elders” (84.1%) and “social connections” (79.7%) (Table 11.1). Other strengths identified were also examples of the supportive social aspects of the community, including “awareness of Labrador culture” (93.2%) and “Church and religious beliefs” (83.5%). There were no differences in these identified strengths with respect to sex, household income or education level.

Understanding the ‘lack of community support’

We as a community is not helping our own, we are not taking care of our own. (St. Lewis focus group)

Although participants felt that the community was very supportive in many ways, they also mentioned certain areas where support from community members is lacking. Some suggested that support is often lacking when people need to mobilize around issues that are of relevance to the whole community rather than one person or family. For example, one woman explained that she had tried to get the community together to lobby for a resource centre, which had been identified as a community need. However, she could not get enough people to help her with the initiative, so she eventually gave up on it. She felt this was because community members are ‘used to having nothing’, and they are unaware of how to go about lobbying for additional services, even if those services are recognized as being needed.

Participant: We’re the only community on the coast that doesn’t have a family resource centre.

Participant: No we don’t.

Participant: I couldn’t figure out why, ’cause everybody else had one, oh no they couldn’t, the community decided a few years ago that they didn’t need it. This is what I was told.

Participant: We had somebody from Port Hope who was willing to come from their family resource centre, you know once or twice a week, no cost, and no, that couldn’t be done. I fought and fought for it to the point where you know, you can’t just keep on fighting. Somebody else did too, but

Researcher Debbie Martin (right) with Colleen Russell at the Moulder of Dreams pottery studio in Port Hope Simpson. Moulder of Dreams was started to provide employment and therapy to people with myotonic dystrophy in Port Hope Simpson. Courtesy of James Valcour.
when it was presented nobody in town felt that there was a need for it, because they were so used to not having anything, and… you know, we’re just tired of fighting…(St. Lewis focus group)

A similar sentiment was expressed in Cartwright. Participants there felt that even when community members are able to get a new program started, attendance for these programs is low. As a result, the same small group of people ends up attending all of the meetings and events. Participants in Cartwright suggested that one reason behind the community’s difficulty in mobilizing is a lack of cohesion within the community. They explained how a resettlement program in the 1960s had integrated members of many smaller communities into Cartwright, and how these small collectives often remain relatively separate, making it difficult for the community to come together as a whole.

I think that they have the access available, but people just don’t tend to go, they don’t tend to attend meetings or volunteer for groups or you know all of that. It’s a very small minority. And that’s ahhhh, I think that that’s because of so many small communities being resettled here and never really joining together, like you know there is still areas in this community that is called “Spotted”, and you know there is another area, then there is a “Batteau”, you know so, and then the back road over there used to be “Seal Islands” but it’s not what I would call a community that has ever really come together. Now in saying that, ahhmmm, if there is anything for the school or for somebody in need, it happens. You know, they’re very supportive of the school and the kids, and if there is a family in need they’re very supportive of that. But to come together for community groups or whatever, that’s always been a difficulty. (Kim Morris, Cartwright)

It might appear to be a contradiction to suggest that communities can be both unsupportive and incredibly supportive at the same time. Highlighting these comments about a lack of support in certain areas is not meant to characterize these communities as unsupportive. Undoubtedly, the people of NunatuKavut have a long history of sharing and caring for each other. Rather, these points are raised here to highlight that in some instances, community members may not have the resources to know how support one another. In most of these cases, the problems that were perceived to be lacking social support from the community were, in fact, related to chronic and historical difficulties faced by virtually everyone in the community, and over which community members have very little control.

Many people in each community suggested that one way to encourage people to support one another is to bring together motivated individuals from different communities, who all hold a collective interest in shared community improvements. If communities begin to pool their resources, it might be easier to begin to develop a network of people from various communities who could support each other’s similar interests. For example, in the Charlottetown focus group, it was mentioned that if a community centre with an ice hockey rink was built in a different community, the people of Charlottetown and surrounding areas should pool their resources to support it so that everyone could enjoy it. Participants felt that essential
resources like schools, nursing clinics and local stores should remain within individual communities as much as possible, but that sharing resources should be explored in cases where this could make it easier to offer new programs and services.

Participant: We can have centralized services like I said, but...there’s many things that we wants right here and nowhere else...there is people saying that they’re not going to Port Hope Simpson ...if there’s a gym or something...we wants it right here...But it don’t work that way.

Participant: ... it don’t work that way, it’s not going work that way.

Participant: Yeah.

Participant: It takes longer. It’s a longer process.

Facilitator: To work together as communities?

Participant: To work as a region. (Charlotte-town focus group)

11.3 Final thoughts: Getting at the root of our health issues

Undoubtedly, major concerns for Nunatu-Kavut people centre around the high cost of seeking health-care outside of the community and the difficulty accessing care when transportation routes are compromised due to weather
or airline schedules. Other important concerns include the logistical problems of seeking care outside of NunatuKavut communities due to family and work responsibilities, as well as the difficulty receiving consistent follow-up care for chronic conditions. While we recognize that these difficulties are serious side effects of an over-burdened health-care system, we must also remain vigilant of the need to stem the tide of chronic disease. Ultimately, stemming the tide of chronic disease requires dealing with many complex social and political issues such as poverty, access to education, unemployment, unavailability of fresh food and water, to name but a few. These factors directly affect health, but are not currently positioned as health issues because they do not directly relate to health-care, per se.

Before discussing recommendations for changes to health-care delivery, we must take into account the broader socio-political context in which these changes will occur. We need to look toward the past to discover why it is that NunatuKavut people do not enjoy some of the same basic services that are taken for granted in other parts of the country. The elders must be asked to share their stories about what it means to be hungry, what it is like to not have access to basic health-care or running water. These stories need to be positioned as part of a bigger picture. That bigger picture is about colonization – the undermining and ignoring of the experiences, beliefs, values and knowledge of NunatuKavut people. Colonization encouraged NunatuKavut people to believe that the ways practiced by elders were wrong and ‘savage’; that Inuktitut, the ancestral language of NunatuKavut, was of no value and therefore should not be spoken; and that knowledge of how to live on the land and to use the land respectfully was of no consequence.

Colonization has created dependence upon government systems that were created without the input or advice of NunatuKavut people. History has also shown that dependence did not always mean that needs were met, which is still the case in many respects.

We heard from NunatuKavut members, however, that despite concerted attempts throughout history to undermine and to ignore NunatuKavut people, the spirit still remains strong. This is further evidenced by the recent submission of a land-claim to the federal government. There are many individuals in NunatuKavut communities who still operate under the principles of a collective society. If someone is in need, the response is to give everything that one has, knowing that one’s neighbour would do the same if the situation were reversed. As markers of southeast Labrador Inuit culture, these basic principles of sharing and respect should be fundamentally tied to any efforts to improve health.
To reiterate, the Inukshuk is a symbol of Inuit culture. As described in Chapter 4, the Inukshuk was chosen as a symbol for our research findings, because it gives us direction, signals our emerging presence in the world of research, and marks our respect for our Inuit ancestors. We return to the Inukshuk to guide the recommendations that have emerged from this report, because in order to improve health within NunatuKavut, our understanding of health must come from an Inuit perspective. This does not mean a complete return to our old ways, as many of the ways of our non-Indigenous allies have served us well and have guided us towards new ways of thinking and seeing the world that have been helpful to us. Rather, we must build upon what we already know about our health through both Indigenous and non-Indigenous perspectives, while re-claiming many of our old ways that have been buried – our practices, our traditions, and our language. We must use these important tools to help us live in a healthy way.
As the findings from this report have indicated, there have been many attempts to undermine and ignore the wealth of knowledge about health that have historically existed, and continue to exist, along the southern coast of Labrador. In large part the diminishment of Inuit knowledge about health has corresponded with the introduction of non-Indigenous health-care, education, and resource conservation models. These models have positioned health as an individual issue that can only be addressed through the non-Indigenous medical system. As Inuit people, we do not always think this way. Our health includes the health of our physical bodies, but it also includes the health of our families, our communities, our plants and our animals. Without a balance of all these elements, neither our surroundings nor we ourselves can be healthy. As such, any approach to health and well-being must encompass the whole person. The physical, mental, emotional and spiritual elements of that person must all be considered equally important, and are inseparable from the health of the world around us.

Our journey towards finding harmony and balance between our surroundings and ourselves began a long time ago. As Greg Mitchell pointed out in Chapter 3, our knowledge about how to survive and live well along the south coast of Labrador extends back thousands of years to our Thule ancestors. We hunted, we fished, we trapped, we celebrated our accomplishments and we mourned our losses. We could say that we lived in harmony with the land, but that implies that our lives were easy and we know that they were not. Although our focus was on survival, our lives were much more than that. We learned how to navigate our surroundings and how to treat our illnesses with medicines that came directly from where our illnesses emerged. Thus, our health was about ensuring the respectful treatment of the world around us, and we know that our surroundings will only continue to provide for us as long as we take care of them.

Although our journey began a long time ago, we are, in many respects at a turning point in this journey. Two years ago, 2010, marked the year that we submitted a comprehensive land-claim to the federal government. This comprehensive land-claim document is comprised of in-depth research that documents our un-ceded relationship to our ancestral territory, Nunatu-Kavut. Should this document be accepted by the federal government, as we believe it will, our historical connections to our territory will be formally recognized and we will be better able to guide the direction of our health-care, education and natural resource sectors, among others. Until that time, we will still work to forge collaborative, productive relationships with our health-care, education and natural resource partners in order to improve the health of our communities. As such, the recommendations we put forward in this report are intended to serve as a starting point for discussion. Most of the issues we have touched on deserve much greater attention than what has been given here, as our intent has been to simply identify health issues and to offer our suggestions for next steps. In some cases, we direct attention to areas that need immediate consideration and resources, but in most cases our recommendations point out where more comprehensive research needs to be done so that strategic initiatives can be developed.

Due to the broad scope of this project, we are proposing a large number of recommendations
that cover a range of issues. Some of these recommendations would require significant financial, social, human, and time resources to implement, while others require significantly fewer resources. We realize that resource and capacity constraints will not allow the implementation of all of these recommendations at the same time – there will need to be a process to prioritize. This important next step should build on the momentum and participation in this needs assessment, to discuss and set priorities in partnership with the communities involved.

