Guiding Health Promotion Efforts with Urban Inuit

A Community-specific Perspective on Health Information Sources and Dissemination Strategies

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ABSTRACT

Objective: To develop a community-specific perspective of health information sources and dissemination strategies of urban Inuit to better guide health promotion efforts.

Methods: Through a collaborative partnership with the Tungasuvvingat Inuit Family Resource Centre, a series of key informant interviews and focus groups were conducted to gather information on specific sources of health information, strategies of health information dissemination, and overall themes in health information processes.

Findings: Distinct patterns of health information sources and dissemination strategies emerged from the data. Major themes included: the importance of visual learning, community Elders, and cultural interpreters; community cohesion; and the Inuit and non-Inuit distinction. The core sources of health information are family members and sources from within the Inuit community. The principal dissemination strategy for health information was direct communication, either through one-on-one interactions or in groups.

Conclusion: This community-specific perspective of health information sources and dissemination strategies shows substantial differences from current mainstream models of health promotion and knowledge translation. Health promotion efforts need to acknowledge the distinct health information processes of this community, and should strive to integrate existing health information sources and strategies of dissemination with those of the community.

MeSH terms: Inuit; urban population; urban health; health services research; health promotion; knowledge translation

La traduction du résumé se trouve à la fin de l'article.

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In the 2001 Canadian Census,¹ 45,070 people (0.2% of the total Canadian population) identified themselves as Inuit. Approximately one quarter of Inuit live in urban areas.² Numerous recent publications have attested to a significant disparity between the health of Inuit, and Aboriginal people in general, and that of the general Canadian population.³⁻⁸ Inuit Tapiriit Kanatami⁹ reports that life expectancy among Inuit is significantly lower and rates of suicide for Inuit are higher than those of the general Canadian population. The health of Inuit infants is also grave, with higher rates of infant mortality, respiratory diseases, meningitis tuberculosis, and other infections.⁸

Researchers and practitioners have developed an understanding of health care delivery to Inuit in rural areas.^{10,11} Less is known about the 25% of Inuit who are living in urban areas and potentially are able to access local health care services. Urbanization may mean that the health care needs of Inuit are changing.^{12,13} Regrettably, there is little evidence that changes have taken place in health organizations to better serve the changing population of Inuit, as there is a paucity of urban Inuit health initiatives among national stakeholders in Inuit health.¹⁴

If researchers and clinicians are to provide effective and appropriate health information and services for urban Inuit, a rudimentary understanding of their health information sources and strategies is a prerequisite. This understanding can be gained through a culture- and community-specific assessment of health care processes.^{15,16} It is through community collaboration that a solid understanding of health information processes for urban Inuit will be achieved, to subsequently guide health promotion efforts. The current study examines health information sources and dissemination strategies within an urban Inuit community. The ultimate objective of this study is to contribute to the development of a community-specific perspective on health information sources and dissemination strategies.

METHOD

Participating community

Tungasuvvingat Inuit is an Inuit-run community-based counselling and resource centre which aims to empower

and enhance the lives of Inuit residing in Ontario. It has been operating in Ottawa since 1987 and offers a variety of community-based counselling and resources, including the Inuit Family Resource Centre (IFRC). The IFRC, where the study was based, houses a pre- and post-natal program as well as the Child and Family programs (community action program for children) and receives funding from Health Canada. The Ottawa-Hull region is home to the third largest urban Inuit population in Canada with a reported population of 450 Inuit.¹ Tungasuvvingat Inuit reports that the number of Inuit in Ottawa is actually closer to 1,000 persons,¹⁷ which would make it the largest urban community in Canada. Ottawa also serves as the tertiary health referral centre for Iqaluit and surrounding areas in the Inuit territory of Nunavut.

Community members who participated in the study included a purposive sample of health directors, front-line health workers, traditional knowledge experts, Elders, youth, and parents who were recruited by community research team members. We define "Elder" as an Inuk person with an area of expertise in traditional knowledge that is recognized by the Inuit community. Twenty community members participated in the first focus group and twenty in the second. Through consultation with the community research team, the composition of the focus groups was constructed to reflect a profile of the community. The sample included individuals of varying ages (18 years to over 65 years) and individuals who lived in Ottawa for six months or more. The group was largely comprised of females, which is generally reflective of the composition of the Inuit community in Ottawa. Five health information stakeholders (health service providers and Elders) from the community took part in individual key informant interviews.

Procedure

The approach drew on current successful models and recommendations for community-based participatory Indigenous health research.¹⁸⁻²¹ Tungasuvvingat Inuit was approached by the principal investigator (JKS) to form a research partnership for the project. With the community representative, a draft community research agreement was prepared explicitly addressing:

the project's governance; community expectations and benefits; ownership, control, access, and possession of information; and dissemination of project results. The community's governing body ratified the agreement. The community representative identified community research team members, who subsequently assisted with recruitment, data collection, data analysis, synthesis, and approval of the study results. The community research team comprised three staff from the Inuit Family Resource Centre. This study was approved by the Health Sciences and Science Research Ethics Board at the University of Ottawa.