It is important to us that the following recommendations are positioned within a context that recognizes the interconnectedness between individuals and their families and communities, as well as their natural surroundings. With this in mind, the findings are organized according to four thematic areas: 1) Health care service provision and management of disease; 2) Health promotion and disease prevention; 3) Healthy environments; and 4) Future research directions.

We begin with an overarching recommendation that we feel should be implemented in order to move forward on many of the recommendations included here:

“That NunatuKavut establish a steering committee that includes representatives from NunatuKavut, Labrador-Grenfell Regional Health Authority, and the Government of Newfoundland and Labrador, Department of Health & Community Services to review all recommendations in this report and subsequently prioritize, advocate and oversee their implementation.”
## 12.1 Health Care Service Provision and Management of Disease Recommendations

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<th>Recommendation</th>
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| **12.1.1**  | That the Labrador-Grenfell Regional Health Authority (Labrador-Grenfell Health), with support and advocacy from NunatuKavut, ensure that community clinic services continue to be built upon so that residents continue to benefit from the expertise of their nursing staff. | Many residents of the southeast coast expressed a high level of satisfaction with the quality of care and with the ease of accessing care through community clinics. Labrador-Grenfell Health should recognize the high level of satisfaction with the care received at community clinics by continuing to enhance resources and services and by ensuring the retention of staff. Residents must receive assurances that their needs will continue to be met within their own communities and that clinics will not be removed or regionalized. | • Labrador-Grenfell Health  
• NunatuKavut  
• Community members  
• Department of Health and Community Services (Government of Newfoundland and Labrador)  
• Local Town Councils/Local Service Districts |
| **12.1.2**  | That Labrador-Grenfell Health, with support and advocacy from NunatuKavut, ensure increased frequency and duration of health-care service provision in NunatuKavut. This includes ongoing consultation with NunatuKavut and community members to ensure services are meeting the communities’ needs. | To reduce the need for travel for NunatuKavut residents, more health-care human resources are needed in NunatuKavut. More frequent visits by family physicians, diabetes educators, dieticians, optometrists, dentists, psychiatrists, etc. would make it far easier to treat our community members, especially those with concerns of frailness, immobility and mental illness (i.e., often those with the most need for extensive health-care). | • Labrador-Grenfell Health  
• NunatuKavut  
• Community members  
• Department of Health and Community Services (Government of Newfoundland and Labrador)  
• Local Town Councils/Local Service Districts |
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| **12.1.3** That Labrador-Grenfell Health (Mental Health and Addictions Services) explore and implement opportunities to improve access to mental health services. This could include:  
- Re-locating more mental health positions to the coast and increasing the number of community visits, and  
- Implementing technological opportunities such as telemedicine (see Recommendation #4 under Health care service provision and management of disease recommendations). | Of the many topics covered with the key informants and focus groups, mental health issues were the most consistently identified issue and were felt to be a key priority needing immediate attention.  
Community members on the southeast coast need to be able to access the professional care they need within their own communities. Research participants felt that existing services in their communities are not enough. A greater presence of mental health workers on the southeast coast would make it easier for clients to initiate and attend appointments. | • Labrador-Grenfell Health (Mental Health and Addictions Services)  
• Department of Health & Community Services (Government of Newfoundland and Labrador)  
• Department of Labrador & Aboriginal Affairs (Government of Newfoundland and Labrador)  
• Women’s Policy Office (Government of Newfoundland and Labrador)  
• NunatuKavut  
• Local Town Councils/Local Service Districts  
• Academic Institutions |
| **12.1.4** That Labrador-Grenfell Health and the Government of Newfoundland and Labrador build upon existing technology to create a more efficient way of linking community members with sources of health-care and health information. | Some of the healthcare challenges related to travel may be able to be addressed using new and existing technology such as:  
- The implementation and support of telehealth and on-line support groups;  
- An exploration of community willingness to use such technology; and  
- An exploration of how technology could be used to support elderly patients who may need long-term care to stay at-home. | • Labrador-Grenfell Health  
• Department of Health & Community Services (Government of Newfoundland and Labrador)  
• Community members  
• NunatuKavut  
• Academic Institutions |
12.1.5 That NunatuKavut, Labrador-Grenfell Health, and the Government of Newfoundland and Labrador work together to develop policies and programs that would reduce the ‘hidden costs’ associated with traveling to access healthcare services. These include:

- Supporting the costs associated with having another person traveling with the patient; and
- Addressing food and lodging costs associated with travel for healthcare.

Travel for health-care is not an option; it is a necessity. It often requires making extensive work and childcare arrangements and leaving the community for extended periods of time. For example, medical services in St. Anthony or St. John’s is often a minimum of a three-day trip (2 days for travel and one for appointment) depending on flight availability and appointment scheduling.

The primary objective of Canadian health policy as outlined in the Canada Health Act is to “protect, promote and restore the physical and mental well-being of residents of Canada and to facilitate reasonable access to health services without financial or other barriers”\(^1\) (emphasis added). Such extensive travel for health services is a major barrier to care – both financially and emotionally, as it creates stress for both patients and their families.

All medical appointments for emergency and preventative care should have subsidies extended to include ‘hidden’ travel costs – for example, the cost for another person (family member or friend) to travel with the patient if that is necessary, and food and lodging stipends should be provided. Such subsidies should be available to all who need them including those on low or fixed incomes.

This is particularly important for elderly patients or children who require a family member or friend to accompany them to their medical appointments.

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12.1.6 That NunatuKavut, Labrador-Grenfell Health, and the Government of Newfoundland and Labrador work together to create a patient services position (similar to a patient navigator position) located on the southeast coast to support and facilitate health-related travel and appointment requirements of residents of the southeast coast. This could include liaison with clinics, hospitals, other healthcare providers and air services.

In addition to expenses associated with attending to appointments outside of the southeast coast, there is often the chance that appointments are cancelled or rescheduled at the last minute or without notice. There are also challenges for community members trying to access flights to attend appointments.

Residents suggested having the hospital improve coordination with air service would assist in better coordination of appointments. A designated patient services position would be able to ensure that no unnecessary travel occurs and patients travelling for appointments are accommodated in a timely fashion. This would be accomplished by providing a liaison role to improve access to health services and ease the reluctance of some community members in booking appointments due to the many challenges involved.

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<td>12.1.6</td>
<td>That NunatuKavut, Labrador-Grenfell Health, and the Government of Newfoundland and Labrador work together to create a patient services position (similar to a patient navigator position) located on the southeast coast to support and facilitate health-related travel and appointment requirements of residents of the southeast coast. This could include liaison with clinics, hospitals, other healthcare providers and air services.</td>
<td>In addition to expenses associated with attending to appointments outside of the southeast coast, there is often the chance that appointments are cancelled or rescheduled at the last minute or without notice. There are also challenges for community members trying to access flights to attend appointments. Residents suggested having the hospital improve coordination with air service would assist in better coordination of appointments. A designated patient services position would be able to ensure that no unnecessary travel occurs and patients travelling for appointments are accommodated in a timely fashion. This would be accomplished by providing a liaison role to improve access to health services and ease the reluctance of some community members in booking appointments due to the many challenges involved.</td>
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| **12.1.7** That Labrador-Grenfell Health (Health Emergency Management) and the Government of Newfoundland and Labrador work with Local Town Councils, Local Service Districts and the Royal Canadian Mounted Police (RCMP) to ensure the development and implementation of emergency planning to improve the coordination of emergency responses (e.g. in a health or police emergency) to ensure consistency in emergency responsiveness. | Many participants expressed concern with their ability to reach services such as the RCMP during an emergency. Concerns were also raised regarding the general availability and coordination of emergency services on the southeast coast. It is important to ensure there is appropriate emergency planning in these communities to ensure consistency in emergency responsiveness. | • Department of Transportation and Works (Government of Newfoundland and Labrador)  
• Department of Health and Community Services (Government of Newfoundland and Labrador)  
• Labrador-Grenfell Health (Health Emergency Management)  
• RCMP  
• Local Town Councils/Local Service Districts |
| **12.1.8** That Labrador-Grenfell Health and the Government of Newfoundland and Labrador explore and implement opportunities to improve the timeliness and consistency of medical transport during an emergency situation. | During a medical crisis the challenges and technicalities of arranging medical transport are often exacerbated. The availability, quality and coordination of emergency medical transportation were a major area of concern for study participants. As outlined in the study, while there are many uncontrollable factors in managing a medical emergency (e.g. weather conditions), it is crucial to ensure that those factors that can be controlled are in place in case of an emergency. | • Department of Transportation and Works (Government of Newfoundland and Labrador)  
• Department of Health and Community Services (Government of Newfoundland and Labrador)  
• Labrador-Grenfell Health  
• RCMP |
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| **12.1.9** That Labrador-Grenfell Health and the Government of Newfoundland and Labrador work together to address affordability concerns related to the increases in pharmacy dispensing fees. | Pharmacy dispensing fees across the province have recently increased and study participants noted in interviews and focus groups that this has had a significant effect on the affordability of prescription medications, to the extent that it sometimes forces a choice between filling prescriptions and meeting other needs such as food or electricity. This has a particular impact on those with multiple prescriptions. | • Department of Health and Community Services (Government of Newfoundland and Labrador)  
• Labrador-Grenfell Health  
• NunatuKavut Community Council |
| **12.1.10** That community clinics put in place measures to increase privacy (including door sweeps, white noise, etc.) in clinic waiting areas so that discussions between patients and their health-care providers cannot be overheard. | Participants expressed some concerns with confidentiality of services due to the layout of many community clinics. Various low-cost interventions could address these concerns and should be explored and implemented. | • Labrador-Grenfell Health (Community Clinics) |
### 12.2 Health Promotion and Disease Prevention

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| **12.2.1** That NunatuKavut bring together relevant stakeholders, including Labrador-Grenfell Health (Community Health and Wellness) and community organizations, to create and support additional full time positions dedicated to diabetes education, prevention, diagnosis and on-going counseling and support. | The prevalence of diabetes in south Labrador communities has increased from 6.6% in 2003 to 10.4% in 2010. In addition, 23.95% of the population reports high blood pressure and 21% reports high cholesterol, both symptoms of pre-diabetes. There is a need for additional resources and supports in all areas of diabetes prevention, management and support. An important component of such a position would be to ensure that program and service offerings are culturally appropriate and include considerations related to food costing and food choice availability. | • NunatuKavut  
• Labrador-Grenfell Health (Community Health and Wellness)  
• Community members  
• Department of Health and Community Services (Government of Newfoundland and Labrador) |
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| 12.2.2 | That NunatuKavut bring together relevant stakeholders, including Labrador-Grenfell Health (Community Health and Wellness) and community organizations to develop new programs and support existing initiatives to increase physical activity among various segments of the population. This could include: Support for the long-term sustainability of successful programs that encourage participation from a wide demographic (youth and elders, men and women). Exploration of the development of physical activity programs that do not require expensive infrastructure and build upon existing resources (i.e. school-based programming running, hiking, snow-shoeing, cross-country skiing, etc.). | While 69% of participants reported meeting national guidelines for physical activity, differences were observed between men and women in terms of amount and type of physical activity. Current programs, in particular the Junior Canadian Rangers Program, were identified as strengths to be built upon. Low-cost programs should be developed or expanded that build upon existing resources and infrastructure. | • NunatuKavut  
• Labrador-Grenfell Health (Community Health and Wellness)  
• Local Recreation Committees  
• School Health Promotion Liaison Consultants  
• Community Youth Network  
• Southern Labrador Family Centres  
• Recreation coordinator |
| 12.2.3 | That NunatuKavut work with community partners to support improvements in accessibility, affordability and availability of healthy and fresh store-bought food options. Consultations with store-owners and other food providers should be held to find ways to improve availability, affordability and accessibility of products like fresh fruits and vegetables, the continuation of food subsidies provided to communities not connected by road, and development of food education programs (in tandem with diabetes education – see Recommendation #11.2.1 under Health Promotion and Disease Prevention). | Interviews and focus group discussions highlighted the challenges of accessing, affording and availing fresh store bought foods. Residents highlighted that even when affordable produce is available, it is sometimes rotten by the time it arrives on the shelf. These challenges are particularly important in light of the high levels of diabetes observed in the region. Fresh healthy food can play a key role as part of a health diet to combat chronic diseases including diabetes and high blood pressure. | • NunatuKavut  
• Local Town Councils/Local Service Districts  
• Department of Labrador and Aboriginal Affairs (Government of Newfoundland and Labrador)  
• Store-owners and other food providers  
• South-eastern Aurora Development Co-operation |
### 12.2.4

**Recommendation:** That Labrador-Grenfell Health (Community Health and Wellness) bring together community-based stakeholders (see right) to work together to expand current injury-prevention initiatives and to develop new ones. Targets for such initiatives could include:

- Snowmobile and ATV safety courses that reinforce the importance of off-road vehicle safety.
- Driving safety courses that include such topics as seat-belt use, and alternatives to drinking and driving.
- Water safety instruction including cold-water survival and use of flotation devices.

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<td>11.6% of study participants reported having had an injury in the previous 12 months. 15.4% of these injuries were snowmobile accidents and some focus groups and key informant interviews reported concerns related to drinking and driving.</td>
<td>• Labrador-Grenfell Health (Community Health and Wellness) • Local Town Councils/Local Service Districts • Southern Labrador Family Centres • Community Youth Network • RCMP • NunatuKavut • Department of Fisheries and Aquaculture (Government of Newfoundland and Labrador) • Department of Natural Resources (Government of Newfoundland and Labrador) • Department of Fisheries and Oceans (Government of Canada) • Transport Canada (Government of Canada) • Mothers Against Drunk Driving</td>
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| **12.2.5** That Labrador-Grenfell Health (Dental Services, Community Health and Wellness) and NunatuKavut explore and implement programs and services that promote oral health and prevent oral disease. | Interview and focus group participants felt that dentist visits to communities are infrequent, and many of their appointments while in the communities are taken up addressing urgent care. As a result it is difficult to get access to dental cleanings, oral health promotion and disease prevention information. Without the knowledge and professional help to take care of one’s teeth and gums, it is difficult to achieve optimal oral health. | • NunatuKavut Community Council  
• Labrador-Grenfell Health (Dental Services, Community Health and Wellness)  
• Southern Labrador Family Centres  
• Department of Health and Community Services (Government of Newfoundland and Labrador)  
• Newfoundland and Labrador Dental Association  
• Newfoundland and Labrador Dental Hygienists Association  
• School Health Promotion Liaison Consultants  
• Academic institutions (i.e. Dalhousie University Faculty of Dentistry) |
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<td><strong>12.2.6</strong> That Labrador-Grenfell Health (Mental Health and Addictions Services, Community Health and Wellness) and NunatuKavut work together to support and expand existing training initiatives that encourage community members to learn how to identify, understand and manage mental health issues (e.g. addressing stigma related to mental health, counselling, suicide prevention and mental health promotion).</td>
<td>In interviews and focus groups community members consistently brought up the ‘culture of silence’ that can surround mental health issues in some communities. Current programs, such as those offered by NunatuKavut address this stigma by providing education and opportunities to learn from mental health professionals on identifying and addressing mental health issues.</td>
<td>• Labrador-Grenfell Health (Mental Health and Addictions Services, Community Health and Wellness) • Department of Health &amp; Community Services (Government of Newfoundland and Labrador) • NunatuKavut • Community members</td>
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<td><strong>12.2.7</strong> That Labrador-Grenfell Health (Mental Health and Addictions Services, Community Health and Wellness) and NunatuKavut collaborate to develop and implement appropriate drug and alcohol awareness initiatives.</td>
<td>Youth substance misuse was raised as a concern in the focus groups, and participants also felt there were few opportunities for people to learn about substance misuse. It was felt that more opportunities for community members to discuss substance use issues would lead to more awareness on how to make responsible decisions regarding drugs and alcohol, and how to seek help if substance misuse becomes a problem.</td>
<td>• NunatuKavut • Labrador-Grenfell Health (Mental Health and Addictions Services, Community Health and Wellness) • Southern Labrador Family Centres • Community Youth Network • Academic Institutions • RCMP (Drugs and Organized Crime Awareness Service (DOCAS) Coordinator) • Local town councils/Local Service Districts</td>
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### 12.3 Healthy Environments

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| **12.3.1** That the NunatuKavut Community Council explore and support ways of reviving Inuit culture along the coast, such as through traditional activities and ceremonies. | The literature review for this project (Chapter 3) demonstrated the important link between culture and health. Such cultural continuity can create a buffer between stressors such as high unemployment and poor health outcomes. The results of this research point to the need to continue and enhance traditions that build on the principles of sharing and respect. Working to expand these principles and traditions will provide support not only in times of dire need, but also during times when the need is less acute, such as in addressing chronic illness and depression, bereavement, grief, etc. | • NunatuKavut  
• Community members, including elders  
• Department of Education (Government of Newfoundland and Labrador)  
• Department of Labrador & Aboriginal Affairs (Government of Newfoundland and Labrador)  
• Newfoundland and Labrador Arts Council  
• Academic Institutions (e.g. the Understanding the Past to Build the Future Project with Memorial University) |
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| **12.3.2** That NunatuKavut’s inherent right to traditional hunting and fishing activities be supported through on-going advocacy and educational efforts. | There is a strong and proven link between hunting and fishing, food, and health. Restricted access to traditional foods must be framed as a health issue that currently threaten the integrity of the southern Labrador Inuit culture. Restrictions placed on traditional food access are threatening the inherent right to many of our traditional food practices. It is recommended that health initiatives (i.e., diabetes initiatives and other healthy eating programs) focus specifically on reinforcing these activities as part of our inherent right as southern Labrador Inuit. On-going advocacy by NunatuKavut regarding inherent rights to traditional hunting and fishing activities; and Educational efforts to promote healthy eating tailored to NunatuKavut communities and that recognize the challenges of accessing consistent supplies of both traditional and store-bought foods. | • NunatuKavut  
• Department of Fisheries and Aquaculture (Government of Newfoundland and Labrador)  
• Department of Natural Resources (Government of Newfoundland and Labrador)  
• Department of Fisheries and Oceans (Government of Canada)  
• Transport Canada (Government of Canada) |
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| **12.3.3**    | That Local Town Councils, Local Service Districts and the Government of Newfoundland and Labrador implement long-term sustainable solutions for communities to access clean water. | The United Nations General Assembly has recognized “the right to safe and clean drinking water and sanitation as a human right...”\(^2\) Access to safe water is a major issue being faced in the more remote communities of Black Tickle, William’s Harbour and Norman Bay, and needs to be prioritized. Next steps could include:  
An examination of the extensiveness and frequency of water rationing.  
Identification of solutions to continuous boil water orders.  
A clearer understanding regarding how much people are spending on store-bought water in lieu of tap water. | • Local Town Councils/Local Service Districts  
• Department of Health and Community Services (Government of Newfoundland and Labrador)  
• Department of Government Services (Government of Newfoundland and Labrador)  
• NunatuKavut  
• Combined Councils of Labrador                                                                                      |