Data collection consisted of two parts: 1) initial focus group for gathering of health information and 2) five key informant interviews. A second focus group was for corroboration of results. The following questions were presented to participants for discussion during the first focus group and key informant interviews:

1. If you wanted information on a physical, mental, emotional, or spiritual health issue, where or to whom would you go in this community?
2. How would you decide if the health information that you received was good or not?
3. What kinds of health information have you used in your day-to-day life and work over the past week?
4. If you wanted to spread a health message in this community, how would you do it?

The first focus group and interviews were all recorded and transcribed for coding purposes. A qualitative descriptive case study design was used, with the community as the unit of analysis.^{22,23} Data analysis used a mixed iterative editorial and immersion/crystallization organizational approach.²⁴ Initially, the coding was completed by two trained academic researchers who listed the most poignant themes of the community's health information processes. The community research team also identified themes and a research team meeting was held to discuss and adapt themes, in order to synthesize them. Following this, the two academic researchers took these preliminary themes and classification systems and conducted a more detailed analysis of the transcripts. Afterwards, a second focus group was held to present the findings for community-

based corroboration and one minor change was made in response to comments by participants. Last, two members of the academic research team (KEM and CMM) reviewed the transcripts of the initial focus group and 5 key informant interviews and coded the presence of themes, health information sources, and dissemination strategies. Inter-rater agreement was 74%. Disagreements were discussed and evaluated for inclusion in the analysis.

RESULTS

A review of the transcripts revealed five themes related to health information processes.

"Inuit way of life is seeing or speaking"

Face-to-face interactions are important for Inuit; they believe that it is necessary to see someone in order to understand that person's health problems.

We Inuit know by seeing them. When a young woman says that they are ready to get a baby or into labour, they [Elders] say "Not yet"... They can predict if she's going to deliver now or later.

Health information is shared through stories. Female Elders provide key advice to their daughters, granddaughters, and other females in the community. Over time, women pass this knowledge on to their daughters who would eventually assume the role of Elders. In contrast, written material about a person's illness is not very useful for Elders unless it is translated into syllabics. In general, Inuit are disinclined to use written material; stating "*Papers are not really our thing*". However, a few participants commented that for a large urban environment, using written communication had some advantages.

Role of Elders in decision-making

Elders are at the foundation of Inuit oral traditions. Individuals consult Elders to confirm health information received from other sources. Elders' advice is commonly sought because of their experience.

When I was pregnant with my son, my first pregnancy, I was having lots of complications and I would, of course, go see my doctors and they would tell me that I don't have enough iron in me, that's why I am having this problem. So I would always go to my Elders first before I would go to the Health

TABLE I**Sources of Health Information**

Conceptual Classification	Source	Impact
Family	Family and extended family	5/6
Community: Inuit Community	Community Elders	5/6
	Local community health centre/family resource centre	4/6
	Community newsletters	2/6
	Conferences, Workshops	2/6
Community: Larger Aboriginal Community	Urban Aboriginal health access centre	3/6
	Community radio	3/6
	Aboriginal organizations	3/6
Community: General	Friends and informal community networks	6/6
	People with past/current experiences of illness	5/6
Society: Medical Systems (non-Aboriginal)	Family doctors	5/6
	Medical centres and hospitals	5/6
Society: Recent Medical Advances	E-mail/mail from other organizations, including Health Canada	3/6
	Tele-Health	1/6
Society: General Information	Pamphlets, posters, bulletin boards	5/6
	Magazines/books/clearinghouses	3/6
	Internet	2/6

Note. Impact represents proportion of transcripts (1 focus group and 5 key informants) within which this information appeared.

TABLE II**Dissemination Strategies**

Conceptual Classification	Strategy	Impact
Direct/Face-to-face	Word of mouth	6/6
	Storytelling by Elders	5/6
	Outreach workers	2/6
	Cultural interpreters	6/6
Discussion	Community meals/events	4/6
	Workshops/program presentations	3/6
Seeing/Reading/Hearing	Local radio	5/6
	Pictures/Posters	4/6
	Television/Videos	4/6
	Community newsletter/newspaper	4/6
Education	Local Aboriginal community organizations	6/6
	Schools	2/6

Note. Impact represents proportion of transcripts (1 focus group and 5 key informants) within which this information appeared. Each source of information (each of the 5 key informant interviews and 1 focus group) was given an equal weighting.

Centre and they would always find, they would always be right.

Medical and health care knowledge passes through families orally and Elders decide the appropriate context in which to share information. Despite significant geographic barriers between Inuit in Ottawa and Elders in the north, individuals in Ottawa commonly call Elders in the north to get information and advice. Individuals also reported that there appears to be increased evaluation of health care information received from both Elders and non-Inuit sources, especially by Inuit youth.