## 12.4 Future Research Directions

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| **12.4.1** That NunatuKavut, Labrador Grenfell Health, and partner academic institutions (e.g. Memorial University, Dalhousie University, and College of the North Atlantic) take steps to build health research capacity in Labrador and specifically NunatuKavut. | This health needs assessment of the southeast coast of Labrador has highlighted and revealed key areas that should be addressed to improve health of the region’s residents. The study has also revealed a number of areas that require further in-depth research and evaluation (see other recommendations). This requires skilled personnel, from within the communities and from academic institutions. The success of this project has demonstrated the benefits of strong community-research partnerships and opportunities to build such capacity within Labrador. | • NunatuKavut  
• Labrador-Grenfell Health  
• Community members  
• Academic Institutions |
| **12.4.2** That NunatuKavut, Labrador-Grenfell Health, and academic institutions partner to develop research that is relevant and applicable to Labrador and to increase the application of research knowledge in decision-making. | Research is most effective for communities if its knowledge is shared and applied. This requires governments and organizations to work in community research partnerships to ensure that: Work is undertaken in community research partnerships to ensure research is relevant and can be applied; and Results of such studies are acted on through evidence-based decision-making that is relevant to the communities. | • NunatuKavut  
• Labrador-Grenfell Health  
• NunatuKavut community members  
• Academic Institutions |
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| 12.4.3 That NunatuKavut, Labrador-Grenfell Health, and partner academic institutions support diabetes research in NunatuKavut to understand why more people are not engaging in treatment or preventive activities to control diabetes and how to develop diabetes education that is culturally appropriate for southern Labrador Inuit. | Diabetes prevalence on the southeast coast of Labrador is 10.4%, which is much higher than that of the Canadian population at 3.6%. To help address this key chronic disease more information is needed on prevention and treatment in the context of southeast Labrador. | • NunatuKavut  
• Labrador-Grenfell Health,  
• Canadian Diabetes Association  
• Academic Institutions  
• Community members  
• Department of Health and Community Services (Government of Newfoundland and Labrador) |
| 12.4.4 That NunatuKavut, Labrador Grenfell Health (Dental Services), and partner academic institutions support and encourage research to explore the complexity of oral health and health care in NunatuKavut, including issues related to the prevention and treatment of dental disease and decay, as well as oral health promotion activities. | This needs assessment touched on some of the many complexities of addressing dental health services in NuntuKavut communities, including issues related to insurance, service availability and travel requirements. More detailed information is needed on oral health in these communities, including baseline oral health data as well as the challenges of accessing oral health services to develop more specific recommendations to address these challenges. | • NunatuKavut Community Council  
• Labrador-Grenfell Health (Dental Services)  
• Academic Institutions  
• Community members  
• Newfoundland and Labrador Dental Association  
• Newfoundland and Labrador Dental Hygienists Association  
• Department of Health and Community Services (Government of Newfoundland and Labrador) |
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| 12.4.5 | That NunatuKavut and Labrador-Grenfell Health (Mental Health and Addictions Services) support and encourage research exploring the nature of mental health issues being faced in NunatuKavut communities including stigma, prevalence, perceptions and access to services. | This needs assessment demonstrated some of the challenges of getting a clear picture of the prevalence and complexities of mental health issues in southern Labrador. This includes a need to address stigma and denial of mental illness. It is important that future research follows culturally appropriate methodologies and pays attention to the sensitive nature of the topic and the stigma attached to mental illness. Such research should involve NunatuKavut and Labrador-Grenfell Health in identifying issues faced, as well as key resources and supports. Some priority areas to explore might include: Providing outreach to communities that do not currently have trained mental health-care workers. Increasing confidentiality of mental health service provision. Developing techniques for community members to identify and discuss mental health issues. Telehealth | • NunatuKavut  
• Community members  
• Labrador-Grenfell Health (Mental Health and Addictions Services)  
• Academic Institutions  
• Department of Health and Community Services (Government of Newfoundland and Labrador) |
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| That NunatuKavut, Labrador-Grenfell Health (Long Term Care), and partner academic institutions support and conduct further research to develop improved options for both long-term and palliative care on the southeast coast. | Currently there is only one long-term care facility located on the southeast coast and many elders must leave their communities and the region in order to receive long-term and palliative care. Many research participants spoke of the serious toll this takes both on those having to leave familiar people and surroundings, as well as friends and family members left behind who are unable to visit due to distance and cost. New and innovative approaches to this challenge should be developed including an examination of how other rural and remote areas address the needs of aging populations. | • Local Town Councils/Local Service Districts  
• NunatuKavut  
• Community members  
• Labrador-Grenfell Health (Long Term Care)  
• Academic Institutions  
• Department of Health and Community Services (Government of Newfoundland and Labrador) |
Appendices
### Appendix A: NunatuKavut Community Health Needs Assessment Timeline and Milestones

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<td>Funding Approved January 2009</td>
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<td><strong>Planning Phase</strong></td>
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<td>Research Team Finalized July 2009</td>
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<td>Ethics Approval Received December 2009</td>
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<td>Key Informant Interviews December 2009</td>
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**Knowledge Mobilization Phase**

- Funding Approved January 2009
- Community Health Survey January & February 2010
- Research Team Finalized July 2009
- Key Informant Interviews December 2009
- Ethics Approval Received December 2009
- Qualitative & Quantitative Data Analysis December 2009–February 2011
- Financial Reports March 2011
- Process and Outcome Evaluation Report & Gender-Based Analysis February 2012
- Final Report & Recommendations February 2012
- Conference, Presentation & Publications Ongoing

**Not yet funded**
Appendix B: Research Study Agreement

Between Labrador Metis Nation and The Labrador Metis Community Health Needs Assessment Research Team (Led by James Valcour of Memorial University of Newfoundland and Debbie Martin of Dalhousie University)

Research Study Title: Labrador Metis Community Health Needs Assessment

Labrador Metis Nation Representative: 
Ms. Darlene Wall  
Health and Social Sector Manager

Contact Information for Ms. Wall: 
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P.O Box 460, Stn. C  
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Co-Principal Investigators:  
James Valcour, PhD

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Debbie Martin, PhD

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School of Health and Human Performance  
6230 South Street  
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Halifax, Nova Scotia, B3H 3J5  
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Phone: (902) 494-7717
Purpose of the Project
In an effort to learn more about the health needs of Inuit-Metis people and the gaps in services which would address those needs, the Labrador Metis Nation (LMN) and the Research Team are undertaking a community health needs assessment. The goal is to identify and to build upon the existing health and health-related resources in Labrador Metis communities, to offer recommendations to improve the health of Labrador Metis communities, and to identify inequities in health care and health-related services.

Methods
The proposed research will use a mixed-methods approach that is broken down into three phases. In Phase I, qualitative methods will be used to interview 8-12 key informants in the community about their perceived health care and health-related needs. In Phase II, information collected from the key informant interviews will be used to adapt the First Nations and Inuit Regional Health Survey to the Labrador Metis peoples. The adapted survey, based on quantitative research methodology, will be administered to approximately 445 individuals over the age of 16. Subsequently, Phase III will include three focus group sessions which will obtain feedback from community members about the study results.

Collective Informed Consent:
The Research Team has received a letter from the President of the LMN indicating his support for this project. In addition, and in order to ensure that all aspects of the project are in keeping with the expectations and goals of the LMN, the Team will obtain ethical approval for the research from the LMN Research Ethics Board prior to collecting data for the research study.

Individual Informed Consent
Prior to the beginning of each phase, potential participants will receive information, outlining the purpose and intent of the study. Each phase of the study has its own informed consent form. All of the information contained in the consent form will be explained and any questions that the potential participants have will be clarified at this time. If the participant wishes to sign the consent form, this option will be presented, however, in keeping with the oral nature of Labrador Metis culture, and, because some participants may have difficulty reading, oral consent will also be an option. If the participant verbally agrees to participate in the study, the person will be asked to make a mark (X) on the consent form and have someone other than the interviewer witness the agreement. The participant will be informed that they may discontinue taking part in the interview at any time and for any reason.

For Phase I and III, participants will also have the opportunity to have their name included as part of the study if they choose. The interviewer will ask the participants whether or not they would like to be acknowledged as ‘Contributors’ to the research. If yes, participants will be asked whether or not they would like to have their names included in the study. For participants in Phase I (key informant interviews), participants will also be asked if they agree to have their quotes cited. This request will allow the researchers to include the name of the participants in the acknowledgements section of the final report, and to have the names of key informants attached to their quotes, if agreed
upon. This information will be asked at the beginning of the interview and re-affirmed at the end. Phase II of the study will not have the option of acknowledging participants’ names, as the surveys will be administered anonymously and participant quotations are not a part of this phase of the study.

Risks of the Study

Individual Risks: Although there are no direct risks for individuals taking part in this study, some of the things discussed during the interview, survey, or focus group may be emotional or upsetting. For example, the topics covered may include the loss of traditional ways of life, or may raise discussions about health or social problems that are being faced by family and community members. These issues may make some people uncomfortable or upset. All participants will be informed that they do not have to answer any questions that make them uncomfortable, and that they may leave at any point and for any reason. Should they wish to leave the study, they will be asked if the information they have already provided may be used by the researcher. If not, all of the information that has been recorded will be deleted. Participants will have the option to leave the study for up to two weeks after all of the data collection has been completed. Additional risks may be anticipated once the final survey and focus group interview guides are prepared. The data collection instruments will be forwarded to the Labrador Metis Nation and to the Dalhousie and Memorial Research Ethics Boards in advance of use for data collection.

Collective Risks: There is little risk involved for the Labrador Metis Nation or the individual communities involved in the study. It is possible that information collected for the study might reveal health or social problems that were previously unrecognized. This may cause some community members to feel uncomfortable or upset. It is hoped that if this is the case, the research, through the identification of the issues, will provide the opportunity for community members, the broader research community, policy-makers and health-care and health service providers to address these issues in a manner that is culturally appropriate for the community in question and to reduce future incidence or occurrence.

Benefits of the Study

Individual Benefits: There are no direct benefits to taking part in the study. Indirectly, research participants may learn something about themselves or other community members with respect to existing health-related services and programs in their communities. This may help them in the sense that they may become aware of services that they did not know were available.

Collective Benefits: The research might also benefit the people who live in Labrador Metis communities by raising awareness of the health care and health-related policies, programs and services that need to be addressed. This awareness might lead to the development of new programs and services that are made available to Labrador Metis communities.

Plans for OCAP (Ownership, Control, Access, Possession) of Research Data

Throughout the duration of data analysis and writing, copies of the data will be held by the Principal Investigators (James Valcour and Debbie Martin), as well as by the Qualitative Research Consultant (Julie Bull). The data will
be treated as being confidential and will be kept in a secure, locked location at all times when not in use. Anyone who has contact with the data will be asked to sign a Confidentiality Agreement, indicating that they will not share the data with anyone who is not authorized to view it. Although the data will be used by the Research Team and the representatives of the Labrador Metis Nation for the purpose of this study, the information collected is owned by the individuals who participated in the study. Information about cultural traditions, ceremonies or other traditional knowledge that is specific to the Labrador Metis will be considered to be owned by the Labrador Metis Nation and its members. Upon the completion of the final report and any publications and/or presentations, James Valcour will act as custodian of the data and retain copies of all data used in the study for an indeterminate amount of time. The Labrador Metis Nation retains all ownership rights over the data regardless of where the data is housed.

**Plans for Dissemination**

A final report will be prepared based on the findings from the key informant interviews, the survey and the focus groups sessions. This document will help with the development of a LMN Health Plan and provide evidence on programs and services delivered by the Labrador-Grenfell Regional Health Authority that would better meet the needs of the Inuit-Metis of Labrador.

Using the above information, the following research agreement has been reached between the Labrador Metis Nation and the Research Team led by James Valcour and Debbie Martin, hereafter referred to as ‘The Research Team’:

1. Representatives of the LMN and the Research Team will each contribute to the all stages of the research study, including its design, data analysis, findings, and dissemination.

2. Representatives of the LMN, and the Research Team will be informed of any changes or amendments being made to the original study design, and will provide timely feedback in relation to any changes or amendments.

3. In future publications and presentations, representatives of the LMN and the Research Team who make contributions to the manuscript or presentations will be listed as co-authors and his/her affiliation will be listed. The LMN will be listed in the ‘acknowledgements’ section as providing support for the project.

4. Funding for this project comes from Health Canada’s Aboriginal Health Transition Fund Adaptation Envelope and the Newfoundland and Labrador Department of Health and Community Services. The LMN and the Research Team will acknowledge these two organizations in all future publications and presentations.

5. Throughout the duration of the research project and during the writing of reports, publications and/or presentations, representatives of the LMN and the Research Team will stay in regular communication regarding all aspects of the project. This will be accomplished through email, monthly teleconferences and fax.

6. Individual research participants (who
may or may not be identified as members of the LMN) will have the option to choose whether or not their identities will be revealed in any subsequent publications or presentations of the research findings. It will be made clear that individual opinions do not necessarily represent the opinions of either the LMN or the Research Team.

7. Representatives of the Labrador Metis Nation and the Research Team will work together to produce the newsletter and Final Report, which will be distributed to the research communities.

8. Any future publications or presentations of the data will be done in consultation with the LMN AND the Co-Principal Investigators, James Valcour and Debbie Martin.

9. Representatives of both the LMN and the Research Team will have the opportunity to review all future publications and/or presentations and provide feedback prior to the findings being presented and/or published.

10. In the case of a disagreement between the Research Team and representatives of the LMN regarding any aspect of the interpretation of the research findings and/or the dissemination of those findings, all parties will attempt to reach a consensus on how to present the information. Should a consensus NOT be reached, differing perspectives will be presented in any future reporting of the results.

11. Upon completion of the study, all data will be held in a secure location (i.e., a locked filing cabinet) at the office of James Valcour, at Memorial University of Newfoundland. It may be used for future analysis and research, as long as the data are not used for purposes other than what has been stated in this Research Agreement.

12. The data will be held by Dr. Valcour for five years after the data has been published. At this time, all audio and electronic files will be deleted and paper copies of the data will be shredded. Dr. Valcour will be responsible for destroying the data.
We, the undersigned, agree to the terms and conditions as outlined in the above agreement.

______________________________   __________________________
Darlene Wall, Labrador Metis Representative (Signature)  Date

______________________________   __________________________
Debbie Martin, Co-Principal Investigator (Signature)  Date

______________________________   __________________________
James Valcour, Co-Principal Investigator (Signature)  Date
Appendix C: Labrador Metis Community Health Survey

You can find a copy of the survey on the NunatuKavut website www.nunatukavut.ca or by following the following link: http://www.nunatukavut.ca/home/files/social_and_health/chna_survey_questionnaire.pdf
Appendix D: Community Profiles

Cartwright

Background

The Netshucktoke (Sandwich Bay) region, where the modern town of Cartwright is located, was a centre of Inuit habitation long before Europeans set foot on its soil. Archaeologists have recently discovered in this area some of the oldest Inuit sod houses on the coast of Labrador. The Inuit referred to this settlement as Netcetumit.

In 1775 Captain George Cartwright chose the area as the site of his trading post. It offered an excellent sheltered harbour, and a lookout on Flagstaff Hill to watch for hostile American privateers. It remained his main post until he returned to England. During his relatively brief stay, Captain Cartwright proved to be a very enlightened man. He favorably interacted and traded with the local Inuit population. Some of his workers married and were integrated into the local Inuit population; their descendants still live in the area today. The business first established by Cartwright was sold to the Hudson’s Bay Company in 1837, and this business still operates in the town today.

Many Inuit communities were resettled into Cartwright during the 1960s, and many other communities such as Seal Islands, Bateau and Spotted Islands were completely abandoned. This makes the town of Cartwright a dynamic centre of Inuit culture in southern Labrador.

The community boasts a view of the Mealy Mountains, the site of a proposed future national park. Ten miles to the north is a 56km stretch of golden sand, so striking the Vikings called it the “Wonderstrands”. To the east lies the Atlantic Ocean and the Gannet Islands Seabird Ecological Reserve - a combination of spectacular landscape and fascinating history, home to the largest razorbill colony in North America, 50,000 common murres, 35,000 puffins and 8,000 other birds. Eighteen miles east of the community lies Table Bay, which is home to the largest colony for breeding eiders in Labrador.

Courtesy of Aimee Chaulk.
Governance

Municipal: Town Council
Provincial riding: Cartwright – L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics
Total population: 572

Employment & Working Conditions
Major Employer: Labrador Fisherman’s Union Shrimp Company Crab Plant (seasonal)
Other Employers: Service Industries (Grocery Stores, Convenience Store, Restaurants, Hotel/Motel)

Social Support Networks
Churches: Evangel Temple (Pentecostal) Parish of Cartwright (Anglican)
Programs: Junior Canadian Rangers, Canadian Ranger Patrol 20 (7 female, 13 male) Cartwright Community Youth Network Junction Trail Blazers Snowmobile Club
Supports for seniors: None that we are aware of

Education, Literacy and Training
Schools: Henry Gordon Academy
Student Enrollment: 83 (2009 Annual report)
Number of teachers: 10
Graduate rate: 91.7% have a high school diploma (2006 census)
Colleges: College of The North Atlantic in Happy Valley, Goose Bay
Other: Cartwright Public Library Eagle River Literacy Office

Health Services
Community Clinic (Labrador Grenfell Health)
Staff: 1 Regional Nurse II, 1 Regional Nurse I, 1 Public Health Nurse who travels to Black Tickle as well, 1 full and 1 half-time Personal Care Attendant, 1 Child Youth and Family Services Social Worker.
A physician visits every six weeks.
A dentist travels to the clinic periodically.

Community Safety
- Policing: Royal Canadian Mounted Police (with policing to the community of Black Tickle periodically)
- Court services: Circuit Court located at Cartwright Hotel, Airport Road. 1 judge serves 12 days a year.

Healthy Child Development:
Southern Labrador Family Centres Inc.
Programs: Baby Steps (0-18 Months)
          Drop-In (0-6 years)
          Toddlers Together (18 Months-3 years)
          Happy Healthy Me (4-6 years)
          School Readiness (4-years)
          Our Night Out (7-12 years)
Physical Environment and Infrastructure

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<td>Seniors home</td>
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Transportation

- Labrador Airways:
  - Airstrip, with flights along the coast 2 days/week (Tuesdays & Thursdays)

- CAI Nunatsiavut Marine:
  - Weekly ferry service between Cartwright, Goose Bay, Rigolet and the north coast. Operates June to November pending ice conditions.

- Trans Labrador Highway: Route 510

Businesses

- Cartwright Hotel
- Northside Motel
- Brenda’s Bed and Breakfast
- Harbourview B & B
- Mealy Mountain Gallery
- Pardy’s Store
- Vicki’s Craft Corner
- Cartwright Mug-Up
- Dewy’s Gas Bar
- Cartwright Building Supplies
- Odd’s and Ends
- In Bloom
- Coastal Computer Consulting
- Eagle River Credit Union
- Experience Labrador (Seasonal)
- Northern Store

Government and Service Agencies

- NunatuKavut Employment Assistance Services
- Industry Trade and Rural Development: Office Located in Goose Bay
• Child Youth and Family Services: Through Labrador Grenfell; travels to the community of Black Tickle periodically.

• Development Associations: Southeastern Aurora Development Corporation

• Department of Forest Resources & Agrifoods

• Eagle River Credit Union
Paradise River

Background

The community of Paradise River was established in 1775 by George Cartwright. The town was originally recognized as the hub of Sandwich Bay. The people of Paradise River were involved in the cod and salmon fishery in the summer months, and fur trapping and hunting in the winter. Today, Paradise River is known as a very scenic community with an abundance of wildlife, fish, and forestry potential. The community is currently comprised of only 15 individuals, all of them over age 50.

Governance

Municipal: None

Provincial riding: Cartwright –L’Anse Au Clair District

Federal riding: Labrador

Aboriginal: NunatuKavut

Demographics

Total population: 15

Employment & Working Conditions

Most employment in the community today involves the operation of small local sawmills, or as guides to fishing and hunting camps on the Eagle River.

Physical Environment and Infrastructure

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Social Support Network

**Churches:** Closest Church is in Cartwright, 42kms

**Clubs:** None

**Supports for seniors:** None

**Education, Literacy and Training**

There are no schools in the community; note that the population is all in the 50+ age group. The closest education facilities are located 42km away in the community of Cartwright.

**Health Services**

Labrador Grenfell Health serves Paradise residents through the community of Cartwright.

[Cartwright clinic is staffed with 1 Regional Nurse II, 1 Regional Nurse I, 1 Public Health Nurse, 1 full and 1 half time Personal Care Attendant, 1 Child, Youth and Family Services Social Worker. A physician visits Cartwright every six weeks. A dentist travels to the clinic in Cartwright periodically.]

**Community Safety**

- Policing: Royal Canadian Mounted Police Detachment (Located in Cartwright, with 3 officers)

- Court services: Circuit Court Location Cartwright Hotel, Airport Road. 1 judge serves 12 days a year.

**Healthy Child Development**

No children reside in the community.

**Transportation**

- Trans Labrador Highway (Route 510)

**Businesses:**

- No businesses currently operate in Paradise River

**Government and Service Agencies**

- No government offices operate out of Paradise River
Background
The community of Black Tickle is located on the Island of Ponds, and was founded in the mid-nineteenth century by a group of British seamen who had jumped ship. In 1865, naval commander Captain Hood reported on the population and fishing catches from Battle Harbour to Red Island in Labrador. One of the largest establishments of that time was Black Tickle. The mainstay of the community is still fishing.

Governance
Municipal: Local Service District
Provincial riding: Cartwright-L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics
Total population: 178

Employment & Working Conditions
Major Employers: Labrador Sea Products Inc.—Crab Plant (seasonal). Closure of this plant was announced in May 2012.