Community cohesion

All Inuit, regardless of geographic community of origin or immediate family rela-

tions, are seen as belonging to the larger Inuit community. This close connection allows messages to travel quickly within the community. Also, a sense of community is preserved over geographic barriers as reflected in the preserved role of Elders as knowledge holders.

As Inuit, whether you are in the same community or a different community from up North, you are in Ottawa, you are down here and if you see someone who is needy you help them, no matter if you are related or not.

Inuit and non-Inuit distinction

There is a sense of distinction between the Inuit community and the non-Inuit world. Inuit-specific services have the most cultural relevance, whereas services that are shared with First Nations may be perceived

as non-Inuit and less relevant. Knowledge or advice from Inuit, either family or community members, is most well received.

Cultural interpreters

Inuit report being more receptive to information delivered from other Inuit. However, few linguistic and cultural interpreters are available to the Ottawa Inuit community. This is particularly significant because Inuktitut-speaking Elders cannot transmit their knowledge to non-Inuktitut-speaking health professionals and community members without interpretation.

Sources of health information and dissemination strategies

Health information sources are presented in Table I and dissemination strategies are presented in Table II. Sources of health information are categorized according to an environmental conceptual framework.²⁵⁻²⁸ The core sources of health information are family members and sources from within the Inuit community. The next set of sources is from the larger Aboriginal community and other community members. The final set of sources is from medical community (non-Aboriginal) and general societal sources.

Dissemination strategies for health information centered on direct communication, through one-on-one interactions or in groups. Larger-scale dissemination strategies would involve written, audio, or video materials. Finally, education-based strategies were seen as originating largely from Aboriginal organizations, and to a lesser extent schools.

DISCUSSION

Previous research has examined the health care needs of Inuit in rural settings¹¹ and of Inuit travelling to urban areas for health care,²⁹ but not the health information processes within urban Inuit communities. The current study identified relevant themes and processes within the urban Inuit community in Ottawa. The major sources of health information are from within the Inuit community, principally through Elders, family, friends, staff of the Inuit Family Resource Centre, and family doctors. Additional sources of health information include Aboriginal and non-Aboriginal medical centres. Strategies for

dissemination included direct, one-on-one communication. This was seen as particularly effective given the cohesive community structure. The preferences for family and community information sources and direct communication dissemination strategies reflect the prevalent themes of health and well-being originating within, and being perpetuated by, the Inuit community itself.

This community-specific perspective of health information sources and dissemination strategies shows substantial differences from current mainstream models of health promotion and knowledge translation.³⁰ Compared to the model of *knowledge translation* put forth by the Canadian Institutes of Health Research, the results suggest a need for a direct link between the knowledge users (i.e., community members) and the knowledge products (i.e., publications). Typical knowledge products (i.e., pamphlets) may need to be replaced by information sources linked to Inuit oral, direct communication traditions (i.e., audiovisual recording). Furthermore, the knowledge users would need to be directly involved in the preparation and presentation of the knowledge. In light of the significant role Elders play as sources of health information, and as disseminators of the information, a considerable part of this process will involve working with already existing community structures. Health promotion efforts will need to acknowledge the distinct health information processes of this community, and should strive to integrate existing health information sources and dissemination strategies with those of the community.

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RÉSUMÉ

Objectif : Étudier des sources d'information sur la santé et des stratégies de diffusion de l'information dans la perspective d'une communauté inuite en milieu urbain pour mieux orienter les efforts de promotion de la santé.

Méthode : Par l'entremise d'un partenariat de collaboration avec le Centre de ressources pour la famille Tungasuvvingat Inuit, nous avons mené une série d'entretiens avec des informateurs clés et organisé des groupes de discussion afin de recueillir des données sur les sources précises d'information sur la santé, les stratégies de diffusion de cette information et les grands thèmes des processus d'information sanitaire.

Constatations : Les données recueillies ont permis de cerner différents types de sources d'information sur la santé et de stratégies de diffusion. Leurs grands thèmes étaient les suivants : l'importance de l'apprentissage visuel, des aînés de la communauté et des interprètes culturels; la cohésion communautaire; et la distinction entre Inuits et non-Inuits. Les sources d'information de base étaient des membres de la famille et de la communauté inuite. La principale stratégie de diffusion de l'information sanitaire était la communication directe, que ce soit dans le cadre d'entretiens individuels ou de séances en groupe.

Conclusion : Cette perspective communautaire des sources d'information sur la santé et des stratégies de diffusion de l'information montre qu'il existe des différences marquées par rapport aux modèles courants de promotion de la santé et de transmission du savoir. Les efforts de promotion de la santé doivent tenir compte des processus d'information distincts dans la communauté en question et tenter d'intégrer les sources d'information et les stratégies de diffusion existantes avec celles de la communauté.