Social Support Network
Churches: The Good Shepherd - Roman Catholic Church (travelling Priest)
Anglican Church serves from Cartwright with periodic services to Domino
Programs: Junior Canadian Rangers, Canadian Rangers Patrol, 22 members (5 female, 17 male)
Supports for seniors: None

Education, Literacy and Training
School: St. Peter’s School (all grades).
Student Enrollment: 28 (2009 Annual Report)
Number of teachers: 5
Graduate rate: 44.4% have a high school diploma (2006 census)
Colleges: College of the North Atlantic in Goose Bay
Adult Basic Education programs: College of The North Atlantic in Goose Bay

Community Access Program: St. Peter’s School

Health Services
Community Clinic (Labrador Grenfell Health)
Staff: 1 Regional Nurse, 1 Personal Care Attendant, 1 Maintenance Repair Worker;
Public Health Nurse visits from Cartwright every 6 weeks.
Dentist visits periodically

Community Safety
Policing: Royal Canadian Mounted Police (traveling from Cartwright periodically)
Court services: Circuit Court located at Cartwright Hotel, Airport Road, 1 judge for 12 days a year.

Transportation
• Airstrip, with flights along the coast 2 days a week (Tuesday & Thursday; service only to Goose Bay & not elsewhere on the south coast)
• CAI Nunatsiavut Marine weekly ferry service between Cartwright, Goose Bay,
  Rigolet and the North Coast. Operates June to November pending ice conditions.
• Biweekly freight service on cargo boat operating between Lewisporte, Black Tickle, Goose Bay, and the north coast.
• No Road Connection

Businesses
- No existing hotel/motel
- T & S Variety (Convenience Store)
- L & K Enterprise (Convenience Store)
- Dyson Enterprise (Convenience store)
- Labrador Sea Products

Government & Service Agencies
There are no government services operating in Black Tickle.

Healthy Child Development
Southern Labrador Family Centers
Drop & Play (ages 0-12) Baby Steps (0-18 months) Toddlers Together (18-36 months)
Our Night Out (ages 7-12) Adult Night Out (parents/caregivers) Prenatal (Pregnant Moms)
School readiness (preschool) JR Caregiver night (13 +) Junior Night Out (ages 3-6 yrs)
Mud Works (ages 2-4) Magic Suitcase (ages 2-5 yrs)
Physical Environment and Infrastructure

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Recreation facilities and programs: Biggest Loser Group (3 times a week)
Norman Bay

Background

The community of Norman Bay was a winter settlement for the fishing stations of Snug Harbour and Venison Tickle. When southeast Labrador fishing stations were encouraged to Resettle in the 1960s, the Ward family at Snug Harbour resisted the pressure to move to Charlottetown or another larger community, and instead made Norman Bay their home. The Wards were later joined by one or two other families. This is why the Norman Bay population is mostly made up of Wards.

Norman Bay lies in an extension of Martin Bay, approximately 30 km northeast of Charlottetown. The community is reliant on Charlottetown for most services, including postal, air, marine, and health services.

Norman Bay can be considered one of Labrador’s most rural communities. Transportation to and from the community is challenging – there is no road connection or airport, so the community can only be accessed by boat or snowmobile. Residents in this area have long advocated for a better system of transportation to their community. However, visitors who make the effort to get there are rewarded with an authentic experience of small town life in a Labrador fishing village.

Governance

Municipal: Local service district

Provincial riding: Cartwright-L’Anse Au Clair District

Travelling by snowmobile in Norman Bay. Courtesy of Aimee Chaulk.
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics
Total Population: 48 (2006 census)
17 dwellings

Employment & Working Conditions
Major Employer: Fishery (e.g., crab, scallop)
Many residents live seasonally in Charlottetown to work in the Shrimp Plant there.

Social Support Network
There are no social clubs or facilities in Norman Bay.

Education, Literacy and Training
School: Raymond Ward Memorial.
Enrollment 2008-2009: 14
Number of teachers: 2

Health Services
A community building is used for periodic visits by the community clinic nurse from Charlottetown. Most medical services are provided in Charlottetown.

Community Safety
There is no police presence in Norman Bay.
Nearest RCMP station is in Mary’s Harbour.

Court services: residents must travel to Port Hope Simpson.

Healthy Child Development
There are no preschool programs or any type of programs for children under school age.

Transportation
• Ferry service between Norman’s Bay-Charlottetown runs several times a week. Operates June to November pending ice conditions
• Connected to nearby communities by snowmobile trail between January and April.
• During ‘spring break up and ‘fall freeze up’, the provincial government provides

Physical Environment and Infrastructure

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a helicopter service approximately twice per week so residents can get in and out of the community for medical reasons, to pick up groceries, etc.

**Businesses**
No businesses currently operate in Norman Bay

**Government & Service Agencies**
There are no government services in Norman Bay. Services are obtained in Charlottetown or other communities on the coast.
Charlottetown

Background
Charlottetown first existed as “Old Cove”, a winter place for summer fishing stations. Charlottetown was selected as a permanent settlement in the 1950s by Benjamin Powell Sr. and Clarence Perry. They were interested in establishing medical, educational and religious services for their families. Old Cove was renamed Charlottetown by Mr. Powell in hopes that it would become the capital of the bay, as Charlottetown is the capital of Prince Edward Island. This same Benjamin Powell Sr. wrote many books about life in Labrador. He is a well-known Labrador author and has been honored with the Order of Canada. In 2001, the Labrador Fishermen’s Union Shrimp Co. Ltd. opened Labrador’s first-ever shrimp processing facility in Charlottetown.

Governance
Municipal: Town Council
Provincial riding: Cartwright-L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics
Total Population: 366

Employment & Working Conditions
• Major Employer: Labrador Fisherman’s
Union Shrimp Company (Shrimp Plant)

- **Other Employers**: Small businesses in the community, NunatuKavut Community Council

### Social Support Network

**Churches**: St. Michael and All Angels, Anglican Church
Calvary Temple, Pentecostal Church
Charlottetown Gospel Hall

**Programs**: There are two short-term programs currently being offered for youth and seniors in the community.

**Supports for seniors**: Short-term programs

### Education, Literacy and Training

**School**: William Gillett Academy

**Student Enrollment**: 74 (2009 Annual report)

**Number of teachers**: 9.75

**Colleges**: None

**Adult Basic Education programs**: None

### Health Services

**Community Clinic**.

**Staff**: 2.5 Regional nurses/Nurse Practitioners.

Equipped with an emergency room (with basic trauma, cardiac monitoring, and resuscitation equipment), dental suite, public health office, 2 holding beds, and a basic pharmacy.

Physician visits every six weeks.

Regular visits from dentists, public health nurses, behavior management specialists, and addictions counselors.

### Community Safety

**Policing**: Royal Canadian Mounted Police travel from Mary’s Harbour.

**Crime**: no data

**Court services**: Residents have to travel to Port Hope Simpson.

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Healthy Child Development

Southern Labrador Family Centres Inc.

**Programs:**
- Baby Steps 0-18 Months
- Drop-In 0-6 years
- Toddlers Together 18 Months-3 years
- Prenatal support (pregnant moms)
- Happy Healthy Me 4-6 years
- School Readiness 4-years
- Our Night Out 7-12 years

Transportation

- Airstrip, with flights along the coast 2 days per week (Tuesday & Thursday)
- Ferry service between Port Hope Simpson-William’s Harbour-Norman’s Bay-Charlottetown; Operates June to November pending ice conditions
- Connected to the Trans Labrador Highway, open year-round
- Connected to nearby communities by ski-doo trail between January and April

Businesses

- BW Powell Ltd
- Changing Season Creative Designs
- Little John’s Take-out
- Marg’s Standards Formation Hair Salon
- Labrador Choice Foods LTD
- Labrador Retail Outlet LTD
- Marilyn’s Creative Sewing
- Puddister Shipping Ltd.
- Wentzell’s Take-Out & Restaurant

Government & Service Agencies:

Innovation, Trade and Rural Development Field Office
Economic Development Officer
Child Youth and Family Services – closest office in Mary’s Harbour
NunatuKavut Employment Assistance Services

**Zonal Board:** Main office located in Port Hope Simpson
Human Resources Labour & Employment – closest office is Mary’s Harbour

**Labrador Aboriginal Training Partnership:** Field Worker;
Pinsent’s Arm

Background

Pinsent’s Arm historically served as the winter place for the fishing communities of Square Islands, Triangle and other stations at the mouth of St. Michael’s Bay. It was settled permanently in the late 1950s. The community is located on the south side of St. Michael’s Bay, about 20kms southeast of Charlottetown. It is believed that the community of Pinsent’s Island to the east was named for an early trader on the Labrador coast, Andrew Pinson. Pinsent’s Arm relies on Charlottetown for essentially all of its service needs, such as schooling, grocery stores, postal services and medical services.

Governance

Municipal: local service district
Provincial riding: Cartwright-L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics
Total Population: 54

Employment & Working Conditions

Major Employer: Labrador Fisherman’s Union Shrimp Company (Whelk Plant)

Almost all residents of Pinsent’s Arm who are not seniors or children work in the Whelk Plant. Operates from June to September

Social Support Network

Social Clubs:
Dart League
Cards
Community Bingo
Community Suppers

Education, Literacy and Training

School: Students from Pinsent’s Arm travel 25 km to Charlottetown to attend school.

Health Services:

Pinsent’s Arm residents travel to Charlottetown

St. Michael’s Bay. Courtesy of Melita Paul.
for all medical needs (clinic visits, public health, filling prescriptions, etc.)

**Community Safety**
Policing: RCMP travel from Mary’s Harbour.

Court services: Residents have to travel to Port Hope Simpson

**Healthy Child Development:**
There are no programs for children under school age in Pinsent’s Arm; they have to travel to Charlottetown to attend these programs.

**Physical Environment and Infrastructure**

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**Transportation**
Trans Labrador Highway, Route 514.

**Businesses**
Labrador Fisherman’s Union Shrimp Company
Plant (Seasonal)

**Government & Service Agencies**
There are no government services in Pinsent’s Arm. Residents access services in Charlottetown or other communities on the coast.
William’s Harbour

Background

William’s Harbour is believed to have been settled prior to the 1840s by the family of an Inuk named Samuel Kibenook (now spelled Kippenhuck), who was later joined by his son-in-law William Russell. Until the late 1970s, William’s Harbour was used only as a summer fishing station for nearby Rexon’s Cove or Port Hope Simpson. William’s Harbour is located on the south side of Granby Island in Alexis Bay. It is accessible by boat and air in the summer and by snowmobile during the winter freeze-up. William’s Harbour is the gateway to Gilbert Bay, which has been designated a Marine Protected Area. A genetically and geographically distinct population of Atlantic cod, known as Golden Cod, live in the Gilbert Bay area.

Governance

Municipal: local service district
Provincial riding: Cartwright-L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics

Total Population: 59 (2006 census)

Employment & Working Conditions

Major Employer: The fishery (crab, scallop & whelk)

Social Support Network

There are no social clubs or facilities in William’s Harbour

Education, Literacy and Training

Schools: William’s Harbour School was shut down June 2010
Colleges: none

Health Services
Community clinic nurse visits from Port Hope Simpson periodically.
For medical emergencies residents must travel to Port Hope Simpson
Residents must travel to the clinic in Port Hope Simpson to visit dentists, public health nurses, behavior management specialists, and addictions counselors.

Community Safety
Policing: Royal Canadian Mounted Police travel from Mary’s Harbour.
Court services: Residents have to travel to Port Hope Simpson.

Healthy Child Development
There are no preschools or other programs for children.

Transportation
Ferry service between William’s Harbour-Port Hope Simpson and Charlottetown runs several times per week. Operates June to November pending ice conditions
Connected to nearby communities by snowmobile trail between January and April.
There is an airport – one flight arrives each week; this flight also delivers the mail

Businesses
Freeman Russell & Sons

Government & Service Agencies
There are no government services in William’s Harbour. Residents access services in Port Hope Simpson or other communities on the coast.

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Port Hope Simpson

Background
Port Hope Simpson was founded in 1934 as a logging camp and has since become the largest community in southeastern Labrador. A saw-mill and town site were built along the south side of Alexis River in 1934, and the community was named after the Commissioner of Natural Resources, Sir John Hope Simpson. The logging station hired several hundred loggers from nearby communities, and unemployed men were brought from the island of Newfoundland.

Governance
Municipal: Town Council
Provincial riding: Cartwright-L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics
Total Population: 500

Employment & Working Conditions
Major Employer: Labrador Choice Seafoods Shrimp Plant (many people drive from Port Hope Simpson to Charlottetown during the season to work)
Other Employers: Service Industries (Grocery Stores, Convenience Store, Restaurants, Hotel)

Social Support Network
Churches: St. Andrew the Apostle, Anglican Church
Calvary Pentecostal Tabernacle
Clubs: Junior Rangers, Canadian Rangers, Biggest Loser weight loss group, men’s and women’s church groups, Darts Club
Supports for seniors: 50+ club
Education, Literacy and Training

Schools: DC Young School

Student Enrollment: 75 (2009 Annual report)

Number of teachers: 10.75

Colleges: College of the North Atlantic Learning Centre
Currently offering an Office Administration Course

Health Services

Community Clinic (Labrador Grenfell Health)

Staff: 3 Regional nurses/nurse practitioners, 1 public health nurse, 1 behavior management specialist, and 1 social worker (CYFS).

Equipped with an emergency room (with basic trauma, cardiac monitoring, and resuscitation equipment), dental suite, public health office, 2 holding beds, and a basic pharmacy.

Labrador South Ambulance Service

A dentist visits the community every six weeks.

A doctor travels in periodically.

Community Safety

Policing: Royal Canadian Mounted Police travel from Mary’s Harbour.

Court services: Provincial Circuit Court – 11 days per year

Healthy Child Development

Southern Labrador Family Centres Inc.

Programs:

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Transportation

- Airstrip, with flights along the coast 2 days per week (Tuesday & Thursday).
- Ferry service between Port Hope Simpson-William’s Harbour-Norman’s Bay Charlotte-town. Operates June to November pending ice conditions;
- Connected to the Trans Labrador Highway, open year-round.
- Connected to nearby communities by Ski-doo trail between January and April.

Government & Service Agencies

Southeastern Aurora Development Corporation
Executive Director
Economic Development Officer

NunatuKavut Employment Assistance Services

NunatuKavut Fishery Guardian

Department of Forest Resources & Agrifoods

Labrador Grenfell Homecare Services
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## Businesses

- Alexis Hotel
- Campbell’s Place
- H&R Block
- JC Variety
- Joy’s Styles
- Cedar Scents & Engravables
- Midway Restaurant
- Moulder of Dreams
- Notley’s Store
- P&K Sports and Automotive
- Parrs Store
- P&B Supermarket
- Penny’s Pitstop
- Penny’s Store
- PHS Apartments
- Search Minerals Inc.
- Eastern Geophysics
- Altera Resources
- Port Hope Hardware and Building Supplies
- Russell’s RV Park
- S&N Wood Products
- Sampson’s Retail and Maintenance
- Strugnell Woods Work
- Woodward oil
- Budgell’s Equipment & Rental’s Ltd.
- Melvin’s Sawmill
St. Lewis

Background

Putlavamuit (St. Lewis) was an early area of Inuit habitation in southern Labrador. St. Lewis was depicted on maps as early as 1502-1503 as ‘Ilea de Frey Luis’. The French included it as part of the Eskimo Coast. As late as 1891 it was still referred to as the Eskimo Village and was much photographed by students and faculty of Bowden College. Because of its sheltered location and proximity to good fishing grounds and seal migration routes, St. Lewis was a prime fishing centre on the southeastern coast of Labrador for over 200 years. It was not only a wonderful place for fishing, but also a good place to construct small boats, and early establishments left crews to winter there for just this purpose. It is the most easterly permanent community on the North American mainland, and is one of the best locations on Labrador Coastal Drive to see icebergs.

Governance

Municipal: Town Council
Provincial riding: Cartwright-L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics

Total population: 210

Employment & Working Conditions

Major Employers:
Coastal Labrador Fisheries, crab plant (seasonal May- July). Closure of this plant was announced in May 2012.
Fishing Industry (seasonal May – Oct)

Social Support Network

Churches: Anglican Church, Pentecostal Church
Clubs: Anglican Church Women, Bible Study Group, Heritage Society.
Supports for seniors: 50+ club

Education, Literacy and Training

Schools: St. Lewis Academy
Student Enrollment: 37 (2009 Annual report)
Number of teachers: 7.25

Health Services

Community Clinic (Labrador Grenfell Health)
Staff: 2 regional nurses/nurse practitioners, 1 personal care attendant, 1 maintenance person
Dental services: regular visits throughout the year

Community Safety

Policing: Policing: Royal Canadian Mounted Police travel from Mary’s Harbour.
Crime: no data
Court services: Provincial Circuit Court – 11 days per year

Healthy Child Development

Staff from Southern Labrador Family Centre travel to St. Lewis once per month to hold activities for children.
Physical Environment and Infrastructure

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Transportation

**Labrador Airways:** Airstrip, with flights along the coast 2 days per week (Tuesday and Thursday)

Trans Labrador Highway (Route 513)

**Businesses**

- Brenda’s Cash-N-Carry
- Canada Post Corporation
- St. Lewis Enterprises
- Mangrove’s Store
- Strugnell’s Fishing Enterprises
- Coastal Fisheries Ltd

**Government & Service Agencies**

- Child Youth and Family Services: Located in Mary’s Harbour

*St. Lewis at sunset.*

Courtesy of Aimee Chaulk

*South Eastern Aurora Development Association: located in Port Hope Simpson*
Mary’s Harbour

Background
Mary’s Harbour was founded in the fall of 1930 (incorporated April 11, 1975). The community of Mary’s Harbour is located on the southern Labrador coast at the mouth of St. Lewis Inlet. Although the community dates back only to the 1930s, the local St. Mary’s River was the site of a salmon fishery dating back to the early 1780s. Mary’s Harbour prides itself on its natural beauty and extraordinary community spirit.

Governance
Municipal: Town Council
Provincial riding: Cartwright-L’Anse Au Clair District
Federal riding: Labrador
Aboriginal: NunatuKavut

Demographics
Total population: 417

Employment & Working Conditions
Major Employer:
Labrador Fisherman’s Union Shrimp Company (seasonal May-August)

Fishery: crab & shrimp (seasonal May-October)
Other local businesses and service agencies

Social Support Network
Churches: St. Mary’s The Virgin Church (active minister stationed)
Programs: Anglican Church Women
Supports for seniors: Battle Harbour Assisted Living Corporation has a seniors’ home that is equipped to take level 1 and 2 residents.

Education, Literacy and Training
Schools: St. Mary’s All Grade School
Student Enrollment: 91 (2009 Annual report)
Number of teachers: 11.25
Colleges: none
Adult Basic Education programs: Not offered in the community

Health Services
Community Clinic (Labrador Grenfell Health)
Staff: 3 nurse practitioners, 1 regional nurse, 1 social worker (who also serves other surrounding communities), 1 personal care attendant, 1 maintenance worker.
Addiction & mental health counselor
A physician visits every 6 weeks
A dentist travels to the clinic every 6 weeks

Community Safety
Policing: Royal Canadian Mounted Police Detachment (With policing to the surrounding communities periodically)
Crime: no data
Court services: Residents have to travel to Port Hope Simpson

Healthy Child Development
Southern Labrador Family Centre
Programs:
Baby Steps (0-18 Months)
Drop-In (0-6 years)
Toddlers Together (18 Months-3 years)
Prenatal Support (expecting moms)
Happy Healthy Me 4-6 years
School Readiness (4-years)
Our Night Out (7-12 years)
## Physical Environment and Infrastructure

<table>
<thead>
<tr>
<th>Services</th>
<th>Yes/No</th>
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</thead>
<tbody>
<tr>
<td>Garbage pick-up</td>
<td>Y</td>
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<tr>
<td>Recycling program</td>
<td>Y</td>
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<td>RCMP</td>
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<td>Grocery store(s)</td>
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<tr>
<td>Seniors home</td>
<td>Y</td>
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</table>

**Seniors home:** Battle Harbour Assisted Living Corporation (Harbourview Manor)

**Trans Labrador Highway (Route 510)**

**Transportation**

Labrador Airways:

Airstrip, with flights along the coast 2 days per week (Tuesday & Thursday)

**Mary’s Harbour. Courtesy of Aimee Chaulk.**
### Businesses
- Acreman’s Store  - JL Investments  - River Lodge Hotel
- Canada Post Corporation  - Noel Lodgings  - Rumbolt’s General Store Consulting
- Eagle River Credit Union  - Mary’s Harbour Craft Shop  - Simms Cash-N-Carry
- Harbourview Restaurant

### Government & Service Agencies
- NunatuKavut Employment Assistance Services located in St. Lewis
- Industry Trade and Rural Development: Office Located in Charlottetown
- Child Youth and Family Services located in Port Hope Simpson
- Battle Harbour Regional Development Office
- Zonal Board office located in Port Hope Simpson
- Eagle River Credit Union Bank
- Human Resources Labour & Employment
- Department of Fisheries & Oceans
- Royal Canadian Mounted Police station
Lodge Bay

Background

Lodge Bay got its name from Ranger Lodge, which was settled by Captain George Cartwright in the 17th century. Ranger was the name of his first ship and Lodge was the name of their homes in England at that time. The settlement later became the winter home of fishermen from Conception Bay who had summer fishing stations off Cape Charles and the Camp Islands.

Governance

Municipal: Local Service District

Provincial riding: Cartwright- L’Anse Au Clair District

Federal riding: Labrador

Aboriginal: NunatuKavut

Demographics

Total population: 98

Employment & Working Conditions

Major Employer:
Labrador Fisherman’s Union Shrimp Company in Mary’s Harbour (seasonal May-August)

Fishery: crab & shrimp

Social Support Network

Churches: St. John the Baptist (Battle Harbour Parish) Anglican website

Clubs: Anglican Church Women

Supports for seniors: Battle Harbour Assisted Living Corporation

Education, Literacy and Training

Schools: Students attend St. Mary’s All Grade School in Mary’s Harbour, traveling 7km by bus.
Colleges: none

Health Services
Labrador Grenfell Health: nearest community clinic located 7km away in Mary’s Harbour

Community Safety
Policing: RCMP detachment located in Mary’s Harbour
Court services: Residents have to travel to Port Hope Simpson

Healthy Child Development
Southern Labrador Family Centres, located in Mary’s Harbour

Physical Environment and Infrastructure

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Seniors home: Battle Harbour Assisted Living Corporation located in Mary’s Harbour, 7km away.

Transportation
Trans Labrador Highway (Route 510)
Nearest airport: Mary’s Harbour, 7km away.
## Appendix E: Community-Based Needs Assessments

<table>
<thead>
<tr>
<th>Project, Location and Date</th>
<th>Organizations Involved</th>
<th>Purpose/Need</th>
<th>Methods</th>
<th>Outcomes</th>
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<tbody>
<tr>
<td><strong>Canadian Aboriginal Communities: A Framework for Injury Surveillance (Auer &amp; Anderson, 2001a &amp; 2001b)</strong>&lt;br&gt;A Canadian reserve-based community&lt;br&gt;1990s (published in 2001)</td>
<td>Led and directed by university-based researchers in partnership with community stakeholders (primarily the Band Council)</td>
<td>To develop a surveillance system that was culturally relevant, acceptable, and owned by the target population and met the specific data and data collection requirements of the community</td>
<td>Reviewed medical service patterns for injured patients, held national focus groups to establish consensus on a conceptual framework to guide development. Community focus groups established safeguards for confidentiality, protocols for data handling and storage, training requirements, piloted data collection, and developed recommendations for standardized community reports.</td>
<td>Focus groups identified that the terms of control of data should be set by community stakeholders while it was observed that surveillance systems usually remain distinct from the communities of interest. This project developed an “Aboriginal Injury Surveillance Model” that begins with communities taking ownership and management of their injury surveillance data.</td>
</tr>
<tr>
<td><strong>Health Assessment with Aboriginal Grandmothers in Saskatchewan (Dickson &amp; Green, 2001)</strong>&lt;br&gt;Saskatoon, Saskatchewan, Canada&lt;br&gt;1990s (published 2001)</td>
<td>The project was a part of a program being offered at a community health clinic; the impetus for the assessment was as part of the funding requirements. However, after the initiation of the assessment, all decisions were made by the grandmothers who conducted the assessment with the assistance of external researchers</td>
<td>To create knowledge and to create a means for the grandmothers to empower themselves</td>
<td>Utilized a Participatory Action Research(^3) approach. The assessment fell into four stages: negotiation and dialogue; orientation; joint research; and joint action; all of which were accompanied by phases of reflection. All data collected was qualitative through individual interviews; participant observation; recording of activities; and documentation of field notes.</td>
<td>In addition to the production of new knowledge, the assessment demystified research for the participants and raised awareness of issues not previously questioned.</td>
</tr>
</tbody>
</table>

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\(^3\) “inquiry by ordinary people acting as researchers to explore questions in their daily lives, to recognize their own resources, and to produce knowledge and take action to overcome inequities, often in solidarity with external supporters” (Dickson & Green, pg. 472)
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<td>Evaluation of Maori Community Programs on Drinking and Driving in New Zealand (Barnes, 2000)</td>
<td>Initiated by the Alcohol and Public Health Research Unit (APHRU) and was developed with extensive consultation with the Maori community through two community trusts (Te Whanau o Waipareira Trust Board and Huakina Development Trust) and the hiring of a local coordinator</td>
<td>APHRU documented higher rates of alcohol-related collisions among the Maori population and the purpose of this project was to develop health promotion programs aimed at reducing these rates</td>
<td>Two Maori trusts each developed programs in consultation with a local coordinator, who provided evidence around effective interventions. The evaluation was carried out by a Maori researcher with close ties to the community. The evaluation informed aspects of program design and development. In addition to a literature review, the evaluation included key informant interviews, participant observation, small group discussions, one-on-one interviews, and environmental scans. A feedback process was designed to include local Maori in both the programs and evaluation.</td>
<td>Success of the project and evaluation was attributed to the communities taking control from the development stages through to the end of the project</td>
</tr>
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<tr>
<td>West Kitikmeot Slave Study Society Community-Based Monitoring Project (Waldrum, Herring &amp; Young, 2006)</td>
<td>Undertaken by the Lutsel K’e Dene First Nation</td>
<td>The purpose of this study was to meaningfully involve community members in understanding and documenting changes in the health of the community. It was undertaken in reaction to plans surrounding a local mineral resource development</td>
<td>Three phases: 1) ideas gathering including Chipewyan terminology for research-related concepts; 2) developing themes and indicators of community health through open-ended home visits with 100 households; 3) a four-step process for monitoring the identified indicators. Methodology included training and employment of community members; communication and working relationships with band membership and leadership; and broad participation and communication</td>
<td>Information gathered was broken down into 12 indicators: Employment, traditional food consumption, youth goals for education/employment, healing, housing, impacts of resource development on the land and water, knowledge of traditional values, cultural programs, togetherness, traditional knowledge and skills (Caribou harvesting), traditional knowledge and skills (land use), and traditional knowledge and skills (drumming). Comparisons were made and changes noted of each indicator over time; the results were used in community planning activities.</td>
</tr>
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<td>Organizations Involved</td>
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<tr>
<td>Community Voices Within Saskatoon’s Inner-City Neighbourhoods: Capacity and Needs Assessment (Anderson &amp; Spence, 2008)</td>
<td>Conducted by The Bridges and Foundations Project on Urban Aboriginal Housing, in partnership with local universities and academics (including the First Nations University of Canada), provincial Aboriginal organizations, the local housing industry, and the City of Saskatoon with funding from SSHRC and Canada Mortgage and Housing Corporation.</td>
<td>To identify gaps, barriers, fragmentation and duplication of services in the community related to Aboriginal housing capacity and needs</td>
<td>The assessment surveyed local agencies and service providers as well as 1000 inner-city residents. Additionally, several focus groups were conducted</td>
<td>Results identified that top issues for community members were different then those perceived by local policy-makers</td>
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<td>Saskatoon, Saskatchewan, Canada 2000s (originally published in 2004)</td>
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<td>Labrador Metis Nation Living Life Preventing, Diabetes Needs Assessment (LMN, 2003)</td>
<td>Labrador Metis Nation</td>
<td>To understand the demographics and health of the population, in order to inform the Living Life, Preventing Diabetes Program</td>
<td>As outlined above, a survey was conducted by the Labrador Metis Nation with one third of their membership who were age 18 or older</td>
<td>A wide range of health and diabetes-related information was collected</td>
</tr>
<tr>
<td>Southeast coast of Labrador, Canada</td>
<td>Published 2003</td>
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<tr>
<td>Community Health Indicators Project (Giles, Haas, Sajna &amp; Findlay, 2009; Grafton, 2001)</td>
<td>Undertaken by the Mohawk Council of Akwesasne, the Miawpukek First Nation, and the Institute of the Environment at the University of Ottawa</td>
<td>To develop community health indicators based on knowledge and valid requirements of the communities</td>
<td>A series of consultative processes were undertaken including interviews and a literature review – results were validated with a door-to-door survey</td>
<td>Although differences were seen between communities, key determinants of health were identified to be used as indicators.</td>
</tr>
<tr>
<td>Akwesasne, Quebec and Conne River, Newfoundland and Labrador</td>
<td>2005/2006</td>
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<td>First Nations Regional Longitudinal Health Survey (Harvard Project on American Indian Economic Development, 2006)</td>
<td>First Nations Information Governance Committee, National Aboriginal Health Organization, Assembly of First Nations, and a variety of regional partners</td>
<td>To control and provide scientifically and culturally validated information to support decision-making, planning, programming and advocacy; and to support First Nations research capacity and control</td>
<td>A national comprehensive health survey delivered on-reserve across Canada in 1999, 2002/2003, and 2009/2010</td>
<td>Results of the survey have been used to inform policy and programming locally, regionally, and nationally. The survey has also increased research capacity within First Nations communities and firmly held to the OCAP principles.</td>
</tr>
</tbody>
</table>

**Photo Credits**

Title pages:

Chapter 1: Cape Charles. Courtesy of Leila Coates.
Chapter 2: Charlottetown. Courtesy of Aimee Chaulk.
Chapter 3: Family, Cartwright area, 1950s or 1960s. Courtesy of Them Days.
Chapter 4: William’s Harbour. Courtesy of Billy Larkham.
Chapter 5: Mary’s Harbour. Courtesy of Aimee Chaulk
Chapter 6: William’s Harbour. Courtesy of Billy Larkham.
Chapter 7: Cape Charles. Courtesy of Leila Coates.

Chapter 8: Boil-up. Courtesy of Margaret Pardy.
Chapter 9: White Hills. Courtesy of Melita Paul.
Chapter 11: Cameron Campbell Oram and Kobe Paul practising snowshoeing. Courtesy of Melita Paul.
Chapter 12: Black Tickle. Courtesy of Aimee Chaulk.

Appendices: Courtesy of Margaret Pardy.

Front cover photos, from top, courtesy of: Leila Coates, Leila Coates, Margaret Pardy, Billy Larkham, Aimee Chaulk, Leila Coates, Melita Paul (inukshuk left leg).